“DROWNING IN SADNESS”: DISCOURSES AND LINGUISTIC FEATURES IN NARRATIVES OF LIVED EXPERIENCE WITH MENTAL HEALTH CONDITIONS

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Mielenterveyden haasteet ovat olleet ja ovat osittain edelleen tabustatuksensa vuoksi vaiettuja ja väärinymmärrettyjä aiheita. Globaalien haasteiden, kuten pandemian ja ilmastokriisin, ja verkkoviestinnän laajentumisen myötä mielenterveyteen liittyvät diskurssit ovat siirtyneet pääosin verkkoon. Perinteisesti mielenterveyden diskursseja on käsitelty pääosin kollektiivisilla, yhteiskunnallisilla tasoilla, kuten terveydenhuollon tai median näkökulmista.

Tässä tutkielmassa huomio kohdistuu yksilöiden kokemuksiin, sillä tutkielmassa tarkastellaan englanninkielisiä mielenterveyteen liittyviä diskursseja niiden yksilöiden näkökulmasta, joilla on omakohtaista kokemusta mielenterveyden häiriöistä. Tutkimusaineistona hyödynnetään kansainvälisen World Health Organization -järjestön vuonna 2022 julkaistua englanninkielistä mielenterveysraporttia, joka sisältää yksilöllisiä narratiiveja eletyistä kokemuksista mielenterveyden häiriöiden kanssa. Tutkimuksessa pyritään selvittämään millaisten diskurssien ja kielellisten piirteiden avulla yksilöt kuvailevat mielenterveyden järkkymisen kokemuksiaan. Tutkimusmenetelmänä on käytetty diskurssianalyysiä.

Analyysissa identifioitiin tutkimusdatasta neljä keskeistä diskurssia: epätoivodiskurssi, stigmadiskurssi, hoitodiskurssi ja selviytyjädiskurssi. Nämä diskurssit nousivat esiin useissa eri narratiiveissa. Yksilöt hyödynsivät narratiiveissaan myös erilaisia kielen piirteitä, kuten metaforia, vastakkainasettelua sekä abstraktiin viittaamista subjektina. Analyysin tukena tutkielmassa esitetään otteita eri narratiiveista.

Mielenterveyteen liittyvien diskurssien tutkiminen edistää mahdollisuuksia tarjota mielenterveyden häiriöiden kanssa eläville oikeanlaista tukea, työkaluja ja hoitomenetelmiä sekä ohjata diskursseja hyödyllisempään suuntaan haitallisen sijaan. Yksilöllisten narratiivien analysointi avartaa käsitystämme eri tavoista, joilla mielenterveyden järkkyminen manifestoituu yksilön kokemuksissa ja kommunikoinnissa. Tutkimus lingvistiikan näkökulmasta auttaa selvittämään, kuinka psykologista kipua ja elämää sen jälkeen kuvaillaan kielellisesti, mikä voi auttaa yksilöitä, terveydenhuollon ammattilaisia sekä yhteisöjä kasvattamaan tietoisuutta kokemusten yksilöllisyydestä ja madaltamaan kynnystä keskusteluun yhteiskunnan eri tasoilla.

Asiasanat – Keywords Mental health discourse, mental health linguistics, discourse analysis

Säilytyspaikka – Depository JYX

Lisätietoja – Additional information

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1 INTRODUCTION

> "When it comes to mental health, verbs are super weird. One of the weirdnesses of pain both physical and psychic, is that pain sort of evades language, like when we talk about physical pain, we might say it feels like a stab in the back or a pounding in our head. But that's what it's like not what it is.". [1]

The statement above is made by author John Green on a video on social media platform. The video is inspired by another platform user who has made a linguistics-related joke about how they do not in fact "struggle" with anxiety, but instead it comes to them quite easily (literallyjohngreen, 2022). On the video, Green explains how the lack of good language for certain experience results in isolation, because one cannot discuss the experience explicitly with others. Green proposes that the society collectively should aim for more accurate language to talk about pain. I was intrigued by the concept of how language is used to describe concepts regarding psychological pain, and therefore decided to direct my bachelor's thesis research on mental health discourses.

The openness and advocacy around mental health matters is a relatively recent phenomenon. Mental health discourses have gained new ground in recent years especially due to the cluster of societal issues, such as climate crisis and the global pandemic that put to test our endurance to withstand uncertainty and isolation. While there is plenty research on mental health discourse, the research has traditionally been conducted from a psychological or sociological perspective rather than a linguistic one. In recent years however, interdisciplinary approaches, like sociolinguistics or

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[1] literallyjohngreen, 2022

discursive psychology, have been progressively adopted and applied (Antón & Goering 2015; Gwyn 2002, p. 9).

In the context of health, individual voices are often dominated by the more prevalent discourses (Hamilton 2001), which appears to cause an imbalance in the epistemology of health. In their editorial, Antón & Goering (2015) advocate for and precedent conducting health discourse research with a focus on "patients' voices" instead of health professionals. Their focus is on chronic illnesses. Few research specifically dives into the discursive practices of individuals with lived experience of mental health conditions. Analysing mental health discourses from the perspective of individuals can help identify the influences of the existing conceptions and climate of debate, allowing for more awareness and deeper understanding of how individuals experience and express fluctuations in their mental health.

