Research Article

A Critical Perspective on Mental Health News in Six European Countries: How Are "Mental Health/Illness" and "Mental Health Literacy" Rhetorically Constructed?

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Abstract

In this study, we aim to contribute to the field of critical health communication research by examining how notions of mental health and illness are discursively constructed in newspapers and magazines in six European countries and how these constructions relate to specific understandings of mental health literacy. Using the method of cluster-agon analysis, we identified four terminological clusters in our data, in which mental health/illness is conceptualized as "dangerous," "a matter of lifestyle," "a unique story and experience," and "socially situated." We furthermore found that we cannot unambiguously assume that biopsychiatric discourses or discourses aimed at empathy and understanding are either exclusively stigmatizing or exclusively empowering and normalizing. We consequently call for a critical conception of mental health literacy arguing that all mental health news socializes its audience in specific understandings of and attitudes toward mental health (knowledge) and that discourses on mental health/illness can work differently in varying contexts.

Keywords

media; mental illness; mental health; mental health literacy; discursive theory; rhetorical analysis; biocommunicability; qualitative; Europe (Sweden, Norway, Belgium, The Netherlands, Cyprus, Greece)

Introduction

Media coverage on mental illness and its effect on public beliefs and attitudes toward mental health problems have long been and still are a topic of scholarly interest (Cabrera et al., 2018; McGinty et al., 2016). Previous research has shown that mainstream media often negatively associate mental illness with danger, violence, and sensation, which might contribute to social and self-stigma and hinder people experiencing mental distress from seeking (professional) help (Corrigan et al., 2013, 2014; Savage et al., 2016). Mental health literacy initiatives and awareness campaigns aimed at educating the public about mental illness, its causes, and available treatments options are considered valuable tools in the reduction of stigma and in the encouragement of more appropriate help-seeking behavior (Jorm, 2012; Kelly et al., 2007; Wahlbeck, 2015). Central to many of these literacy projects is the "mental illness as a disease like any other" approach. This approach aims to replace beliefs, myths, and moralistic understandings of the nature, cause, and treatment of mental illnesses with bioneurological scientific facts, which

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are considered to improve public attitudes toward mental illness by reducing perceived individual responsibility and blame (Gardner, 2003; Read et al., 2006). The emphasis on such medical literacy has been related to linear understandings of news media as means to transmit taken-for-granted scientific information to a lay audience (Hallin & Briggs, 2015; Seale, 2003). Critical health communication researchers have critiqued this approach: rather than focusing on the scientific and medical accuracy of health news coverage, these scholars emphasize the constructed nature of health news and have indicated the need for more research that recognizes and studies the different ways in which media are actively involved in the social construction of what constitutes health and illness (Dutta, 2010; Lupton, 1994; Zoller & Kline, 2008).

In this study, we aim to contribute to the field of critical health communication research by examining how notions of mental health, mental illness, and mental health literacy are discursively constructed in the mental health reporting of newspapers and magazines in six European countries. In the following sections, we first align ourselves with critical-discursive theories of mental health/illness. Next, we connect these perspectives to the field of critical health communication by drawing on Briggs and Hallin's (2016) recently developed framework of biocommunicability. This framework conceptualizes the different ways in which media constructions of (mental) health and (mental) illness operate in the governing of the healthy citizen as they implicitly communicate to the audience ideas on what constitutes legitimate (mental) health knowledge and who produces, circulates, and consumes it. Following the arguments of Briggs and Hallin (2016), this study is thus not concerned with demonstrating the value of mental health news in enhancing the scientific and medical literacy of the readers, but rather aims to study how all news stories communicate specific ideas on mental health/illness and on how different actors should engage with mental health (knowledge).

Critical-Discursive Perspectives on Mental Health/Illness, Mental Health Literacy, and Mental Health News

Scholars and advocates from various disciplinary fields have emphasized the epistemologically and ontologically ambiguous nature of mental illness[1] and have contested the uncritical adoption of psychiatry, clinical practice, and their classifications of mental health and illness as scientific-objective, neutral, and acultural (Bracken & Thomas, 2017; Kleinman, 2012; Pickersgill, 2012). Drawing on conceptions of human (inter)subjectivity as embedded in social, historical, and cultural contexts, these authors instead disclose mental health/illness as a value-laden notion that is grounded in specific cultural constructions of the relationship between mind, body, and society (Teo, 2015). Building on the works of Foucault, Rose (1998, 2009) has studied the cultural impact of psychiatric discourse on our understandings of (mental) illness and health. He illustrates how neoliberal and biopsychiatric subjectivities currently intersect in discourses that center around the *enterprising self*, which have increasingly come to occupy domains of life such as leisure, education, and media. In this process of *biomedicalization*, the enterprising self appears as a rational subject that manages social risks, which now appear as the individual genomic risk (to develop a mental disorder) that everyone carries, by constant self-monitoring and by making well-informed health and lifestyle decisions (see also Clarke et al., 2010; Dumit, 2003).

The framework of biocommunicability, recently developed by Briggs and Hallin (2016), is especially concerned with the performative and pedagogical power of health news in the production of cultural understandings of health, disease, biomedicine, and the healthy citizen more generally. The framework aims to elaborate on the concept of *biomedicalization* by relating it to the process of *biomediatization*, referring to media's "co-production of medical objects and subjects through complex entanglements between epistemologies, technologies, biologies, and political economies" (p. 5). In line with critical-interpretive perspectives on health communication (on this, see Dutta, 2010; Lupton, 1994; Zoller & Kline, 2008), Briggs and Hallin (2016) consider public health and medicine on the hand, and communication and media on the other as impinging upon and co-producing one another, rather than as two separate spheres, with the role of the latter reduced to representing to an audience that needs to be informed about the preexisting medical objects and subjects of the former (Seale, 2003). Indeed, the fact that psy-discourses are no longer confined to traditional professional and institutional psy-domains and have instead come to occupy mainstream and popular media channels (Binkley, 2011; Kirkman, 2001) requires an understanding of mental health news as actively negotiating cultural legitimacy for specific conceptions of mental health/illness (knowledge) (Kurchina-Tyson, 2017).

