Journal Of the Iraqia University (74-7) November (2025)

ISSN(Print): 1813-4521 OnLine ISSN:2663-7502
Journal Of the Iraqia University
available online at: https://www.mabdaa.edu.iq

The Cognitive Linguistic Construction of Mental Disorder Anti-Stigma in WHO Reports

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البناء اللغوي المعرفي لمفهوم مناهضة الوصمة المرتبطة بالاضطرابات النفسية في تقارير منظمة الصحة العالمية

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Abstract

This study investigates how the World Health Organization (WHO) constructs anti-stigma messages about mental disorders in its reports. It employs the Dynamic Model of Meaning (DMM) to explore how language creates mental disorder anti- stigma through past and present knowledge. The DMM implements the semantic and pragmatic levels. The study aims at; finding out if WHO reports utilize personal or social knowledge, discovering whether WHO addresses certain individuals or the wider society, identifying the types of intention used to fight stigma in WHO reports. Based on these objectives, the study attempts to answers three research questions: do WHO reports depend on personal prior experiences or on general social prior knowledge about mental disorder stigma? Do WHO reports target specific individuals with mental disorders or do they aim to reduce stigma from a wider social perspective? What are the types of intention behind WHO reports that fight stigma (communicative, informative, private, social, or we-intention)? The study uses a qualitative approach supported by manual statistics. The methodology is the DMM which shows how meaning is created by combining prior experience with current context. The findings show that WHO uses general social knowledge more than personal stories. The reports focus on society as a whole and use mostly social intentions. The study concludes that WHO promotes a social and collective approach to reduce stigma against mental disorders. It uses language as a tool to influence behavior and encourage public understanding and inclusion.Key words: cognitive linguistic, concept, mental disorder, stigma, WHO.

المستخلص

تسعى هذه الدراسة إلى الكشف عن الكيفية التي تبني بها منظمة الصحة العالمية (WHO)رسائلها المناهِضة للوصم المرتبط بالاضطرابات النفسية في تقاريرها الرسمية. وتستند الدراسة إلى النموذج الدينامي للمعنى (Dynamic Model of Meaning) بهدف استكشاف كيفية توليد المعنى من خلال المزج بين المعرفة السابقة والسياق الحاضر. وتركز التحليلات على المستويين الدلالي والبراغماتي. تهدف الدراسة إلى تحقيق ثلاثة أهداف رئيسية. أولًا، تحديد ما إذا كانت تقارير المنظمة تستند إلى المعرفة الفردية أو الاجتماعية العامة. ثانيًا، الكشف عما إذا كانت التقارير تخاطب الأفراد أم تتوجه إلى المجتمع ككل. ثالثًا، التعرف على أنواع النوايا التي تستخدمها المنظمة في خطاباتها المناهِضة للوصم. وانطلاقًا من هذه الأهداف، تسعى الدراسة إلى الإجابة عن ثلاثة أسئلة بحثية. هل تعتمد تقارير منظمة الصحة العالمية على الخبرات الفردية السابقة أم على المعرفة الاجتماعية العامة بشأن وصمة الاضطرابات النفسية؟ وهل تستهدف هذه التقارير أفرادًا بعينهم أم تسعى إلى تقويض الوصم من منظور

اجتماعي أوسع؟ وما أنواع النوايا التي تتضمنها هذه التقارير مثل النية التواصلية أو الإعلامية أو الخاصة أو الاجتماعية؟ تعتمد الدراسة على منهج نوعي مدعوم بإحصاءات، وتُطبق النموذج الدينامي للمعنى الذي يوضح كيفية بناء المعنى عبر تفاعل الخبرات السابقة مع السياق الحالي. وقد أظهرت النتائج أن منظمة الصحة العالمية تعتمد بدرجة أكبر على المعرفة الاجتماعية العامة مقارنةً بالقصص الشخصية. كما تُوجَّه رسائل التقارير في الغالب إلى المجتمع ككل، وتعتمد أساسًا على النوايا الاجتماعية. وتخلص الدراسة إلى أن منظمة الصحة العالمية تتبنى منظورًا اجتماعيًا وجماعيًا لمواجهة وصمة الاضطرابات النفسية، وتستخدم اللغة كوسيلة للتأثير في السلوك وتعزيز الفهم العام والشمول المجتمعي