Further research can promote more considerate support and right kind of treatment for individuals with such conditions, on behalf of close circle, community, healthcare professionals and the society. Understanding the dimensions of mental health discourse helps to identify and challenge harmful stigmas as well. Analysing discourses may also help identify gaps and biases in mental health services, policies, and legislation, as suggested by Borcsa and Willig (2021).

The research aim of this thesis is to examine what kind of discourses individuals with lived experience of mental health conditions construct when discussing their experiences and what kind of linguistic features they employ when describing those experiences. Research data consists of individual narratives that are included in World Health Organization's mental health report from 2022. The research method is discourse analysis.

This thesis begins with an overview of the theoretical background. First, I discuss the definition and characteristics of *discourse*, and subsequently *mental health discourse*. The linguistics of mental health discourse are explored after. In the third section, I describe the research process of this present study by explicating the methodology – in particular the research questions and aims, research data and method. The analysis section is divided into subsections by four discourses identified in the research process.

I present each discourse with excerpts from the data and analyse them accordingly. Lastly, I interpret how the findings of this study compare and contribute to existing research on mental health discourse and its linguistic features.

2 THEORETICAL BACKGROUND

In this section, I introduce the concepts that are fundamental in a well-founded analysis of mental health discourse. The section begins with briefly defining and describing the immense concept of discourse. I proceed to reviewing the current attributes of mental health discourse and explore its linguistic features with retrospect of previous research. Because mental health discourse overlaps in various disciplines, the theoretical background combines perspectives of multidisciplinary scholars and research such as linguistics, sociology, and psychology.

2.1 Definition of discourse

Discourse is an ambiguous concept to straightforwardly give a definition to, partially because of its simultaneous ubiquity and profundity, and partially because definitions of different theories and methodologies define it differently (Hart & Cap, 2014, pp. 8-9). On a societal level, discourses represent the courses, tendencies, and currents of how we, individually and collectively, use language to construct our societies. Discourses are considered essential tools in analysing societal structures and phenomena, and they can be examined for example from the perspectives of linguistics, social psychology education, and feminist studies (Denscombe, 2014, p. 287). In the context of language, discourses are usually studied with “structure of language” or “content of the language being used” as the focus. (Gee, 2010, p. 8). Language can be analysed whether it is in the format of speech, text, or images.

The origin of the word *discourse* is in Latin, *discursus*, which translates quite characteristically to “running around”, considering discourses are in fact omnipresent (Pietikäinen & Mäntynen, 2009). Pietikäinen and Mäntynen (2009) construct their definition on the notion that discourses are dynamic in nature, perhaps because discourse analysis has been adopted as a common method in multiple disciplinaries and its interdisciplinary use has continued to broaden the dimensions further. The authors also elaborate that discourses have a double focus: they entail both the linguistic expressions and entities but also the concrete use of language in social contexts.

2.2 Mental health discourse

Health and illness have throughout time been constructed through language (Gwyn, 2002), but especially due to the emerge of print media and online communication, they are now specifically given meaning through an abundance of text (Koteyko, 2014, p. 543). As a result of the information flood, matters of mental health, like many other issues, have become more and more fragmented by different disciplines (Hastings, 2020). To conclude, mental health discourse has developed and expanded from predominantly verbal interpersonal communication between patients and health professionals to global, multidimensional discourse that is constructed mainly through written communication channels, such as online platforms.

The biomedical perspective of mental health discourse is deeply rooted in how mental health conditions are perceived and discussed, to the extent that it oftentimes eclipses the individual experiences of these conditions. Challenor et al. (2021) propose that in the current climate, we need to take into consideration the absence of discourse in which individuals experiencing mental distress participate. The social constructionist approach suggests that the dominant discourse focusing on mental health conditions as bodily functions has resulted in unaddressed emotions and experiences, which have subsequently led to more mental distress (Challenor et al., 2021, p. 108).

This manifests in linguistic practices as well. Gwyn (2002, p. 13) points out that mental health conditions are not discussed with medical terms only between individuals and medical professionals, but the individuals also use this medical vocabulary with their immediate circle. Rather than the individual experience on mental health conditions, the public focus is often on the physiological and psychological scope of how humans generally are affected by the conditions and how they are medically treated.

Moreover, the social context of mental health affects how the individuals with mental health conditions view themselves and how others view them. The society poses a moral imperative to be healthy which leads to people with illnesses striving to present themselves as healthy (McKinlay and McVittie, 2011, p. 99). These kinds of expectations adhere to the phenomenon of stigmatisation, often reproduced through language. Makita et al. (2021) studied mental health discourses in social media platform Twitter and found that out of the four key subthemes, two related to stigmatisation or fighting stigma. They conclude that the linguistic techniques of stigmatising included for example associating mental conditions with criminal activities or equating the opposing political or religious view to a mental health condition.