According to Briggs and Hallin (2016), the performative or biopedagogical power of health news manifests itself in the two layers that can be distinguished in each health news story: in addition to providing the audience with cultural understandings of health and disease, they teach the public about what counts as valuable health knowledge, who produces it, how it circulates, and who receives it. Health news is thus performative and pedagogical in the sense that it interpellates different actors to take different positions toward health knowledge and socializes the audience in specific ideas of what counts as

biocommunicable success (accepting ascribed positions) or biocommunicable failure (failing to take up or challenging ascribed positions). Although the framework of biocommunicability focuses on health and disease in general, Kate Holland (2017, 2018a, 2018b) has engaged with it to study how media and communication figure in the biopolitics of mental health/illness in particular.

The framework of biocommunicability distinguishes three cultural, normative models of production, circulation, and reception of (mental) health knowledge, each of them "woven into the words and images of stories themselves" (Briggs & Hallin, 2016, p. 26). The *model of biomedical authority* assumes media communication on health to follow a linear-hierarchical trajectory in which biomedical authorities produce health knowledge that is subsequently communicated to a not-yet-knowing and passive lay audience. Distinctions between knowledge and nonknowledge about health are constructed in terms of good science (i.e., objective facts, technological progress) versus bad science (i.e., pseudo-science, myths, and beliefs) (Briggs & Hallin, 2016). In this context, health news often appears as a form of health education given its commitment to enhance the public's medical and scientific literacy (Hallin & Briggs, 2015). With regard to mental health, this model can be related to the "mental illness as an illness like any other" approach to mental health literacy (Read et al., 2006).

The *patient–consumer model*, which according to Briggs and Hallin (2016) has overruled the dominance of the former model, assumes a more agentic role for the service user/patient and shifts biocommunicable power relations to introduce a concept of the public as consisting of rational and active information seeking individuals that are capable of making choices and managing their own health/treatment (Briggs & Hallin, 2016). This resonates with Rose's (1998) notion of the enterprising self, with (mental) health appearing as a commodity that should be actively and responsibly pursued by everyone. In this context, (mental) health journalism takes up the role of informing the public about all of the treatment choices available, often drawing on the genre of first person celebrity-accounts or stories about persons overcoming their (risk of developing) mental health problems (Binkley, 2011; Briggs & Hallin, 2016; Holland, 2017). Again, (mental) health news acts as a form of health education, with mental health literacy appearing as a matter of access to information to make the right health decisions, and as an asset that might actually "do much of the work" and reduce either the need for or the unnecessary use of (costly) public services (Teghtsoonian, 2009, p. 32).

The *public sphere model* disrupts the traditional biocommunicable hierarchies evident in the two previous models by considering health, medicine, and science as value-laden, contingent, and contestable notions that can and should be debated publicly. Service users/patients and the public at large are addressed as citizens who have both stakes in public health discussions and valuable contributions to make. By being an (implicit) ally to the public or taking up an activist stance themselves, journalists support a process of renegotiating what counts as legitimate or expert knowledge about health (Briggs & Hallin, 2016). With specific regard to mental health/illness, much of the activist and theoretical work in this area has been done by advocates, researchers, and professionals involved in the critical disability and survivor movements, whose efforts have called attention to the complex interplay of the material, historical, cultural, and political constituents of mental health problems (Goodley et al., 2019; LeFrançois et al., 2013).

In an important note on the three models, Briggs and Hallin (2016) remark that the discursive workings of a health news story often cannot be confined to one particular model, but rather form *biocommunicable cartographies* in which different models combine and intersect in complex, sometimes contradictory ways. The complexity of mental health/illness news thus calls for an analysis that goes beyond binary classifications of media representations as either positive or negative. In the next section, we explain how we set up a qualitative study using rhetorical analysis as a methodological lens to examine the cultural understandings of mental health/illness and the biocommunicable cartographies produced and circulated in mental health news in six European countries.

Research Method

Context of the Study

This study is part of the larger "MentALLY—Together for better mental health care" research project. The project has received funding from the European Parliament and aims to gather qualitative information on mental health professionals' and service users/patients' perspectives and the public mental health debate to gain a better understanding of notions of access and quality in European mental health services. In the project, researchers from six European countries, that is, Cyprus, Greece, Belgium, the Netherlands, Sweden, and Norway, collaborate to form an interdisciplinary research team that covers the disciplines of clinical and social psychology, public health studies, and discursive-rhetorical studies. The selection of the six countries was informed by their scores on the 2015 Euro Health Consumer Index which includes 35 countries measured on 48 indicators. The six countries reflect an adequate amount of European diversity considering patient rights and information, accessibility of health care, health outcomes, range and reach of services provided, prevention efforts, and use of pharmaceuticals.

Table 1. Overview of Collected Data Per Source Per Country.

Source	Greece	Cyprus	Belgium	Netherlands	Sweden	Norway
Newspapers						
Popular newspapers	38	12	50	56	44	43
Quality newspapers	26	20	58	56	7	50
Magazines						
Senior's magazine	/	/	/	4	/	/
Men's magazine	4	/	7	/	/	/
Women's magazine	5	4	4	1	23	2
Lifestyle magazine	2	/	1	/	/	/
Sports magazine	3	1	1	/	/	/
Scientific magazine	/	/	1	/	/	/
TV magazine	4	/	6	1	/	7
Opinion/news magazine	14	9	7	1	/	/
Teen magazine	5	/	/	/	1	/
Total	101	46	135	119	75	102

Furthermore, the selection of three pairs of countries allows for a diversity in economic-political and cultural contexts (e.g., with the economic situation of Greece and Cyprus largely characterized by the consequences of the "crisis years" and severe austerity measures), yet also assures the inclusion of countries with comparable cultural contexts, but different mental health service systems (e.g., the Norwegian system being much more centralized than the Swedish system). The project was ethically approved by the Ghent University Ethical Commission on March 6, 2018 (for more information, see http://mentally-project.eu/).