Introduction Mental disorders affect a large population all over the world. The WHO estimates that approximately 450 million individuals (nearly one in four people) will experience a mental disorder during their lifetime (WHO, 2011, 2014). A significant challenge in tackling mental health issues is the stigma linked to mental disorders. Stigma refers to the negative attitudes, ideas, and prejudices that society holds about individuals with particular traits. It is frequently manifested as discrimination, exclusion, and marginalization (Hinshaw, 2007).Efforts to combat stigma must extend beyond healthcare interventions and include linguistic strategies that shape public perceptions and behaviors. In relation to this, international organizations like the WHO play a key role in these efforts. Through their reports and public messages, they try to change public perceptions. This study explores how mental disorder anti-stigma is cognitively and linguistically constructed in WHO reports. The study follows cognitive linguistic approach which states that language and thought are connected. This study uses the Dynamic Model of Meaning (DMM) as a methodology in the data analysis. This model has been proposed by Kecskes in 2023. It explains how people use past knowledge and current situations to understand meaning. It shows that meaning is not fixed. It is created during real conversations. This study analyzes eight extracts form WHO reports that explicitly tackle mental disorder stigma. It investigates the semantic level (lexical choices), and pragmatic level which includes intention, context, and implicature. The study aims at:

1.Determining whether WHO reports depend more on personal prior knowledge (related to particular individuals) or on general social prior knowledge on mental disorder anti-stigma.

2.Finding out whether WHO reports target particular individuals (who suffer from mental disorder) or they fight mental disorder stigma from a wider social perspective.

3.Exploring the types of intention of WHO reports behind fighting mental disorder stigma (communicative, informative, private, social, and we-intention).

4.Identifying the implied meanings that are imbedded in mental disorder anti-stigma construction.

2. Theoretical background

Mental disorder significantly influences the lives and health of millions worldwide. Mental disorders are essentially psychological conditions that change behavior and may affect physiological functioning, as interpreted through psychological principles. The National Association for the Mentally Ill (NAMI) defines mental diseases as "disorders [that] can profoundly disrupt a person's thinking, feeling, moods, ability to relate to others and capacity for coping with the demands of life" (Thompson, 2007, p. 4). A significant challenge in tackling mental health issues is the stigma linked to mental disorders. Stigma refers to the negative attitudes, ideas, and prejudices that society holds about individuals with particular traits. It is frequently manifested as discrimination, exclusion, and marginalization (Hinshaw, 2007). The theoretical foundations of stigma were significantly shaped by Erving Goffman (1963) who defined stigma as "an attribute that is deeply discrediting," reducing individuals from "whole and usual" to "tainted, discounted" ones (p. 3). Link and Phelan (2001) expanded the concept of stigma by emphasizing its relationship to power, arguing that stigmatization is contingent on access to social, economic, and political power that enables the identification of differences, the construction of stereotypes, and the complete execution of disapproval, exclusion, and discrimination.According to Myers and Dewall (2016), stigma develops systematically through distinct stages and gradually becomes ingrained as a stereotype over time (Cilek & Akkaya, 2022). The conceptualisation of stigma is later on influenced by factors such as cognition, cultural norms, and religious beliefs, which associate the stigmatised people with harmful traits and stereotypes. As a result, a distinction between "us" and "them" emerges, and stigmatized people become more exposed to acts of discrimination (Sayce, 1998, as cited in Cilek & Akkaya, 2022).Experts identify three main types of stigma that affect people with mental disorders. Social stigma involves prejudiced attitudes and unfair actions. Seele (2017) explained that people with serious mental health issues such as substance use disorders, schizophrenia, post-traumatic stress disorder (PTSD), or obsessive-compulsive disorder (OCD) often face strong rejection from society. Self-stigma, or perceived stigma, arises when individuals internalize the negative views of the society, leading to shame, guilt, and worsened mental health. This internalization can reduce the effectiveness of treatment

(Seele, 2017). Structural stigma refers to institutional practices and policies (whether governmental, corporate, or educational) that limit the rights and opportunities of individuals with mental disorders.