Link and Phelan (2013, p. 525) explain that stigmatisation has been a disputed, and perhaps a limited, concept in mental health research since the 1960s. They shed light on the intertwining of the stigma around mental health conditions and the individual's perception of how others view them, which can lead to several harmful consequences. However, they also highlight on the positive effects of labelling when it comes to right kind of treatment. To offer a more nuanced approach, Link and Phelan (2013, pp. 527-531) have introduced a conceptualisation of stigmatisation that recognises the many components of stigma around mental health, such as social labels and status loss.

Mental health being such a contested and complex issue, it is essential to acknowledge what affects the individual and communal understanding of mental health. The term *health literacy* is defined by Antón et al. (2015, pp. 106-107) as interaction practices that an individual has with "health contexts and healthcare providers" in addition to "educational, social, and cultural factors at home, work and in the community”. Jorm et al. (1997, p. 183) on the other hand have defined health literacy as “knowledge and beliefs about mental disorders which aid their recognition, management or prevention”. They emphasise the connection between having knowledge and harnessing the knowledge to help oneself or others. Health literacy is an essential tool in obtaining relevant mental health-related information also because it entails our ability to understand and communicate our symptoms, needs, and emotions.

Health literacy varies between individuals but can vary distinctively between larger communities as well. Jorm et al. (2012, p. 238) argue that in developing countries the use of mental health services is low among cultural minorities due to the lack of mental health literacy. Antón et al. (2015) demonstrated the inequality in health literacy in the United States by comparing the quality of care and medical outcomes between English and Spanish-speaking minority patients with diabetes. In their research, they found that essential medical information fails to reach many Spanish-speaking patients. National policies and perspectives are still a common factor in health legislation, but there are more global approaches emerging, which accentuate that neither biological nor cultural factors solely explain mental health conditions (Borcsa et al., 2021, p. 3). The strive for intersectionality, in health communication as well, is needed.

2.3 Linguistic features of mental health discourse

The connection between a person’s mental health and how they use language is still quite an understudied subject. However, scholars have suggested hypotheses of how the use of different linguistic features is connected to mental health. For example, first-person singular pronouns and “sadness words” could be used to predict changes in both physical and mental health symptoms (Consedine et al., 2012). Some written language patterns, such as higher levels of self-focus, have also been studied as possible indicators of depression (Weerasinghe et al. 2019). Hunt and Harvey (2015) suggest that individuals with mental health conditions can use language for example to distance oneself from the illness by externalising it into an active subject. On the other hand, Challenor et al. (2021) have utilised discourse analytic methods to study what is omitted from language, since what is left unsaid and who is unfavoured by the silence can also act as significant factors in research.

A prevalent linguistic feature highlighted in the research on the linguistics of mental health discourse are metaphors. Metaphors are commonly used when describing physical or emotional discomfort. Greens' (2022) video, presented in the introduction, discusses the fact that when we cannot find the words to describe our pain, we use metaphors to describe our emotional state or evaluate the level of pain. Previous studies support Green's notion. There are multiple studies concluding that metaphors are a useful communication strategy for people with mental health conditions to interpret their challenges to others (Moulds et al., 2010; Fullagar & O'Brien 2012, cited in Goering, p. 74). Metaphors are also stated to help individuals share their individual experiences, which would, otherwise unaddressed, lead to the individual being stigmatised by others and result in avoidant behaviour (Rofé 2009, pp. 473-475).

While Lakoff and Johnson (1980, pp. 57-58) have contended that using metaphors is nearly required to understand and conceptualise concepts, Green (2022) on the grounds of lived experience, personally challenges this view. Green expresses their frustration of relying only on metaphors when talking about mental health, stating metaphors are indicators of "what it's like, not what it *is*".

3 THE PRESENT STUDY

This chapter presents the framework of the present study. The chapter beings with an introduction to the aims and research questions. Then, I thoroughly describe the characteristics and reasoning behind choosing the research data. The section concludes with a proposition of why the chosen method is appropriate and substantial in consideration of the aims and research questions.

3.1 Aims and research questions

This research aim is to construct an overview of the kind of discursive practices and linguistic characteristics that individuals utilise to discuss their lived experience with mental health conditions. The intention is to analyse the discourses and linguistic features found in the narratives of WHO's mental health report from 2022. The research questions are as follows:

1. What kind of discourses are constructed in the narratives of individuals with lived experience in WHO's 2022 mental health report?
2. What kind of linguistic features individuals use to describe lived experience with mental health conditions in the narratives of WHO's 2022 mental health report?

3.2 Research data

Today, majority of health-related information is derived from online sources by not only patients but health professionals and organisations as well, and because of the online presence, participation, and interactions of these groups – the health and illness discourses are constantly developing new dimensions (Hunt & Harvey, 2015, p. 135). Both organisational health websites and online support groups can function as a channel for patients to share their own experiences or familiarise themselves with the experiences of others (Hunt & Harvey, 2015, p. 136). Due to the digital jump of health communication, I determined that an international health organisation with a strong online presence serves as an appropriate platform for compiling the data for this research.