Data Collection and Descriptive Coding

Data were collected through a systematic key word search in mainstream media sources in all six European countries. More specifically, in each country, the two most read[2] quality newspapers and popular newspapers were searched as well as the most read senior's, men's, women's, lifestyle, sports, popular scientific, TV, opinion/news, and teen magazine. It has been argued that various new media, such as social media, blogs, and websites, have become important sites of information exchange, social support, and even mental health service itself (Giles & Newbold, 2011; Lal & Adair, 2014; Moorhead et al., 2013). Nevertheless, newspapers can still be considered mainstream in the sense that they remain influential in the construction and dispersion of public understandings of mental health (Chadwick, 2013), or, as Briggs and Hallin (2016) stipulate, in "setting the terms of public debate" (p. 15). Our search was limited to the online content of the sources with the aim of developing an online database to store the collected data. As we collected both freely accessible articles and articles that were behind a paywall, we had access to largely the same content of the paper versions of the sources. Moreover, given the fact that in 2018, more than nine out of 10 households in the Netherlands, Sweden and Norway, more than eight out of 10 households in Belgium and Cyprus, and more than three out of four households in Greece had internet access (Eurostat, 2018), we believe that online information (especially of mainstream media sources) represents not an exhaustive, but a representative sample of all information content in the particular countries.

Given the various ways to name mental health (problems), we used a broad range of key terms that were scanned for in all text, including "mental health," "mental wellbeing," "mental illness," "mental disorder," "psychiatric problems," "psychological issues," as well as the names of specific mental health issues, such as "depression," "burn-out," "schizophrenia," and "bipolar disorder." Data collection covered a period of 2 weeks between September and October 2018 resulting in a data set of 578 articles. Table 1 presents an overview of the collected data for each of the six European countries. All of the newspaper and magazine articles that mentioned one of the key terms were included in the study and were descriptively coded using the following tags: title, date, language, and abstract (one-sentence summary) of the article, "who speaks" in the article (e.g., academic scholar, celebrity, professional), target group (e.g., adolescents, women), mental health issue (e.g., depression, burn-out), newspaper section (e.g., science, lifestyle, opinion piece), and key terms evident in the article. Based on the reading and descriptive coding of the articles, each country identified the five main topics in their public mental health debates. An overview of these topics is provided in Table 2.

Table 2. Overview of the Five Main Topics in the Public Mental Health Debate Per Country.

	Greece	Cyprus	Belgium
1	Celebrity narratives on mental health issues	Crime and mental health	Celebrity and personal narratives on mental health issues
2	Disseminating research findings on mental health	Addiction as a multifaceted problem	Crime and mental health
3	Crime and mental health	Disseminating research findings on mental health	Discussing the cause of mental health issues
4	(Attempted) suicides	Nonscientific discussion of mental health issues	What counts as good mental healthcare?
5	Drug addiction	Exclusion of people with disabilities	Mental health issues in popular culture (e.g., TV series)
	The Netherlands	Sweden	Norway
1	Celebrity and personal narratives on mental health issues	Celebrity and personal narratives on mental health issues	Celebrity and personal narratives on mental health issues
2	Crime and mental health	Discussing the cause and treatment of mental health issues	Disseminating research findings on mental health
3	Stress and burn-out	Crime and mental health	Political parties discussing mental health
4	The structural organization of mental healthcare	Mental health issues in popular culture (e.g., TV series)	Opinion pieces on mental health issues
5	Mental health issues in specific target groups (e.g., women)	Advertisement and expert advice on mental health	National and international trends related to mental health issues

Rhetorical Analysis

We selected a smaller subset of data for the interpretive analysis of the cultural understandings of mental health/illness and the biocommunicable cartographies produced and circulated in the newspaper and magazine articles. Each country selected five representative articles for each of their five main topics. To include less dominant perspectives, all countries also selected an additional five articles that did not belong to any of the five main categories. This resulted in a data set of 180 articles.

Our interpretive analysis specifically builds on the field of rhetoric as a methodological framework. In line with discursive studies of "mental health/illness," a rhetorical analysis attempts to account for the complexity in how people make sense of "mental health/illness" and associated service use (Sims-Schouten & Riley, 2019). Rhetorical studies of mental health communication, however, are particularly concerned with how certain understandings of mental health/illness become persuasive and thus productive in the constitution of the healthy subject, and how and why they appeal to specific audiences that are either already there, assumed, or created (Dumit, 2003). In this study, we conducted a rhetorical cluster-agon analysis to (a) first identify larger patterns in the media sources' cultural construction of mental health/illness and (b) then gain deeper insight into the rhetorical strategies that are used to persuade people of both these understandings and their concomitant biocommunicable positions. The first stage of the analysis thus takes a more inductive approach and examines *what* understandings of mental health/illness mainstream media currently rely on, while the second stage more deductively draws on the framework of biocommunicability to explain *how* these understandings of mental health/illness are rhetorically constructed and *how* they persuade the audience of specific ideas on who produces, circulates, and consumes valuable and legitimate mental health knowledge (cf. mental health literacy) (on the importance of using qualitative methods to understand both the *what* and the *how* of health communication, see Foley et al., 2019).

The analytical method of cluster-agon analysis is primarily based on the assumption that when we communicate, our terminology comes together in associational clusters (Burke, 1966). The analysis then, is aimed at identifying "what goes with what" (positive terms, such as synonyms, characteristics, comparisons) and "what goes against what" (negative or agon terms, such as negations, terms in competition, or at odds with each other) in these clusters and how these linguistic patterns (re)produce certain understandings of reality (Foss, 2004). A cluster-agon analysis consists of three steps. First, the key terms of the rhetorical action have to be determined, which in our case corresponded with the search terms each article was tagged with during the descriptive analysis (e.g., mental illness, mental wellbeing, depression, and so on). Next, the researcher examines the contexts in which the key terms occur and identifies the terms that positively and negatively cluster

around the key term in these contexts. To interpret what terms are most meaningfully associated with the key terms, the principles of frequency, location, and emphasis can be applied. In a third and final step, the text is interpreted by discerning wider discursive patterns in the associations or oppositions discovered in the clusters (for a more extensive explanation, see Foss, 2004).

To deal with the issue of analyzing materials in different languages, each researcher analyzed the articles of their geographical area individually for the first two steps of the rhetorical cluster-agon analysis and then reported on the results in English by providing an overview of each article's key terms, positive clusters terms, and agon cluster terms using a shared template. The third step of the analysis was performed by the researchers with expertise in the domain of rhetorical and discursive studies and was reported back to the research team to make sure the findings of the study aligned with the rest of the team's interpretations of the data.

Findings

We identified four dominant terminological clusters in the newspaper and magazines' mental health reporting, with mental health/illness conceptualized in terms of (a) danger and risk, (b) a lifestyle issue, (c) a unique story and experience, and (d) social trends and factors. Below, we describe how each of these understandings is rhetorically constructed by discursively associating and disassociating specific groups of cluster terms. We also elaborate on how each of the clusters communicates specific ideas on what counts as valuable mental health knowledge (cf. mental health literacy) by relating them to the three models of biocommunicability.