WHO is a specialized agency of the United Nations responsible for international public health. Established on April 7, 1948, WHO promotes health, keeps the world safe, and serves the vulnerable by coordinating efforts to address global health challenges such as infectious and non-communicable diseases and health emergencies (World Health Organization, 2013)

In the area of mental health, WHO plays a crucial role in challenging stigma and discrimination, developing toolkits like the MIND and MOSAIC frameworks, and shifting public discourse through inclusive, person-centered language. These discursive practices contribute to cognitive shifts in public perception, aligning with the aims of Cognitive Linguistics in reframing mental health narratives (World Health Organization, 2022).

Cognitive Linguistics (CL) views concepts not as fixed mental representations but as dynamic structures shaped by embodied experience and context. Unlike classical theories which define concepts by necessary and sufficient features. CL builds on structuralist ideas, particularly De Saussure's notion of the linguistic sign (Bruner et al, 1956; Gibbs, 2005). According to Saussure, language is a system of signs. A linguistic sign connects a signifier (sound image) to a signified (concept), forming a psychological entity (Langacker, 2008). This structure shows how language encodes meaning and supports conceptual construction (Khalil& Al- Al- Zubaidi, 2022).

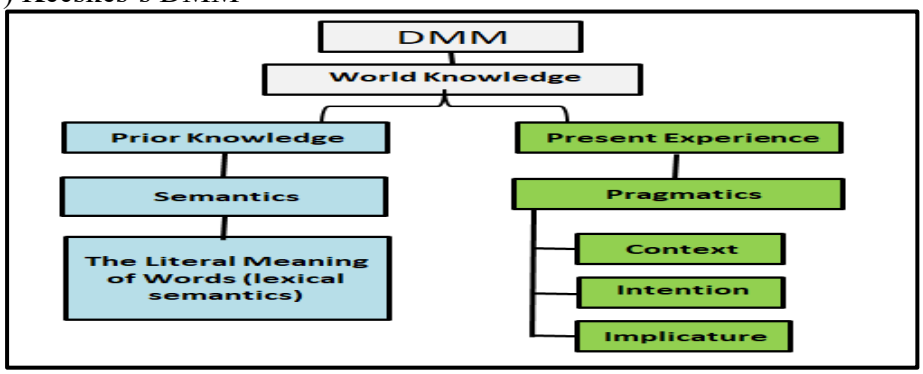
CL emphasizes that conceptualization is influenced by sensory, emotional, and cultural factors (Evans, 2019; Lakoff & Johnson, 1999). Evans and Green (2006, p. 162) defined conceptualization as "a dynamic process whereby linguistic units serve as prompts for an array of conceptual operations and the recruitment of background knowledge". For instance, the concept of "CAT" is understood through direct physical experience rather than a set of features. In line with the weak version of linguistic relativity, CL holds that language influences, but does not determine, thought (Evans, 2014). Linguistic expressions prompt mental imagery and activate background knowledge (Evans & Green, 2006; Langacker, 1987). Two levels of conceptualization are recognized; primary conceptualization is based on direct, physical experience and involves organizing the world through simple categories and perceptions. Secondary conceptualization involves more abstract thinking, such as metaphorical reasoning and symbolic associations, allowing humans to understand intangible phenomena (Wen & Taylor, 2021).

CL emerged in the late 20th century as a response to formalist approaches like generative grammar, which focused mainly on syntax and ignored meaning. Pioneers such as George Lakoff, Ronald Langacker, and Leonard Talmy argued that language is not an isolated mental module but is tightly integrated with general cognition (Lakoff, 1987; Langacker, 1987; Talmy, 2000). CL is interdisciplinary, drawing from psychology, anthropology, and neuroscience, offering a holistic view of language as a cognitive phenomenon. Evans and Green (2006) describe CL not as a single theory but as a movement or enterprise, bringing together diverse perspectives united by shared principles (Janda, 2007).

