Do we all speak the same language? A critical systemic functional discourse analysis of psychiatric hospital brochures

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Short title :

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Abstract

Background

Over the last decades, treatment of patients with mental health diseases has shifted from longer-term in-hospital diagnosis and treatment to brief crisis diagnostic and/or treatment stays in hospital wards combined with ambulatory care preventing relapse and promoting patient-centered recovery. To guarantee a shared understanding of the nature of the care provided, it is important that hospital brochures and ambulatory care information are aligned, both in the way in which they define and understand recovery and regarding how they approach the empowerment and activation of the patient.

Aim and research questions

The overall aim of the study was to shed light on whether (1) hospital brochures used in crisis intervention centres in Flanders reflect the tenets of recovery-oriented and empowering care, and (2) the encoded messages are reflective of patients and their needs.

Methods

A systemic functional critical discourse analytic framework was used to analyze a small corpus of

hospital brochures.

Results

Our findings suggest that the answers to both research questions are negative.

Conclusion

This small-scale qualitative study on the under-researched population of psychiatric patients admitted to crisis intervention wards highlights the complexities involved in imparting well-aligned psychiatric care messages to the patients, their home caregivers, the medical community and the general public.

Keywords: Psychiatric hospitals; continuity of patient care; communication; patient-education materials

Introduction

Treatment of patients with mental health diseases has developed over recent decades (Johansen et al., 2021). The focus has shifted from longer-term in-hospital diagnosis and treatment to brief crisis stays in hospital wards combined with ambulatory care preventing relapse, and from deciding *for* the patient to activating and empowering patients and assisting them in making health promoting decisions. Within this context, awareness has grown of the need to educate patients about their illness, signals of relapse and recovery, as well as strategies patients can use to cope with their mental health difficulties.

For patients who first get into contact with mental healthcare during a mental health crisis, hospital brochures constitute a first important element of patient education. A psychological or psychiatric crisis occurs when someone is in a situation of serious psychological distress and the environment has not (yet) been able to provide appropriate support. Possible registration complaints include suicidal behaviour, severe depression, anxiety, confusion, a family or school crisis with acute impact on mental health.

To guarantee continuation of care, it is important that hospital and ambulatory care are aligned, both in the way in which they define and understand crisis and recovery and regarding how they approach the empowerment and activation of the patient. In other words, recovery messages that will be imparted outside the hospital and in ambulatory care should already have been passed on and even, to the extent possible, grinded in the patients' minds while in hospital.

The aim of this study was to investigate to what extent recovery movement inspired messages are present in mental healthcare hospital brochures used in Flemish psychiatric crisis intervention centres.

Thus, our research questions were: “Do hospital brochures used in crisis intervention centres in Flanders reflect the tenets of recovery-oriented healthcare?”, and “Does the encoded message demonstrate an understanding of the patient’s perspectives and needs?” To answer these questions, we combined heuristic and theoretical perspectives from critical discourse analysis (Van Dijk, 2015; Wodak, 2013), systemic functional linguistics (Halliday, 2004) and (patient) audience research (Hall, 1973; Krippendorff & Nalabi, 2020), applying insights from linguistics to researching the voice of medicine (Mishler, 1984) and how it fits patient expectations (Robinson & Heritage, 2014) Whereas conversation analytical approaches have been applied to the analysis of direct patient-doctor contacts (Barnes, 2019), similar research of written hospital communication, especially with respect to discourse used in acute psychiatric wards, is extremely sparse (Udvardi, 2019).

Background

Hospital brochures, such as those used in psychiatric crisis intervention centres, function within a particular social, organisational and cultural context (McLeod, 2013), where they are used by caregivers to educate patients. If these brochures are to facilitate the patients’ healing process, it is essential that they take account of the clients’ understanding and experiences so that they can build on them and promote biopsychosocial recovery.

Enhancing client empowerment via patient-centred care is a major concern in mental health care. Already in the 1980s, the Picker Institute (1987) put forward some essential tenets of patient-centred care, including emotional support and alleviation of fear and anxiety, the provision of information and education regarding mental illness, respect for patient values, preferences and needs, and continuity and transition.