Mental Health/Illness in Terms of Danger and Risk

In each of the six countries' public mental health debates, we identified a cluster that approaches mental health problems in terms of danger, risk, and violence. This cluster is most apparent in news articles that relate mental health problems to (pseudo-)criminal activities, with the terminology used to refer to people with mental health problems ranging from judicial language (e.g., the accused, the offender) to biomedical language (e.g., psychiatric patient) and language that relates to madness (e.g., a disturbed person, a sick mind). Interestingly, these terminologies do not appear as the agon of one another, but instead paradoxically intersect. For example, in one article, a woman who struggles with mental health problems is referred to as both a "notorious troublemaker"/"attacker" and a "vulnerable psychiatric patient"/"sweet lady."

Especially in the case of serious crimes that seem to have no clear motive, such as a parent murdering a child or a very young perpetrator committing a violent crime, news reports ambiguously draw on terminology that refers to both determinism and agency. Statements such as "there was no intention or motive," "I wasn't myself," or "I couldn't control my impulses," suggest a passive role for the individual involved and instead consider mental illness to be both the explanation and the agent of the action. Still, individual responsibility is implied as is illustrated in terms such as "remorse," "apologize," or "mental illness is used as an excuse." A more explicit reference to the assumption of agency can be found in judges' or journalists' indication that the person who committed a crime did not seek psychological help in time or did not take their medication on a regular basis (Table 3).

The association of mental health issues with danger, risk, and threat is a trope that, as Holland (2018a) notes, is not specifically accounted for in the model of Briggs and Hallin (2016) which focuses on the issue of health news more generally. However, our data suggest that news coverage that relates mental health problems to crime is still largely informed by the biocommunicable model of biomedical authority, with most of the terminology surrounding the concept of mental distress referring to biomedical psychiatry (i.e., illness, disorder, diagnosis, treatment, medication, and psychiatric expert). Interestingly, within this cluster, the biomedical authority model might work as both a destigmatizating force by taking away part of the blame and responsibility for the crimes committed, and as a stigmatizing force by reinforcing conceptions of mental illness as medical dysfunctions that cannot be remedied. The language reflecting the agency of the person with mental health problems illustrates that the patient–consumer model operates in this cluster as well. By associating crime and punishment with reluctance to turn to professional help in time or to take one's medication in a responsible way, news stories on crimes committed by people with mental illnesses can function as examples of biocommunicable failure to manage one's mental health.

Another group of articles that reinforces both the biomedical authority and the patient–consumer model by relating mental health problems to danger and risk, consists of news reports that disseminate recent research findings on what increases or decreases the possibility of developing mental health problems. Central to the terminology of these articles is the concept of "risk," that functions to present mental illness as an ever-present threat to "healthy individuals" and "healthy societies." In line with the biocommunicable model of biomedical authority, journalists generally take on the role of passing on scientific

Table 3. Overview of the Cluster Terms Focusing on "DANGER" in "Cluster 1: Mental Health/Illness in Terms of Danger and Risk."

Mental health/illness in terms of danger	
Positive terms (what goes with what?)	Agon terms (what goes against what?)
Clusters terms that focus on danger	
danger, dangerous, dangerous without right treatment, crime, lose control, violent, risk, protect society, safety, threat, aggressive, police, arrested	
Cluster terms that name the person involved	
offender, perpetrator, attacker, notorious troublemaker, the accused, patient, vulnerable psychiatric patient	
Cluster terms that refer to mental health issues	
mental disorder, mental illness, diagnosis, medical diagnosis, medical proof, evidence, psychiatric testing, psychiatric evaluation, expert, psychiatric expert, behavioral expert, psychiatrist, psychologist, disturbed, sick mind, delusional, mentally unstable, unreasonable	
Cluster terms that focus on the tension between determinism and agency	
no intention to, no awareness, not willingly, no responsibility, cannot be held accountable, I wasn't myself, impulses, no motive, mental illness as explanation	didn't seek psychological help, no critical self-evaluation, stopped medication, taking medication irregularly, feeling guilty, remorse, apologize, admit mistake, mental illness as excuse, "claims" diagnosis
Cluster terms that focus on orientations to act	
therapy, treatment, hospitalization, compulsory treatment, counseling, therapy still possible	punishment, conviction, jail, sentence, strict legislation, mental health services inadequate to protect society, recidivism, never ending story, danger of relapse

expert knowledge on what constitutes a "risk profile" or who belongs to a "risk group" to a not-yet-knowing audience. Specific demographic groups, in our data mostly adolescents, the elderly and (pregnant) women, are singled out as "especially vulnerable" and thus especially responsible to manage their risk of developing mental difficulties. Only very rarely, journalists comment on the fact that there is no consensus on the validity of certain research findings yet among scholars and (mental health) professionals.

Our cluster analysis furthermore shows that scientific terminology often intersects with neurological and technological terminology to create the equation that more technology equals more individual, neurological, statistical data which, in its turn, is assumed to lead to less risk of mental health problems and thus healthy individuals and healthy societies (Table 4). In several news articles, economic interests are integrated in the formula as well, with the costs of persons who experience mental health problems (in terms of economic, social and human capital) presented as posing an economic threat to healthy societies.

Mental Health/Illness in Terms of Lifestyle

Although the first cluster mainly focuses on "mental illness" or "mental health problems," this cluster emphasizes the importance of actively pursuing "mental wellbeing," "quality of life," and even "happiness" (Table 5). In the public mental health debates, the first and second cluster often do not operate as each other's agons. Rather, they intersect in prevention logics that take the individual as their primary object of intervention and that are heavily embedded in the patient–consumer model of biocommunicability and its notion of the enterprising self. Within this cluster, news articles encourage the general public to actively manage their mental health, with the key to a healthy mental life to be found in a healthy lifestyle, which includes healthy eating habits, healthy sleeping patterns, physical exercise, and a responsible use of technology and social media. The strong presence of lifestyle-terminology (way of life, life attitudes) in conjunction with self-terminology (self-improvement, self-care, self-regulation) suggests that taking care of one's mental condition is not only primarily a responsibility of the individual, but also a lifelong commitment.