DMM is a cognitive linguistic approach that explains how people construct meaning through language. It is based on the idea that world knowledge is essential for understanding meaning (Kecskes 2023).This knowledge exists both in the minds of the speakers and in the real-world situation where communication happens (Khalil, 2008). World knowledge includes both past and present experiences of the people involved in communication. The knowledge from past experiences is stored in words while the knowledge from the current situation is part of the present context (Kecskes 2023).

This model explains that meaning comes from two main sources. The first is semantic meaning which is the direct meaning of words and sentences. The second is pragmatic meaning which is the meaning people understand based on the situation and what the speaker intends to say. The model helps researchers in cognitive linguistics understand how meaning is created during real communication. It shows how meaning changes and develops through the interaction between the meaning of words and the context of the situation. The DMM highlights the connection between the fixed meanings of words and the flexible meanings that depend on context and speaker intentions (Kecskes, 2023).

Figure (1) Kecskes's DMM



Methodology Th study adopts a qualitative research methodology supported by manual statistics based on Kecskes '(2023) DMM, within the approach of CL. The model is applied to examine how WHO reports linguistically construct the concept of mental disorder anti-stigma. The DMM presents a comprehensive model that integrates both semantics (prior experience and literal word meaning) and pragmatics (present experience, including context, intention, and implicature). The study allows the researcher to explore how language shapes perception and reduces stigma through dynamic interaction between stored conceptual knowledge and the communicative context (Creswell & Creswell, 2018).The data consists of eight extracts. These extracts were selected from eight WHO reports. Each report explicitly addresses mental disorder anti-stigma. These reports were accessed through the official WHO website. Each extract was chosen based on its relevance to the content. Based on Kecskes' (2023) DMM, the study analyzes meaning construction at two levels: the semantic level which focuses on word meanings as carriers of prior conceptual knowledge, and the pragmatic level which focuses on sentence-level features such as context, intention, and implicature. The DMM emphasizes how interlocutors co-construct meaning through a dynamic interplay between prior experience (encoded in word meanings) and present context (shaped by interactional factors). It highlights three pragmatic elements essential to interpretation, the first of which is context. Mey (1993) adopts a dynamic perspective on context, arguing that it is not a static concept but rather one in continuous development. According to Mey, context is shaped by the ongoing interaction between language users, who actively contribute to its development. The second is intention which is measured by Sperber & Wilson's (1986) relevance theory (RT). RT is a theory of communication and cognition that claims human cognitive processes are naturally oriented toward maximizing relevance (Khalil, 2014). According to this theory, new information, on the one hand, is relevant if it interacts with old information to produce various contextual effects, and the more contextual effects it produces, the more relevant it is. On the other hand, the more processing effort it involves, the less relevant it is. Ithe third pragmatic concept is Grice's (1975) mplicature. Grice's theory of conversation explains that conversational implicature is based on the Cooperative Principle and four maxims: quality, quantity, relation, and manner. These maxims guide how speakers provide truthful, relevant, clear, and sufficient information (Wasen & Hkalil, 2025). Implicature arises when these maxims are followed or deliberately violated, allowing listeners to infer meanings beyond what is said. In contrast, Kecskes DMM views implicature as a dynamic process shaped by both prior knowledge and the present context. Meaning is co-constructed through interaction in real time between interlocutors.