The research data consists of written narratives by people with lived experience of mental health conditions included in the World Health Organization's digital mental health report. The report was published on WHO's official website in June 2022. The full report is available in four languages: Arabic, English, Spanish and Ukrainian. In my research, I only analyse the content of the English version. According to WHO (2022), the report "is designed to inspire and inform better mental health for all" through combining scientific, collective, and individual perspectives by presenting current data, giving examples of viable practices worldwide, and including individual narratives. WHO states that the purpose of the report is to cumulate change in mental health practices around the world by advocating for the collaboration of all operators, institutions, and organisations of our society.

The report begins with an overview of mental health in our world today. There are also sections dedicated, for example, to the challenges humanity is facing and the impact of these challenges to our mental health. The report also entails contemplation on the means and benefits of improving the environments and systems to better support mental health of communities around the world. In between the informative sections, there are brief, half a page or page-long narratives. Majority of the narrators are individuals with lived experience of mental health conditions, but there are also a few narrators who are addressing the public on behalf of their family member who lives with a mental health condition.

The narratives represent different genres and styles of writing. Some contain elements of storytelling and others have a more formal, informative approach. Altogether, there are 32 narratives in the 296-page report. The people whose narratives have been collected represent diverse backgrounds with varying nationalities, genders, linguistic repertoires, and age groups. The report does not disclose if the narratives are originally written in English or translated into English. The narrators are referred to as "contributors" in the report, so it is possible the original version has gone through an editing process before publishing. As these narratives are included in a public report with the consent of the narrators, using them as research data is considered ethically acceptable.

3.3 Method

Since the main objective is to examine *how* and *what kind of* language is used by individuals in mental health contexts, qualitative approach and subsequently discourse analysis seemed appropriate as the method. Denscombe (2014, p. 288) elaborates that discourse analysis can be used to "deconstruct" sociolinguistics, meaning this method requires scrutinising the sometimes-hidden meanings in the text by looking beyond the words and into the cultural context in which the words are used. This research utilises a perspective commonly applied in discourse analysis: a combination of interpreting micro-level linguistic characteristics of individual perspectives and contrasting them to the society on a macro-level (Denscombe 2014, p. 289; Koller & Mautner, 2004).

In this research, discourse analysis is used as a methodological framework for analysing the means of language use in constructing the relationship between individual and societal understanding of mental health conditions. Considering the nature of the research questions, pragmatics is also used as a guiding tool. Although the intention is to examine reoccurring themes in the narratives, the focus is not to quantify the occurrences in the data but rather to analyse how the data offers significance in the research context (Koller & Mautner, 2004, p. 224).

Applying discourse analysis as a method can also help unveil power dynamics of the society or further connections between societal understanding of mental health and identity construction. To summarise, discourse analysis is utilised in this study to examine how individuals use language to construct their healthiness or illness and how this construction is related to the society-wide discursive practices regarding mental health.

4 ANALYSIS

In this section, I analyse the discursive practices of the narratives in WHO's mental health report from 2022. Discourse analysis is utilised as a method to scrutinise the reoccurrences in the narratives and their distinct detailed linguistic features. The section includes excerpts from the narratives to provide examples, but these are not the only instances fitting to the discourse. Out of the 32 narratives in the report, I present examples from 26 of them. For this analysis, I identified four distinct discourses from the narratives: despair discourse, stigma discourse, treatment discourse, and survivor discourse. Each discourse has their own subchapter in this section.

4.1 Despair discourse

Many of the narratives share common themes when discussing the effects of the decrease in mental health. Like theorised in previous studies (Moulds et al., 2010; Fullagar & O'Brien 2012, cited in Goering, p. 74), metaphors were, in the WHO report as well, utilised by the narrators to describe their experiences. Metaphors appear to be used in the narratives especially when describing internal state, particularly feelings of despair. Different verbs are employed with the symptoms or conditions, like "falling into depression" and "drowning in sadness". When someone is falling or drowning, they have little control over the situation, which could reflect on the helplessness they might feel when they cannot change their course. One narrative also contains a metaphor “trapped in my own horror film”. They describe being “plagued with irrational beliefs and fears”. The verbs “trapped” and “plagued” represent the emotional distraught experienced by the narrator.

The word “terror” is also used in two different narratives. One narrator describes being “filled with terror” and another describes a period of intense emotional pain as “a maelstrom of internal terror that I hoped would go away”. Another narrative describes being in “a devastating cycle of despair”, in which the word “cycle” suggests a feeling that is constantly reproduced and never-ending. One narrator highlights a feeling of having lost their soul and being in “soul pain”. However, not all the narratives highlight the despair. For example, another narrator describes feeling “empty”, suggesting there is not even despair to be felt.