Within this cluster, mental health literacy appears as a prominent aspect of mental health care and is conceived of as a pedagogical project with news and magazine articles "informing" and "educating" the audience with "tips," "tricks," and "advice" on how to maintain a healthy lifestyle. Although this lifestyle journalism has a clear relation to the patient–consumer model, we identified examples of biomedical authority within this

Table 4. Overview of the Cluster Terms Focusing on "Risk" in "Cluster 1: Mental Health/Illness in Terms of Danger and Risk."

Mental health/illness in terms of risk	
Positive terms (what goes with what?)	Agon terms (what goes against what?)
Cluster terms that focus on risk	
risk of, more/less likely to develop mental health problems, risk group, risk profile, vulnerable groups, risk factor, at risk, social risk, danger, protection, specific target groups, that is, adolescents, women, mothers/pregnant women, elderly	health, healthy body, healthy societies
Cluster terms that focus on research	
research, academic, study, data, knowledge, scientific literature, evidence, statistics, numbers, results, data	lack of data, lack of knowledge science is ambiguous, trial and error, humility, no consensus
Cluster terms that focus on orientations to act	
measure, sensor, detect, analyze, register, test, expose, screening, predict, prevent, avoid, reduce, warn, supress, root out	
Intersection with the technological cluster terms	
technology, artificial intelligence, digital biomarkers, psycho-app	
Intersection with the neurological cluster terms	
brain activity, neuroscientist, neurotransmitters behavior, individual behavior	
Intersection with the economic cluster terms	
economic interests, profitable, productivity, work, labor expert, absenteeism, efficient, consumers, market, invest, social/human capital	

cluster as well. In several of the articles, the association of mental health and lifestyle is underpinned by biomedical scientific and professional expert knowledge, often invoking neurological explanations referring to the brain and hormones. Nevertheless, this cluster complements traditional authoritative knowledge on mental health/illness with new sources of information, including expert advice from life coaches, labor experts, and health insurance companies, advertisements from pharmaceutical companies, and insights from people who personally experienced mental health issues.

Mental Health/Illness in Terms of Unique Stories and Experiences

We identified examples of people sharing experiences of dealing with mental health problems with a larger public in all of the six countries' media sources. In some of the countries, these so-called "first person accounts" even dominated public discussions of mental health/illness. The term "story" and other narrative terminology seems of particular importance to people's description of their (or a friend's or relative's) experiences of dealing with mental health problems and of processes of stereotyping and stigmatization (e.g., "everyone has their own story," "see the story behind people," or "don't judge a book by its cover"), which emphasizes the subjective and personal dimension of experiencing mental health problems. Indeed, the testimonials often do not conceptualize mental health problems from a single perspective, as is reflected in the biopsychosocial terminology in this cluster (cf. terminology referring to the bodily, psychological, emotional, and social dimensions of mental health problems). Likewise, a variety of potential sources of support are mentioned, including professional help from a family doctor, therapist or psychiatrist, psycho-pharmaceuticals, alternative therapies, and nonprofessional help such as support from friends, family or fellow-sufferers/survivors, and self-care. A closer examination of the testimonials reveals that several stories are built around a linear "made it"-narrative: after people's journey to find the help most suited for them, they reach a point of "peacefulness" or "stability" and "finally feel like themselves self again." Such "redemptive story turning points" have been considered important in the process of regaining personal agency (Kerr et al., 2020). However, one of the messages conveyed to the audience in such stories seems to be that everyone can find out "what works for them," which resonates with conceptions of biocommunicable success within the patient–consumer model. Indeed, in one of the news articles, a scholar critiques the "conditional openness" of media toward stories that fit certain "feel good"-narratives. Occasionally, we found the third cluster to intersect with the first and second one in articles that report on people's successful attempts to prevent mental health issues (see titles such as "I almost suffered from a burn-out"; Table 6).

Understandings of mental health issues in terms of personal stories or experiences also adhere to the more emancipatory dimension of the patient–consumer model

Table 5. Overview of the Cluster Terms in "Cluster 2: Mental Health/Illness in Terms of Lifestyle."

Mental health/illness in terms of lifestyle	
Positive terms (what goes with what?)	Agon terms (what goes against what?)
Clusters terms that focus on health/wellbeing	
mental health, wellbeing, wellbeing policy, health, healthy, health trend, health insurance, healthy societies, healthy bodies, healthy relationships, public health (problems), motivated, happiness, energetic, boost your mood, positive psychology	unhealthy emotions, intense and ambivalent emotions, dysfunctional thoughts, problematic relationships, pressure, stress
Cluster terms that focus on lifestyle	
lifestyle, lifestyle magazine, lifestyle diseases, change lifestyle, quality of life, change behavior, change attitudes, way of life, daily life, diet, healthy diet, food, nutrition, sleep patterns, quality of sleep, exercise, physical exercise, being in shape, mindfulness, breathing exercises, walking, daylight, less technology and social media, work–life balance, no smoking and alcohol, relax	(i.e., what can and should be prevented by improving your lifestyle) stress, anxiety, exhaustion, burn-out, depression, postpartum depression, loneliness, aging, dementia, diabetes, ADHD, psychological problems in general
Cluster terms that focus on the individual	
individual behavior, you, personal, self-care, self-regulation, self-improvement, self-awareness, self-esteem	
Cluster terms that focus on orientations to act	
"3 signs that . . . ," warning signs, "5 tips to . . . " tricks, advice, advertisement, improve, succeed, reach outcomes and goals, make choices, recognize, prevent, manage, coach, protect, counteract	
Cluster terms that focus on pedagogy	
educate, train, psycho-education, education, parents, increase your knowledge	
Intersection with economic cluster terms	
economic interests, profitable, productivity, work, labor expert, efficient, consumers, market, invest, social/human capital, expensive, societal costs, medical costs, destruction of resources	
Intersection with neurological cluster terms	
brain, neurotransmitters, neuroscientist, hormones, dopamine shots, serotonine, melatonine, brain activity, exercise your brain, a quick and sharp brain, brain development	

Note. ADHD = attention-deficit/hyperactivity disorder.

as they validate the experience of service users/survivors as a legitimate source of knowledge on "what works best." Various testimonies question the dominance of the biomedical psychiatric perspective as the only or most authoritative form of knowledge on mental health problems. They display ambiguous attitudes toward the use of pharmaceuticals, mention negative experiences with professional help or share stories about the beneficial effects of alternative therapies and nonprofessional help. Some of these more critical testimonies explicitly speak from a public sphere model of biocommunicability and address their critiques directly to the mental health care system and the politicians, policy makers and professionals behind it (on this, see also Cluster 4).