Results and Discussion According to the data analysis, it has become evident that both semantic and pragmatic strategies are extensively employed in WHO reports to construct the concept of mental disorder anti-stigma. This use of language helps to promote a balanced and persuasive message that targets multiple audiences. The analysis has been conducted at two levels.The first level focuses on semantics. It investigates how the lexical choices used in WHO reports activate prior knowledge related to mental disorder and stigma. Words and phrases are selected carefully to reflect certain meanings that are already stored in the minds of people. These meanings are linked to previous experiences and shared knowledge about mental disorders. By choosing specific terms, WHO creates a mental framework that supports understanding and encourages positive attitudes. This helps shape how people think about mental disorders and the stigma associated with them.The second level centers on pragmatics. It explores how the WHO uses context, intention, and implicature to communicate deeper meanings beyond the literal meaning of words. This level focuses on how the reports relate to present experiences and real-life situations. It looks at how addressees interpret the message based on the context and the addresser's intention. WHO often relies on implied meanings to make their message more effective. Together, this two-level analysis provides insight into how WHO employs the strategic use of language to change public attitudes and reduce stigma.The first objective of the study states "Determining whether WHO reports depend more on personal prior

knowledge (related to particular individuals) or on general social prior knowledge on mental disorder anti-stigma." in this regard, the analysis has come up the following frequencies and percentages of prior knowledge have been done:Table (1): General social and personal prior knowledge

Prior knowledge	Freq.	Per.
General social prior knowledge	5	62%
Personal prior knowledge	3	38%
Total	8	100 %

Obviously, WHO reports rely more on general social prior knowledge (62%) than on personal prior knowledge (38%). This indicates that WHO places greater emphasis on the social shared understanding and common beliefs about mental disorders rather than on individual experiences. By focusing on collective knowledge, the WHO aims to address widespread attitudes, cultural norms, and systemic issues that influence mental disorder perceptions and policies across different communities.However, personal prior knowledge appears less frequently in WHO reports, and this can be attributed to several important reasons. One key factor is stigma-related silence. Many individuals choose not to share their experiences with mental disorder due to fear of rejection or discrimination. This widespread hesitance to speak openly reflects the powerful impact of social stigma. Furthermore, the absence of personal stories may serve as an indirect indication that stigma is still present in society, creating an environment where people do not feel safe or supported enough to reveal their struggles. In addition to these social factors, WHO may also intentionally limit personal narratives to protect privacy and avoid attributing people to their illness. By doing so, the organization maintains ethical standards and focuses instead on systemic solutions and broader social change.Moreover, WHO focuses more on behavior than emotion regarding mental health discourse because its main goal is to create real change. The organization does not aim to only stir emotions but works to change behaviors and attitudes and improve policies toward people with mental disorders. "The goal is not only to change how people feel about mental health, but to influence what they do — how they behave, how they treat others, and how they advocate for inclusion" (WHO, 2022)In addition, emotional language can be unstable because emotions vary from one person to another and many people find it hard to express their feelings clearly. For this reason, WHO adopts a rational tone in its reports. To influence decision-makers and institutions and communities, the language must be logical and objective rather than emotional or personal. Showing strong emotions may also increase stigma. People with mental disorders might be seen as weak or incapable, which can strengthen negative stereotypes. WHO wants to bring change that supports mental health through actions and attitudes that respect human rights and reduce discrimination.The second objective of the study states "finding out whether WHO reports target particular individuals (who suffer from mental disorder) or they fight mental disorder stigma from a wider social perspective". This objective has been achieved by analyzing context, the first strategy in the pragmatic level. It navigates through the contexts of the eight extracts to find out whether they simulate particular contexts with particular interlocutors and particular settings or not. Sometimes, instead of narrowing the contexts to specific interlocutors, the extracts view mental disorder anti- stigma form a wider social current contexts. They target contexts of situations that simulate the sufferings of mental disordered individuals as a group of people who share the same difficulties. To achieve the second objective, the following frequencies and percentages of prior knowledge have been done:Table (2): Wider social contexts and particular (personal) contexts

Reports focus	Freq.	Per.
Wider social contexts	7	88%
particular (personal) contexts	1	12%
Total	8	100 %