Below, we enlarge on the heuristic framework we have developed to investigate to what extent a corpus of crisis intervention hospital brochures can facilitate patient learning and contribute to their empowerment and activation already in the hospital ward and in preparation of dismissal and continuation of care in the home environment. First, we define what we understand by recovery-oriented care and situate it within a social constructivist learning framework. Next, we present the components of our analytic framework that originate from critical discourse, audience reception and linguistics research.

Recovery-oriented mental healthcare as dialogic socially constructed learning

The aim of recovery care within psychiatric crisis intervention centres is to first stabilize people and then help them start the process of regaining power over their lives and actively re-socialize in society

(Egeland et al., 2021). The goal is activation, empowerment, re-engagement in society and personal recovery, not only clinical recovery or symptom reduction. Personal recovery is more concerned with people's experiences of mental illness and emphasizes the centrality of identity, living a meaningful life and personal responsibility (Slade, 2010, cited in Egeland et al., 2021, p. 26).

Even though research over the years has shown that people can learn from a wide variety of pedagogical processes, there is empirical evidence that some ways of learning are more effective than others in some situations. As social constructivist theory (Moll, 1990) has argued, learning is facilitated when learning contents build on what learners already know, and when learners are involved in an external or internal dialogic situation putting into words their own experiences and listening and reflecting on others' words and thus scaffold one's own and the other person's learning. From a Bakhtinian perspective, Seikkula and Trimble posit that "dialogue is a precondition for positive change in any form of therapy" (2005, p. 461). Together, the patient and the therapist develop a shared language which facilitates mutual understanding and collaborative therapeutic work. Using this shared understanding, caregivers can scaffold patients' learning and help them discover alternative ideas, coping mechanisms or perspectives, as well as personal powers and competencies. In network therapy too, in which the patient's surroundings (e.g., home carers) participate, sharing experiences and putting them into words has proven to be a very powerful way of learning and healing (Van der Velden et al., 1984).

Hospital brochures as discourse: a critical systemic functional discourse analytic heuristic

The analytic framework aims to take account of the interplay between the hospitals that aim to involve their patients in a particular manner in the therapeutic community on the one hand, and on the other the patients' experiences on being admitted to the hospital ward and on being willy-nilly included in that same therapeutic community.

Discourse as controlling people's minds

Discourse, such as a hospital brochure, can be defined as a communicative event which gains meaning from the characteristics of the text (its language, contents, organization, visuals), its function (e.g., to teach, to inform, to persuade, to prohibit) as well as the context (e.g., hospital, learning environment) in which it features. The communicative situation in which discourse functions consists of such categories as setting (time, place) (e.g., crisis centre, time of admission), ongoing actions (e.g., participation in therapy group), the participants in various communicative, social, or institutional roles (e.g., client in consultation with doctor), and participants' goals, knowledge, opinions, attitudes, and ideologies (e.g., participants' convictions regarding usefulness of admission and stay in psychiatric crisis ward). (Van Dijk, 2015, pp. 470–471).

Researchers working within the Critical Discourse Analysis (CDA) paradigm (Wodak, 2013; Krippendorff & Nalabi, 2020), primarily study “the way social-power abuse and inequality are enacted, reproduced, legitimated, and resisted by text and talk in the social and political context.” (Van Dijk, 2015, p. 470). Specifically, they study what roles or identities are granted to which participants (e.g., patient as passive recipient of care), what topics are included and which omitted (e.g., information on care options from which to choose), what knowledge is imparted and which is not (e.g., information regarding disease, what to expect, how to best handle it). Their focus is also on lexicogrammatical details (e.g., lexicon, morphology, syntax, metaphor), demonstrating, for example, that the language used in a text is not the language of the audience, implying that the text functions as a gatekeeper, not as an imparter of knowledge. Also, “If controlling the contents and structures of text and talk is a first major form of the exercise of power, controlling people’s minds through such discourse is an indirect but fundamental way to reproduce dominance and hegemony.” (Van Dijk, 2015, p. 472). As seen by CDA, discourse controls the readers’ knowledge, plans, actions and

ideologies (mind management), and it is the discourse analyst’s task to spell out how power elites, such as doctors, or institutions, such as hospitals, enact and sustain their power over patients in language.