Some narrators refer to mental health conditions as active subjects operating without their consent. One narrator describes how the “illness stole precious moments from me and my girls”, referring to it as something capable of action. Narrators also describe how depression was allowed “to grow”, or how anxiety “stayed” with them. The latter narrative continues to describe an inability to express how they were feeling with words, which coincides with what Green (2022) proposed that humans struggle to find the words to describe emotional pain. Besides the condition itself, other psychological abstractions also referred to as subjects: “my emotions were all over the shop” and “feelings blazed chaotically”, both reflecting on the inability to contain or control their emotional state, which relates to Hunt & Harvey’s (2015) indication how individuals externalise their condition into an active subject capable of operating on its own.

4.2 Stigma discourse

Stigmatisation related to mental health conditions uncovers from multiple narratives. Narrators describe their feelings of worthlessness, encounters with stigma or outright mistreatment while dealing with mental health conditions. According to the study by Makita et al. (2021), stigmatisation and fighting stigma were similarly identified a key subtheme in online mental health discourse. The narratives discussed the difference between how the society views and values people with and without a mental health condition. In this subsection, Link and Phelan's (2013) conceptualisation of stigma, presented in the theoretical background, is used as guiding tool to analyse the discourse.

In excerpts 1 and 2, the narrators discuss the low expectations of the society towards them and their peers with mental health conditions.

> Excerpt 1
> "Living with a mental disorder is not synonymous with limitation. Society forces us to believe, perhaps unintentionally, that we are not capable of having responsibilities because of the crises we sometimes face."
>
> Excerpt 2
> "…a group of people with psychological disabilities like me who were terrorized and stigmatized by society."

Both excerpts contrast "society" and the people with mental health conditions – excerpt 1 with first-person plurals "we" and "us" and excerpt 2 with "a group of people…like me". Similar positioning was practised by Deegan (1993) who, with lived experience, titled their noteworthy article "Recovering Our Sense of Value After Being Labelled Mentally Ill". Deegan includes people with similar experiences by using the first-person plural "we". Link and Phelan (2013, p. 530) propose this phenomenon of categorisation by "social labels" as one of the key components of their conceptualisation of stigma.

The narratives also showcase an internalisation of a prevailing misconception that mental health conditions are a sign of weakness, as shown in excerpts 3 and 4. Link and Phelan (2013, p. 530) point out a similar feature of stigmatisation which is linking differences with "negative attributes". The internalisation of this conception can be detected from the multiple narrators' fear of speaking up about their challenges with mental health, often resulting in isolation.

Excerpt 3

> "Depression meant failing to me. … I could not stomach the fact that I needed help. To me, that meant I was weak, incompetent. … I strived hard to maintain the image I thought society wanted to see. … I started to understand that I had a part to play in the stigma against mental health conditions."

> Excerpt 4
> "I felt that I would be perceived as "weak" and "not able to do my job" and I felt I'd lose the respect of my colleagues."

Many human experiences and emotions are socially constructed and conceptualised by humans according to social standards (Van Beveren et al., 2020). The excerpts above replicate McKinlay and McVittie's (2011, p. 99) theory that people with mental health conditions aim to fit to the social standard of being healthy. The fact that narrators describe seeing themselves as "weak" due to their experience, reflects on the underlying notion of our society that mental health conditions are individual faults or failures. In excerpt 4, the narrator particularly discusses their experience in the context of workplace. The excerpt suggests that the narrator views their experience from the perspective of their work peers according to the social standard. This highlights how, particularly in capitalist societies, there is still a gravitation towards viewing people's value through their performance and contribution at work.

Some narratives accentuate the graver effects of stigmatisation. One of the narratives is an extract from a parent's letter to WHO in which they illustrate the severely poor conditions of the facility their child is living in, a place that has been "forgotten by the world and God". They disclose someone commenting to them that the sanctuary "is but the waste of society". This comment is a dangerous reflection of the misconception that people with mental health conditions lack the capability to participate meaningfully to the society, or that individuals need to abide by a certain society standard to earn their value in the society in the first place.

However, some narratives also demonstrate the rejection of these surrounding stigmatising conceptions as an aftereffect of the progress they have made through their recovery. Excerpts 5, 6, 7, and 8 demonstrate this notion.

> Excerpt 5

> “Living with a mental health condition does not make you less of a person, nor does it need to take away your ability to function optimally.”
>
> Excerpt 6
> “And I get to share them with my daughters so that they know suffering with a mental health condition is not a weakness or a source of shame.”
>
> Excerpt 7
> “Mental illness is not a death sentence nor a sign of weakness.”
>
> Excerpt 8
> “I am a functional and productive member of society.”

These excerpts represent ways to challenge how the society generally defines people based on their conditions. “Weakness”, “shame” and “death sentence” echo the societal stigma behind mental health conditions. Through these statements, the narrators refuse to reproduce the stigma and educate that mental health conditions are not untreatable individual shortcomings to be ashamed of. In excerpts 5, 6, and 7, the narrators make their statement on a general level, rather than from a personal perspective. In excerpt 8, the narrator takes a stance from a first-person singular perspective, highlighting their own empowerment.