It is clear that the majority of the extracts target the wider society in their fight against mental disorder stigma. 88% of the the extracts focus on changing public attitudes and reducing discrimination in general social settings. Only 12% of the extracts target particular individuals who suffer from mental disorders.The result of this objective is compatible and in harmony with the results of the first objective. This means that the reports are mainly directed to society as a whole rather than at particular individuals. WHO aims to create broad social change by addressing public attitudes and systemic barriers related to mental disorders. These reports speak to communities, institutions, and decision-makers. Their goal is to reduce stigma within health systems, schools, workplaces, and other public settings. By focusing on the social environment, nevertheless, the particular (personal) contexts, which focused on doctors within the health system, accounted for 12% of the data. The health system is one of the environments where stigma against individuals with mental disorders may begin. In

this context, people with mental disorders are not the only target of WHO. Instead, the focus is also directed toward doctors and healthcare providers within hospitals. These professionals are often the first to practice stigma through negative attitudes or unfair treatment. Therefore, some reports specifically target this group to correct misconceptions and encourage them to adopt unbiased and humane practices.The third objective states "exploring the types of intention of WHO reports behind fighting mental disorder stigma (communicative, informative, private, social, and we-intention)." This objective has been achieved by analyzing the extracts by RT to find out the intentions and, then, to assign their types. Achieving such an objective helps figuring out how the WHO employs language to deliver public messages that fight stigma. Moreover, it helps understanding the orientation of WHO in this respect, whether social, communicative on individual (we-intention). Depending on the analysis, the following table has been generated:

Table (3): The Intentions and their types with percentages and frequencies

Intention	Type	Freq.	Per.
Highlighting the negative consequences of mental disorder stigma	Social	24	75%
Showing how people negatively encounter mental disorder			
Promoting mentally disordered individuals to address this issue			
Addressing stigma and ignorance.			
Showing how cultural beliefs increase stigma			
Revealing the emotional pain caused by isolation			
Challenging one-sided representations of mental disorders			
Encouraging support and hope for recovery			
s lives.'Stigma causes real problems in people			
Stigma can be life-threatening			
Highlighting fear and silence caused by stigma			
Showing how stigma can lead to real harm			
Telling health workers to change how they treat patients			
Raising awareness about the dangers of stigma			
Showing why people do not seek mental health care			
Explaining the role of stigma in preventing access to care			
Showing the increase of people living with depression			
Enhancing anti- stigmatization and mental health care.			
Showing that stigma is a social issue			
Promoting the idea of sharing personal stories			
Encouraging human connection to reduce stigma			
Encouraging support through communication			
Showing the harm of mental disorder stigma			
Calling for change			
Highlighting fear and silence caused by stigma	Communicative	7	22%
Showing how stigma can lead to real harm			
The extract explains a term used in medical care			
Providing concrete examples of procedures to provide mental health care			
Raising awareness of the gaps in treatment and their causes			
Showing how stigma and silence can prevent support			

Pointing out the negative consequences of stigma			
Call for action	We- intention	1	3%
	Total	32	100%

According to table (3), WHO reports focus on social intention. This type appears in 75% of the extracts. Communicative intention is the second most common. It appears in 22% of the extracts. We-intention is the least type used. It is found in only 3% of the extracts. The reason why social intention appears the most in WHO reports is because the reports to create change in society. They try to change how people think and act toward individuals with mental disorders. The goal is to reduce stigma and make communities more supportive and fair. This kind of change needs the whole society to be involved. That is why WHO uses social intention to speak to everyone. They want people to work together to stop discrimination and promote mental health for all. Social intention aims to fight discrimination and prejudice by promoting inclusive tendencies because stigma is found within social interactions.By promoting mental disorder anti- stigma with social intention, WHO reports aim to put mental disorder within normal frameworks and to create supportive environments. Moreover, social intention is inclusive and broad since it targets wide social strata. It aims at influencing societal behavior contrary to communicative and we-intention, which focus on specific and localized interactions.Responding to the first three objectives, it is obvious that the WHO reports have consistent orientation towards targeting the concept of mental health anti- stigma form wider social viewpoints. Mental health stigma arises from social biases and stereotypes. Misinformation of mental health disorders is deeply embedded in many social structures. Thus, tackling this concept requires engaging societies to achieve collective understanding.The fourth objective states "identifying the implied meanings that are imbedded in mental disorder anti-stigma construction." To achieve this objective, conversational implicature has been applied to the data. The analysis has revealed a considerable number of implied meanings. Many of them carry very close indications, but they could not be restated verbatim because each extract employs different wording and context to embed the implied meaning. Therefore, they have been classified into six categories as shown in table (4):Table (4): The implied meanings imbedded in mental disorder anti-stigma construction