Choosing linguistic items to express one’s view of the therapeutic relationship and community

Systemic functional linguistics is an approach to linguistics, among functional linguistics, that considers language as a social semiotic system (Halliday, 2004). In brief terms, this approach implies that every language user, such as the author of a hospital brochure, can choose from a range of equivalent linguistic items to impart meaning, and that these choices are socially motivated and determine the kind of relationships that will be instantiated or maintained between the language user and the audience, i.e. in our case the patient. This principal idea does not only apply to the lexicogrammar of the language, but also to text organization and structure, contents to omit or to include or the choice of visuals. The linguistic-semiotic choices are made to encode a particular image of a particular sociocultural environment (ideational function) in a particular socioculturally-situated text (textual function) and thus to involve a particular socioculturally embedded audience in a particular relationship (interpersonal function) (Llinares & McCabe, 2020). For example, the language used may emphasize collaboration, emphasizing the will and wants of the patients, or, by contrast, underscore the helper-helpee relationship, referring to the patient as a passive recipient of care, as someone in need of help, as undergoing therapy, not as someone taking ownership of his or her care trajectory. Linguistically this becomes obvious from the frequent use of the passive voice, the use of impersonal pronouns or a preference for vague lexical items leaving the patient to guess what is meant by the jargon used in the text. Static nominalizations (e.g., *progress* instead of *progressing*) may emphasize lack of possibility of change or recovery.

And how is the message received?

As pointed out by Ytre-Arne and Das (2018, p. 285), one of the ambitions of current audience research should be "to speak in the interest of audiences (…) and focus on the people who experience [media]". The question to ask is indeed how the audience, i.e. the patients admitted to a psychiatric crisis ward, receive, understand and act upon the discourse presented to them via their ward brochure. Given the limited (mental) health literacy of a substantial part of the population (Jorm, 2012), can patients comprehend what is written? Given their illness and emotional distress (Sly et al., 2009), can they surmount their confusion and read complicated texts, using unfamiliar language or long sentences? As pointed out by Pavlenko (2012), affective state affects interpretation of the object and the text. She defines affective processing as the "somatovisceral responses triggered by automatic appraisal of verbal stimuli, which may or may not register as subjective feelings at the level of higher cognition." (Pavlenko, 2012, p. 409) This suggests that in situations of emotional confusion, such as when entering a crisis intervention centre (Sly et al., 2009; Snorrason et al., 2021), one's usual modulators of emotional experiences may not function as before, which may affect patients' ability to process information imparted to them. Particular words, for example those related to olfactory, tactical, kinesthetic, aural and visual modalities, may re-activate autobiographical memories, as well as their effects. Anxieties, self-censorship, masking, compliance, dependence, and memories of dramatic events or continuous suffering may re-appear. In sum, the question to ask is whether the text is on the side of the audience and supports recovery, taking account of patients' vulnerability, or only on the side of those who produce it.

The study

Materials and methodology

Corpus

11 Dutch-medium patient brochures from 11 acute psychiatric wards were included in the study. They were sent to us on a voluntary basis. One brochure originated from an academic hospital. While some brochures are elaborate and count over 10 pages, others are comparatively short (up to 2 or 3 pages). Some look attractive and contain images, while others only contain text. Whereas previously brochures were intended for internal use only, since the relatively recent introduction of quality assessment schemes in psychiatric healthcare, hospitals have also started to address external audiences, presenting favourable and fresh images of the care they offer.

The population served by the different hospitals is similar and does not show substantial differences in terms of the cultural background or socio-economic status of the patients it attracts. People admitted to acute psychiatric wards present themselves with severe mental illnesses and high levels of

disruption. In practice, admission decisions are often centred on an assessment of the immediate risk of harm to self or others.

Methodology

An interpretative discourse analytic approach was used to investigate the brochures' text. This will become apparent from the findings, which will be presented as a research narrative. For reasons of space, images (Kress & Van Leeuwen, 2021) will not be considered here.

Results

We are experts

A striking first finding concerns the fact that all but one brochure can be characterized foremost as texts presenting and promoting the hospital and its therapeutic program, and not as texts centring patients' experiences or needs. After a brief introduction, most brochures start with a more or less elaborate description of each care team member's expertise and responsibilities, using mainly sentences in the

active voice, thus underlining that the institution is actively taking all initiatives, and that patients, who are not knowledgeable, are to wait for the caregiver's help. Excerpt 1 below makes this clear: the patient *be assigned to a nurse* (passive voice) and the nurse is said to be responsible for everything, almost as if the patient is passivated and has no role to play in any of the activities mentioned (e.g., washing oneself and putting on clothes).