As a concluding note, many of the narratives presented in this subsection convey different coping mechanisms with stigmatisation (Link and Phelan, 2013). These mechanisms include not sharing their labelling information, such as mental health symptoms or diagnoses, with others (“secrecy”), disclosing the reality of living with a mental health condition as opposed to how people perceive it (“education”), and expressing that the stigmatising comments or views are not acceptable (“challenging”) (Link & Phelan, 2013; Link et al., 1989; 1991; 2002).

4.3 Treatment discourse

As noted in the previous subchapter, stigmatisation has a strong effect on the self-view of individuals with mental health conditions. The narrators also discuss it as an obstacle to seeking or receiving accurate treatment. They also reveal a variety of other challenges in the treatment practices of mental health conditions around the world. Examples of these are the lack of adequate resources, awareness, or mental health literacy. This subchapter explores the narrators' portrayal of their treatment and recovery, and how they discuss the role of mental health professionals, communities, and themselves during their experiences.

4.3.1 The role of health professionals

Multiple narrators review their encounters with health professionals, some of which have been crucial and others harmful for their recovery. Excerpts 9 and 10 include direct critique to how they have been encountered by health professionals. Both narrators highlight having met several professionals, suggesting a wider issue. They describe their experiences with words like "frustrating" and "not even slightly helpful", suggesting a negative treatment experience. Furthermore, many narratives raise awareness on the lack or scarcity of mental health professionals, health services and medication, and the poor conditions of healthcare institutions (for example, see WHO, 2022, pp. 61, 63, 72, 89).

> Excerpt 9
> "For 15 years, I have seen mental health professionals. Every appointment saw me talking to a different person, repeating my case history time and time again and receiving at best, a medicine review – so frustrating and lacking any obvious desire to give me a good quality of life" (WHO, 2022, p. 138)
>
> Excerpt 10
> "I met with quite a few therapists and rehabilitation experts. I did not receive a diagnosis of trauma, even when I shared some of what I had gone through, and unsurprisingly, therapy was not even slightly helpful. I remember saying over and over again that I was feeling detached from myself, that all I was trying to do was to detach myself, and yet, no one spoke to me about dissociation and the implications of trauma."

Excerpts 11 and 12 demonstrate the positive experiences. The narrators have encountered a health professional who they feel has the right kind of approach and sufficient knowledge to help them.

> Excerpt 11
> “[The psychologist] showed me how I could break things down which allowed me to cope better and not become so overwhelmed with life.”

> Excerpt 12
> “[S]he saw me as a person rather than my mental illness. … Her willingness to collaborate with me, create care plans that suited me as an individual, while still giving me the space to make autonomous decisions, helped me build the confidence to thrive not only mentally, but in all other areas of my life.”

Similarly to what McKinlay and McVittie (2011, p. 105) explicated, both narrators highlight that the emphasis on their own empowerment led into a successful relationship. What most of these positive experiences seem to have in common, is that the individuals express a feeling of being met with what could be called kindness and offered practical guidance on how to live with a mental health condition. In conclusion, these lived experiences show how valuable it is that health professionals can recognise the symptoms of different mental health conditions and suggest suitable forms of treatment.

4.3.2 The role of communities

Narrators also discuss the role of their community through their lived experience. In excerpt 13, the narrator describes the despair they felt due to the attitude of the surrounding community, which led to a feeling of loneliness. Focusing on the stigmatised concept of the condition rather than how it could be treated and coped with suggests a lack of knowledge on how to encounter and support people with mental health conditions. Lack of acknowledgement and mental health literacy is highlighted in excerpt 14 as well.

> Excerpt 13
> “The single-sided story of bipolar illness that was narrated in my community focused only on the struggles it caused, rather than how to overcome them.”

> Excerpt 14

> “[M]y family and the society we lived in didn’t acknowledge mental health and didn’t know how to take care of a loved one living with mental health challenges.”

Some also point out that the traditional cultural beliefs of their community affected how they and their family members reacted to their symptoms. The narrator of excerpt 15, who during their own struggles with the condition, recognised a need to spread awareness on OCD in their community. As a result, the mental health literacy of the community increased. Excerpt 16 demonstrates how cultural beliefs of one’s family can affect the lived experience. Both excerpts reflect on the importance of health literacy in the context of mental health (Jorm et al. 2012; Antón et al. 2015).

> Excerpt 15
> “Knowledge is power. Just knowing that their distress was caused by a mental health condition and not some evil spirit was a relief to most people.”
>
> Excerpt 16
> “[I] was then taken to a traditional healer by my grandfather who, due to his cultural beliefs around mental health, believed I was possessed by an evil spirit. My attempted suicide was never spoken about. Instead, it was kept a secret and my mental health condition remained undiagnosed and untreated.”

Finally, a variety of the narrators describe how their lived experience has resulted in either a new career related to mental health; establishing or joining an organisation supporting mental health well-being; or finding a community that offers support. These narrators highlight on the importance of their lived experience in understanding and helping others with mental health conditions. There appears to be a consensus that their lived experiences should be recognised and promoted as a resource more actively to improve mental health literacy of individuals and communities as well. Excerpt 17 encapsulates this notion below.