No.	Implied meaning category	Freq.	Per.
1	Silence and Avoidance of help - seeking	6	20.5%
2	Discrimination and Social exclusion	6	20.5%
3	Raising Awareness for Change	5	17%
4	Health and Life Risks of Stigma	4	14%
5	Failure of the Health System and Professional Bias	4	14%
6	Non – repetitive points	4	14%
Total		29	100%

Implied meanings related to "silence and avoidance of help-seeking," have been most frequently observed scoring 20.5%. Silence is one of the most common symptom of mental disorder stigma. In many cultures and societies people are often taught to hide their emotional pain. This creates a common habit of staying silent because of shame and fear. WHO focuses on this meaning because breaking silence is the first step to reduce stigma and to help people seek support. The tendency to remain silent and avoid help-seeking is one of the biggest obstacles for effective care for people with mental disorders. When people stay silent or wait to ask for help because of stigma, their condition often gets worse. The disorder becomes more serious and harder to treat. This meaning reflects how stigma leads individuals to remain silent about their mental health struggles and avoid seeking support because of fear of judgment or social rejection. Its high frequency suggests that WHO is highly aware of the internal barriers stigma creates, using this implied message as a call to break the silence and promote openness in mental health discourse.Equally frequent is the implied meaning of “discrimination and social exclusion,” which has also scored 20.5% in the data. This meaning emphasizes how individuals with mental disorders are often marginalized or treated unfairly within social systems, including employment, education, and public life. The recurrence of this meaning indicates that WHO aims not only to address stigma on a personal level but also to highlight the structural and societal forms of exclusion that require systemic change. These two most frequent meanings represent the two key dimensions of stigma: the internal experience of isolation and

fear, and the external reality of social injustice.Additionally, the third most frequent implied meaning is "raising awareness and advocating for change," scoring 17% of the cases. This meaning emphasizes the indirect call of WHO to action, inviting communities and institutions to challenge stigmatizing attitudes. Raising awareness and advocating for change are vital strategies to fight the stigma and discrimination that surround mental health. In addition, these strategies target the root causes of stigmatization because they empower both individuals and communities to achieve systemic reforms. They aim at creating a world where mental health disorder is prioritized and the individuals with mental disorder live free from inequality and discrimination.Following this, two additional implied meanings "health and life risks of stigma" and "failure of the health system and professional bias" each appear with a frequency of 14%. The former meaning reflects the serious consequences of stigma, including mental struggling or even suicide. The latter reflects institutional critique, revealing how stigmatizing attitudes are not limited to society but are also found within the healthcare system itself, where professionals may show bias against patients with mental disorders. These implications underline WHO's concern with both individual and structural harms that result from stigma.Finally, non-repetitive or unique implied meanings accounted for 14% as well. These included less common but meaningful themes, such as betrayal by close relatives or culturally embedded stigma. Although these meanings occurred infrequently, they enrich the content by reflecting varied lived experiences of individuals, and emphasizing that stigma may demonstrate in subtle, culturally specific ways.

Conclusion

The analysis shows that WHO uses both word choice and hidden meanings to fight stigma against mental disorders. The reports focus on correcting the common beliefs about mental disorder, such as the fear of people with mental disorders or linking the disorder to shame. The reports do not often include personal stories because of privacy and fear of judgment. Instead they focus on shared ideas and social change. WHO also gives more attention to actions than emotions. They want people to treat others fairly and support mental health in real life. The reports mostly talk to the whole society not to individuals. The main goal is to change how communities think and act.

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