In most cases, however, the "experience" (or "proximity" in the case of relatives or friends) of people dealing with mental health issues works as a form of "knowledge" or "expertise" to convince people with similar experiences that change is possible and that there is no shame in asking for (professional) help. "Knowledge by experience" is ascribed both an informative and a supportive role, as is evident from expressions such as "our insights are like medicine" or "hearing and sharing stories can be therapeutic." In addition, it is engaged with as a means to break persisting stereotypes and taboos surrounding mental health problems and to create a climate in which mental health issues can be talked about more openly. A major rhetorical strategy deployed in the testimonies' antistigmatization work, is the establishment of a process of identification with the readers, emphasizing throughout the stories that people with mental health issues are actually "just like *you*," that "we are *all* humans" and that "*everybody* struggles." Interestingly, on some occasions, attempts to identify with the larger public coincide with the creation of new divisions. Especially in the case of mental problems such as depression, anxiety, and burn-out, people sometimes emphasize the importance of opening up about mental struggles, yet

Table 6. Overview of the Cluster Terms in "Cluster 3: Mental Health/Illness in Terms of Unique Stories and Experiences."

Mental health/illness in terms of unique stories and experiences	
Positive terms (what goes with what?)	Agon terms (what goes against what?)
Narrative clusters terms	
story, unique story, own story, journey, search, story behind people, heavy stories, intense stories, everyone has a story, don't judge a book by its cover, genre of "depression literature", sharing experiences in a book, theater play, comedy show	
Cluster terms describing mental health problems and "what works"	
body, physical, ill, illness, brain, thoughts, in my head, mental difficulties, feelings, emotions, trauma, past, part of me, professional help, specialist, help from expert, psychiatrist, family doctor, psychotherapist, therapy, medication, antidepressant, mood regulators, hospitalization, dance therapy, animal as mental support, hypnotherapy, humor, support from family and friends, self-care	
Cluster terms that focus on biocommunicable success	
reborn, start over, the light, new, strength, brave, overcome, back on my feet, made it, be myself again, feel better, get better, found myself, found refuge, turning point, peaceful, rescue, life changing, inspiration	never free from it, medication is no miracle cure, no problem solvers, psychiatrist didn't help, ambiguous, hate-love relationship with medication, feel worse, side effects, got wrong medication and treatment, government fails
Cluster terms describing the aim of the testimonies	
share, knowledge, experience, knowledge through experience, experts by experience, information, demystify, tips, insights, lessons, prevention, coach, help and support others, talking openly, openness, no shame, break taboo, break silence, understanding, sharing and hearing stories is therapeutic, encourage help seeking, be a good example, visibility, coming out, going public	conditional openness, limited openness, branding, edited media realities
Cluster terms that focus on identification and division	
not alone, like the others, like me, the same, smalls vs big problems instead of disorders, everybody struggles, humans like us	not crazy, "clean" now, not like the stories in the news of crazy people yelling on the streets, normal weaknesses/ just problems vs mental problems
Cluster terms that focus on "sensation"	
celebrities, world famous stars, confession, reveal, revelation, shock, secret, inside information, leaked images, crazy	

simultaneously reassure the audience that they are "not crazy." The language of "craziness" or "madness" is also apparent in some of the more sensationalist media reports "revealing" the mental health problems of celebrities, turning their "confessions" into objects of curiosity and entertainment for the audience (see, for example, click-bait titles such as "Doctor, I am crazy and I am dying: Greek singer shocks!").

Mental Health/Illness in Social Terms

Although in the three previous clusters, the individual is most prominently featured as the object of attention, the fourth cluster focuses on the social dimension of mental health/illness (Table 7). Since this cluster does not have a specific thematic focus, we will elaborate on three topics that frequently recurred, each of them characterized by a specific set of associated cluster terms.

The first topic concerns critiques on the organization of the mental health care system, in most cases formulated by (mental health) professionals or service users/ survivors. The problems most frequently targeted in the critiques include the inaccessibility of mental health services, waiting lists getting longer due to a lack of care accommodation, and the system's overreliance on medication as a quick fix for complex psychological problems. Politicians, policy makers, pharmaceutical companies, and medical professionals are explicitly addressed as the audience of the critiques, with calls to increase the government's mental health care budget, to develop care-centered instead of administration-centered policies, and to educate professionals on the value of various therapies.

Table 7. Overview of the Cluster Terms of "Cluster 4: Mental Health/Illness in Social Terms."

Mental health/illness in social terms	
Positive terms (what goes with what?)	Agon terms (what goes against what?)
Cluster terms "mental health care system"	
mental health system, mental health services, mental health care, waiting lists, no accessibility, no availability, lack of care accommodation, not enough treatment capacity, unacceptable, illegal use of force and isolation cells, medication as quick fix, over prescription and overuse of medication, pharmaceutical companies, selling illness, bureaucracy, market forces in care system, constant monitoring, administration, hold politicians accountable, government fails, participation society fails, policy, financing, budget, resources	alternative help circuit (e.g., care farm), person centered care, care time, care centered policy
Cluster terms "societal trends"	
technology, social media, Facebook, WhatsApp, work mail, technostress, information society, labor market, stress, high pressure, high expectations, performance society, neoliberal society, productivity, tsunami of burn-outs, burning boomers, generation Z, psychological problems or our time	
Cluster terms "societal power differentials"	
"experts in discrimination", discrimination, inclusion, diversity policy, violation of rights, democracy, social exclusion, repressive policies, intersectionality, power, politics, marginalized population, equal citizens, government	"experts in therapy," lack of training in "stigmatized identities"
advocacy organizations, voice, activism, organized actions, political awareness as therapy	chemical imbalance and treating symptoms psychological problems
power imbalance and tackling societal issues, unequal society, socioeconomic living conditions, health insurance, financial poverty, neoliberal conservatism, capitalism, productivity, disposable people	

The terminology in this cluster pinpoints attention to a question that is often left out in the previous clusters, namely, whether we can guarantee that a person that wants to be helped professionally will be able to find and access appropriate care. This not only raises the question whether our mental health care system allows people to take on the role of the active and empowered patient–consumer, but, on a more fundamental level, challenges the notion as such. For example, in cases where people who need professional help distrust the system (e.g., due to psychotic episodes), putting the responsibility to ask for and find professional help mainly with the individual in mental distress (and their close environment) might hamper their chance of getting the appropriate care.