> Excerpt 17
> “People with lived experience are courageous people whose insight and experiences are invaluable for progressing mental health care worldwide…”

4.3.3 The role of the self

Although the previous subsections advocated for better external support, many narrators emphasise the significance of their own role in treatment and recovery. Some highlight realising they have autonomy over their condition or treatment, and others finding suitable "self-help strategies" that can be applied either independently or with professional guidance (Jorm et al., 2012, p. 234).

Excerpt 18 is an example of how individuals tend to experience the mental health symptoms in isolation if they do not have adequate awareness on mental health matters. This excerpt demonstrates the repercussions of communities and societies failing to equip individuals with mental health literacy. I suggest that in comparison to how our societies manage health literacy regarding matters of physical health, such as dietary or hygiene instructions, there is a noticeable gap between the two entities of physical and psychological.

> Excerpt 18
> "[I] did not have the awareness to express myself or to ask help from anyone."

Some narrators self-reflect on how they see features of health literacy as a result of their lived experience. Excerpt 19 highlights the importance of understanding their own power and excerpt 20 describes information as a form of power.

> Excerpt 19
> "But what I've learned is that for myself and my mental health nothing is more valuable than the belief that I have the power within me to change myself. Consent is still not considered necessary in our mental health care system; but now I have the power not to give the system consent to make me feel inferior."
>
> Excerpt 20
> "I believe that disseminating information on mental health is very important. Information gives us the power to generate change. It helps raise awareness in society to prevent mental health conditions or identify them early, and to create empathy and social inclusion. Information makes us freer – a human aspiration."

The short yet affirmative "I have the power" repeats twice in excerpt 19, hinting at the focal point of the narrator's statement: the shift in power from others to themself.

Power is also referred to by another narrator (excerpt 20), who gives an impressive statement of the importance of awareness, health literacy and having information available as keys towards getting accurate treatment and making it to recovery. As suggested by Jorm et al. (1997, p. 183), health literacy, awareness, and the ability to recognise changes in mental health are essential resources for people with mental health conditions to understand their own conditions and know how to help oneself or ask for the right kind of help.

4.4 Survivor discourse

The fourth prevalent discourse is titled according to examples of how the narrators describe the renewed state of their mental health after their recovery. A metaphor that connects well with the survivor discourse, is the word "battle". For example, the narrators refer to "[t]he battle within me" or "my battle with mental health". Contrasting the lived experience to a personal battle emphasises the requirement to fight and the toll it can have on these individuals.

Nevertheless, majority of the "battles" in these narratives end on a hopeful note, highlighting the successful recovery of the narrator. Some narrators refer to their processes for example as a "road to recovery, "recovery journey" and "pathway to mental-health well-being". Associating the process to a "road", "journey" or "pathway", suggests it is a process that has required them to keep moving ahead to reach the destination that is recovery.

Metaphors are also used in the process of making progress in recovery: two narratives parallel the progress as "weight" that has been lifted. Some concluding statements highlight the narrators' newly found happiness: "I am living happily…" and "I live happily". Some state they "returned as a much stronger person". Another interesting characteristic of the survivor discourse is demonstrated in excerpts 21 and 22. In these excerpts, the narrators compare lived experience to something extraordinary, using words like "superhero" and "superpower". These excerpts suggest the narrators feel like the experiences have reshaped them into seeing lived experience as a resource rather than a hindrance.

> Excerpt 21
> “No one told me that I was basically a superhero… -- I hope that in the future, survivors who want to recover from the difficult experiences they’ve been through will be treated like heroes, like humans who have been through extreme human experiences, and who deserve compassion, respect, and value.”
>
> Excerpt 22
> “[I] realized that my illness was a superpower I could use to help others.”
>
> Excerpt 23
> “I have more goals to meet and challenges to overcome but I think the important thing is not to give up.”
>
> Excerpt 24
> “I fell time and again to find my own way back up. I will continue trying and learning and, for effort alone, I will always succeed.”

However, it must be added that although the survivor discourse highlights the progress that the individuals have gone through, many narratives point out that their mental health still requires their attention. Excerpts 23 and 24 call attention to the fact that recovery is a long, complex process. Both narrators express their awareness of the challenges ahead of them, but that they feel confident in their own resilience.

5 DISCUSSION AND CONCLUSION

The research aim was to examine mental health discourse with a focus on individual experiences. The research questions were based on finding out what kind of discourses are constructed and what kind of linguistic characteristics are utilised when individuals describe their lived experience with mental health conditions. Discourse analysis was employed as the research method. The data consisted of 32 individual narratives in WHO's 2022 mental health report. The analysis section included excerpts from 26 of these narratives. The narratives provided an abundance of insightful data from which four discourses were discovered and selected for closer scrutiny: despair discourse, stigma discourse, treatment discourse, and survivor discourse.