The second topic that draws on social terminology in its discussion of mental health, concerns the identification of societal trends that might impact the wellbeing of the general population. High pressure workplace environments as well as technological developments, social media, and the concomitant expectation of always being available are singled out as leading to "a tsunami" of stress, burn-out, anxiety, and depression. Although some articles complement their analysis with calls on employers to develop wellbeing policies or with a more radical rejection of our "performance society" altogether, others turn their attention to the individual again, asking "what we can do to live a life that is free of technostress?" or arguing that "changing our reactions to culture can be liberating." Here again, appeals are being made to the "enterprising individual" that, once informed about the social risks threatening its wellbeing, will be able to make the right health choices (see also Cluster 2).

Finally, a small number of articles discusses how social inequalities and power differentials in our societies affect the mental wellbeing and mental health care of marginalized groups. Furthermore, some articles critique how in current political and ideological debates people who struggle with mental health issues are portrayed as threatening out-groups (together with, for example, people who suffer from drug addiction or prostitutes) as a way to rationalize their exclusion from a society that is not capable of—or not willing to—provide basic needs for the most vulnerable members of its population. The terminology used in these articles differs from the terms traditionally dominating public discussions of mental health/illness. For example, instead of "stigma," concepts such as "discrimination," "violation of rights," and "social exclusion" are used to describe experiences of repression, criminalization or exclusion in society and the mental health care system. Orientations to act shift from "hearing and sharing stories as therapy" to "activism," "advocacy," and "political awareness as therapy" with specific attention being paid to the material realities in which people are expected to take care of their mental wellbeing. These articles contained the most outspoken references to a public sphere model of biocommunicability with the unusual targeting

of politicians, policy makers, and mental health professionals as the objects of pedagogical or literacy interventions in which they need to learn from "experts in discrimination." Interestingly, in some articles the term "psychological problems" appeared as an agon term, reminding the audience that not all problems can be reduced to individual mental distress and that in some cases "tackling societal issues and power imbalances" rather than "treating symptoms or chemical imbalances" might be the more appropriate way to act.

Discussion

In this study, we examined media coverage on the topic of mental health problems and mental wellbeing in a broad range of newspapers and magazines from six different European countries. We specifically analyzed how the discursive association and disassociation of cluster terms (cf. "what goes with and against what") creates specific understandings of what constitutes the mentally healthy or ill subject. Drawing on the framework of biocommunicability, we furthermore sought to examine how each of the clusters relates to the concept of mental health literacy and persuades its audience to take up particular attitudes toward mental health (knowledge).

Our findings illustrate that public discussions of mental health/illness inevitably draw on terminological clusters, with the clusters of "mental illness as dangerous," "mental wellbeing as a matter of lifestyle," "experiencing mental health problems as a unique story," and "mental illness as socially situated" being the most dominant in our data. While some news and magazine articles clearly aligned with one of the four clusters, we identified many examples where different clusters and biocommunicable models intersected to create complex, sometimes paradoxical, terminological and biocommunicable cartographies. These findings suggest that particular discourses can function differently in public mental health debates and that they cannot be unambiguously judged as either exclusively problematic and stigmatizing or exclusively good and empowering.

We argue that the method of rhetorical analysis might respond to the methodological challenge to capture the nonlinear and complex effects of specific discourses on public understandings of and attitudes toward mental health/illness (Briggs & Hallin, 2016), since the rhetorical and productive power of psy-discourses precisely lies in the fact it might accommodate multiple interests (Thornton, 2010). In our analysis, we indeed identified several examples of the complex and multiple workings of specific discourses (or terminological clusters) in relation to topics such as stigma, empowerment and mental health literacy.

For example, discourses of dangerousness and risk, sometimes in coalition with discourses of sensation, were clearly present in our data. This is in line with previous research findings (Nairn, 2007; Sieff, 2003) and was perceived as negative and conforming stereotypes of people with mental difficulties being out of control in many of the first person accounts. Although mainstream media thus contribute to the persistence of negative stereotypes, they also take an active role in counteracting them with the taboo-breaking first person accounts appearing as one of the most dominant types of mental health reporting in several of the six countries. The biomedical "mental illness as a disease like any other" approach was often engaged as a tactic to normalize mental illness and taking psycho-pharmaceuticals in particular in these narratives. However, research has shown that increased medical literacy does not necessarily result in increased social acceptance of people with mental illness (Schomerus et al., 2012) and might even strengthen ideas of dangerousness and unpredictability (Read et al., 2006). Our analysis of the crime reports provides an apt illustration of this double rhetorical effect of stigmatization and destigmatization of biopsychiatric and medical discourse. In many of these articles, concepts such as "diagnosis" and "illness" functioned to take away blame, yet also coincided with punitive, law and order, and criminalizing terminology as they strengthened deterministic beliefs that "this person will not change" and "there is too high a risk of relapse."

Inviting empathy and understanding is considered to be another effective rhetorical strategy of anti-stigmatization and normalization in mental illness narratives (Lewiecki-Wilson, 2003). In our study as well, establishing identification with the audience was central to many of the first person accounts' efforts to normalize the experiences of people with mental health problems. In a few cases, however, people's identification attempts coincided with a reassurance of the audience that they were "not crazy," implying a hierarchy between more and less socially acceptable mental health problems. Although our data did not contain explicit references to mental problems considered to belong to the last category, most of the personal narratives and lifestyle advice focused on burnout, depression, suicidal thoughts, anxiety, and mental health problems in general, with bipolar disorder, psychosis, and schizophrenia less frequently or not at all openly discussed. Similarly, a study of newspaper coverage on mental illness in the United Kingdom indicates that in the past decades coverage for depression has become less stigmatizing, but has remained largely negative for schizophrenia (Goulden et al., 2011). This could possibly be explained by mainstream media's tendency to sanitize mental health news and focus on upbeat and safe narratives that largely fit biomedical authority and

patient–consumer conceptions of biocommunicable success (Holland, 2018a), rather than on stories about schizophrenia and psychosis that have long been associated to "classical madness" (Wahl, 1995, p. 15). One a more fundamental note, Rothfelder and Thornton (2017) question whether empathy and understanding are unambiguously desirable rhetorical effects at all. They remark that the growing acceptance and popularization of the term obsessive compulsive disorder (OCD) (cf. expressions such "I am so OCD as well") might have some unproductive effects, such as too simplistic and unquestioned understandings of what OCD is and what it means to live with it. Rather than focusing our communication exclusively on empathy and acceptance, we should be more sensitive toward the critical potential of "rhetorical acts that do not seek uncomplicated acceptance or understanding from their audiences" as tools of antistigmatization and resistance (Rothfelder & Thornton, 2017, p. 360) and should look into the diversity of reasons people have for choosing whether or not to disclose their mental health issues (Bril-Barniv et al., 2017).