The despair discourse shows similarities to previous studies, suggesting that individuals often rely on metaphors to express pain (Moulds et al., 2010; Fullagar & O'Brien 2012, cited in Goering, p. 74). In the context of despair discourse, metaphors were abundantly utilised when describing the emotional realm. With the help of metaphors, narrators described the feelings of sadness, despair and helplessness that resulted from their struggles with mental health. As Hunt & Harvey (2015) have previously theorised, the abstract matters were referred to as subjects capable of action. The despair discourse revealed the various ways in which individuals describe their symptoms with the help of different linguistic features. However, analysis on these features is still hypothesised, and the narrators' own interpretations of their use of language could differ from the analysis.

As the analysis suggests, stigmatisation is especially pertinent to the narrators' experiences of how the society, including themselves, perceives mental health conditions. Link and Phelans (2013) conceptualisation of stigmatisation offered a rich contact surface that highlighted similarities between their theory and characteristics found in the narratives. Stigma discourse also corresponds the research in which awareness and advocacy, stigmatisation, and fighting stigma were statistically three of the most common subthemes in the collection of tweets related to mental health (Makita et al., 2021). In the narratives, stigmatisation is processed especially through positioning the society into a separate entity while internalising the society's belief that mental health conditions affect the capabilities of an individual. Narrators suggest this leads to feeling weak or inferior, and hiding their struggles from others by isolating.

The multi-faceted treatment discourse demonstrates that mental health recovery and treatment are affected on many levels, the individual themselves, the surrounding community, and health professionals all have their role. The narratives include profuse critique of healthcare practices, calling for more resources and humane approaches to mental health services. The narratives call for collaboration between individuals with lived experience, mental health organisations, healthcare institutions and governmental entities. Awareness is a prevailing theme in the treatment discourse. Although none of the narrators explicitly use the term health literacy, the concept unravels through their strive for better knowledge and using that knowledge to help others, as Jorm et al. (1997) suggested in their research.

Cathartically, the survivor discourse wraps up the analysis. The excerpts demonstrate the self-empowerment of individuals, and how their recovery journey has led them renewing the view of themselves. In relation to the stigma discourse, several narrators bring up the rejection of the society's view through their healing process. McKinlay and McVittie (2011, p. 105) as well have highlighted empowerment as a key to recovery.

Altogether, the narratives form a nuanced collection of experiences with mental conditions. The individuals highlight the importance of the availability of these kind of narratives in diminishing the taboo status of mental health conditions, increasing health literacy, and improving treatment practices. The narratives reveal a strong consensus that lived experiences should be considered and utilised as an asset in improving mental health care.

There were some limitations in this research. In the analysis section, four most prevalent discourses were presented, but there were other noteworthy discourses as well. However, due to the scope of my research, all features and themes could not be analysed. The discourses are constructed in a selection of narratives although the narrators are diagnosed with different conditions and represent a variety of cultural backgrounds, ages, ethnicities, and genders, for example. The backgrounds of individuals are not taken into closer consideration in the analysis since the focus is merely on the discursive and linguistic practices. It must also be mentioned that the mental health report does not describe the process of selecting the narrators or the editing process of the narratives. All narratives are in English, but it is possible that the narrator's original narrative was translated from a different language to be included in the report. If this is the case, it would be interesting to further examine the connection between the original text and the English version, especially in terms of the metaphors included.

Further importance could also be added with acknowledging the discourses as a culturally sensitive matter and recognising the diversity of mental health discourse across different cultures and communities. This was specifically contested in subchapter 4.3.2. through the narrators' discussion on how their symptoms were encountered or evaded in their communities. More focused research could help improve health literacy and tailor interventions and support systems to be culturally relevant and at the same time identify barriers to receiving accurate care.

Finally, the dimensions of mental health discourses provide ground for far more extensive, interdisciplinary research. Throughout history, physical health has been the focal point of health research, but particularly because of the decrease in mental health worldwide, research on mental health should be deemed equally important. As revealed in the narratives, especially the communication practices between patients and mental health professionals during the treatment process strike as a matter that requires more research. Hunt & Harvey (2015, p. 151) also advocate for more linguistic research to enable better interactions between patients and health professionals, especially in terms of professionals paying attention to the expressions the individuals use. For example, this present study and previous explorative research on linguistic features as indicators of mental health (Consedine et al., 2012; Weerasinghe et al.,2019) could be explored further to inspire new approaches for developing mental health care practices.

To conclude, research from a linguistic perspective offers insight on how individuals word their lived experience and what kind of discourses emerge from the experiences. Studying mental health discourse plays a vital role in shaping how mental health is understood, discussed, and addressed in all-level interactions. This research shows that from an epistemic perspective, the experiences and knowledge of individuals with mental health conditions could provide a needed resource in improving mental health practices. With the help of research on individual experiences, we can unlock essential knowledge on appropriate treatment for people with mental health conditions, subsequently creating a healthier society in which individuals have the awareness to understand and support themselves and others. Green (2022) suggested we need better language to talk about emotional pain. As a giveaway of this research, I suggest the first step towards that is to fortify the voices of individuals who have lived experience with mental health conditions.

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