In the same way discourses play various roles in the rhetoric of (de)stigmatization, they can perform differently in the rhetoric of empowerment as well. The findings of our study largely confirm Briggs and Hallin's (2016) argument that, in the context of (mental) health, current understandings of empowerment are largely embedded in patient–consumer models of biocommunicability, which emphasize client/consumer-centered practice and individual decision-making as leading principles of (mental) health care. Similar to the case of biopsychiatric discourse, Juhila et al. (2016) argue that empowerment-discourse gains its power from its potential to underpin varying projects of change in current welfare states and services. In our data, logics of agency (e.g., notions of "expertise by experience" in personal narratives) intersected with logics of consumerism (e.g., media presenting a healthy lifestyle as a commodity to be purchased by their readers) and individualization (e.g., translating social problems to problems of individuals being at risk), to create understandings of empowerment that simultaneously affirm the audience's autonomy to make choices and their responsibility to make the right choices. These discourses of responsibilization often prioritize the notion of mental health literacy over mental health service and focus attention to the information and knowledge gaps of individuals or the general public rather than the social and materials contexts in which individuals are expected to monitor their mental health (Esposito & Perez, 2014; Teghtsoonian, 2009). We did encounter some resistance toward these discourses within the fourth cluster, which tried to change the scope of analysis and intervention from the individual to the collective and societal level as well as within some of the personal narratives which addressed shortcomings in mental health practice and policy, rather than in the general public's mental health literacy.

Although patient–consumer models heavily impacted understandings of empowerment and mental health literacy in our data, there was a clear presence of the biomedical authority model as well, especially in the form of neuro-discourses. We did not elaborate on the bio-neurological perspective as a separate cluster since it nearly always appeared in conjunction with the three first clusters. Dumit (2003) notes that neurological conceptions of mental illness have become so persuasive that the brain has almost become a synecdoche for one's identity. When combined with the autonomy as responsibility-logic, this leaves people with the difficult choice between the "too-simple cultural alternatives of either being responsible for your sickness or not being your brain" (Dumit, 2003, p. 8). Our data did indeed contain some evidence of people trying to negotiate understandings of their neurological (Rose, 2009) or pharmaceutical (Dumit, 2003) selves, balancing between understandings of their mental health problems as "a part of them" versus as "a brain dysfunction that needs to be fixed with medication so I can be myself again." This again reminds us that we cannot simply judge specific discourses as either stigmatizing or empowering and that we need to understand the choices of people with mental health problems to self-identify in certain ways within larger sociocultural understandings of what constitutes good and healthy citizens.

Conclusion

This article has aimed to contribute to the field of critical (mental) health communication studies by examining how newspapers and magazines actively mediate public understandings of mental health/illness and simultaneously communicate ideas on who should produce, circulate, and receive mental health knowledge. Our analysis of the performative effects of the terminological clusters that underpin public discussions of mental health/illness revealed that we cannot take for granted the straightforward destigmatizing or empowering effects of biopsychatric discourses or discourses aimed at empathy and understanding. We consequently argue that, rather than searching for the ultimate correct and destigmatizing mental health/illness knowledge and discourse, health communication research should examine how discourses work differently in varying contexts and how they might be productive in both the formulation of positive self-identifications and in the creation of new lines of division and exclusion. In addition, such a "discursive awareness" might be relevant for clinical practice as well, since professionals might become "mindful of the effects of their

use of language and make the contingent nature of their knowledge explicit" (Lofgren et al., 2015, p. 470). One of the limitations of this study is its restriction to a 2-week period of news coverage, which means that specific topics might have been overrepresented or missing in our data. However, as our aim was not to track down changes over time in media coverage of mental health/illness, we contend that our data set was comprehensive and diverse enough to allow us to gain insight into larger terminological patterns and complexities in current mental health/illness reporting. In line with Lynch and Zoller (2015), we furthermore contend that methodological perspectives from the field of rhetorical studies might offer valuable contributions to the field of health communication, especially because of its potential to study how language constructs specific cultural understanding of health, illness and literacy and how, at particular moments, these constructions become persuasive to particular audiences and particular causes. We confined our analysis to the empirical study of written, online mental health news. However, future studies might fruitfully draw on the framework of biocommunicability and the method of rhetorical analysis to study how cultural understandings of mental health (literacy) are constructed in a variety of other empirical contexts, such as service users' activist and advocacy work, policy documents, or professional discourse. Since research has shown that dynamics of media coverage and stigmatization might be different for specific mental health issues, future research might also study the rhetorical effects of specific discourses for specific mental health problems, such as depression, burn-out, or schizophrenia. In addition, although this did not fall within the scope of this study, future research might apply comparative methodologies to gain insight into the potential impact of political, economic and cultural contexts on media coverage of and main themes about mental health within countries. Finally, we suggest that mental health awareness campaigns and mental health literacy policy initiatives broaden their scope from focusing on the need of the general public to educate themselves on one form of mental health knowledge to the need for everyone, including journalists, policy makers, professionals, service users, and researchers, to develop a critical mental health literacy, which includes a critical meta-awareness of the ways in which we are all confronted with various cultural constructions of mental health/illness, and "recruited to take our assigned roles in producing, circulating, and receiving health knowledge" (Briggs & Hallin, 2016, p. iv).

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Notes

1. We recognize that, according to theoretical or political position, terminological preferences to refer to "mental health (issues)" and "service users" can differ. In this article, we will use varying terminology mainly trying to remain as closely as possible to the specific terms used in the public debates and the literature we study.
2. Definitions of "most read" differ according to the information available in each country, for example, highest number of (online) subscribers or highest number of sold copies.

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