Excerpt 1

On the ward, you will be assigned to a nurse, who will accompany you throughout your stay. He will try to answer all your questions. The nurse is also responsible for general body care, administering medication, preparing for the necessary examinations, etc.

Given that patients are presented with an overwhelming number of different people (a psychiatrist, social worker, psychologist, nurse, psychotherapist, psychomotor therapist, occupational therapist, music therapist, physiotherapist, creative therapist, voluntary workers, physical doctors, electro

convulsionist) who are all said to take care of them, the patient is reduced to a care receiver. This reduction is contrary to the spirit of recovery oriented psychiatric care where patients are incited to work towards taking up responsibilities, and are considered active collaborators in their recovery process.

In the one brochure that does depart from patients' needs, very different wordings are used, emphasizing collaboration (e.g., *work with us, cooperation*), solutions (e.g., *work with us to understand the difficulties in your life* situation) and possibilities (e.g., *prepare your discharge*), as appears from Excerpt 2 below.

Excerpt 2

First of all, we let you relax. We invite you to work with us to understand the difficulties in your life situation. To make your stay as meaningful as possible, cooperation is very important. With your input and vision and our professional experience, we prepare your discharge and try to keep your stay as short as possible. We hope you will find the courage to work on it with us.

When patients are welcomed like this and a sense of cooperation and equality is instilled, people may feel somewhat less belittled and hopeless than is the case when power hierarchy is underlined via topic and language selection.

The presentation of the care team tends to be followed by a succinct presentation of different kinds of therapy on offer at the clinic (e.g., creative therapy, talk therapy), again underlining the hospital's expertise as in Excerpt 3 below where it is suggested that psychotherapy is theoretically well-founded and evidence-based, which may be information that is irrelevant for the patient on entering an acute psychiatric ward.

Excerpt 3

There are various forms and methods of psychotherapy, they can be applied individually or in groups and they are all based on one or more psychotherapeutic schools.

Even if some brochures provide more substantial information, this information is quite complex and may not be accessible or understandable by all because of frequent use of morphologically complex medical jargon which also functions as a gatekeeper. In Excerpts 4 and 5 below, this jargon includes *neuromodulation, transcranial magnetic stimulation, bipolar or manic-depressive disorder,* and *short introspective psychotherapeutic treatment*.

Excerpt 4

ECT and TMS

There is a specialised centre for neuromodulation via electroconvulsive therapy (ECT) or via transcranial magnetic stimulation (TMS). ECT is used for major depression, bipolar or manic-depressive disorder and some forms of psychosis. TMS is used for depression, compulsion, voices and pain. Treatment is provided in hospital or outpatient settings.

Excerpt 5

In an admission to the PAAZ, different emphases can be placed. The focus can be on a short crisis admission, diagnostics, orientation or a short introspective psychotherapeutic treatment. We offer a diverse range of group therapies consisting of verbal and non-verbal therapies.

Just do as you are told

Unlike brochures used in physical care, psychiatric crisis ward brochures fail to provide specific information on what the patient can expect of the treatment, what steps will be taken in the care process, how these can help, how the patient will know the cure is successful, what patients can do while in hospital and after they have been discharged. This suggests that physical patients, contrary to

psychiatric patients, are considered literate and able persons who can organize their lives around their illness or surgery and can thus be considered co-creators of their physical recovery. The patients addressed in the psychiatric hospital brochures are not presented as active participants, but rather as passive recipients of care, as in Excerpt 6 below. The power hierarchy is clear: the hospital knows best, even if some brochures (see Excerpt 7) state that caregivers and patients will decide jointly on what components of the therapeutic programme to participate in, using language of collaboration (*you will explore your problem with the psychologist*) and pronouns (*you* and *your* instead of *the patient* and *his*) referring to the patient's ownership of his/her therapeutic trajectory.

Excerpt 6

After the diagnosis and treatment have been established, the patient is discharged or referred to our day clinic for further outpatient treatment.

Excerpt 7

At the request of your doctor and the care team, you may be invited by the psychologist for a more extensive exploration of your problems, additional counselling or a psychological examination.

In relation to the therapy programme, patients may be told what to do and what not to do in a directive way, with the text using *must* and *mustn't* as well as frequent

imperative phrases, thus promoting a sense of prohibition and obedience, or as Excerpt 8, even threat.

Excerpt 8

Rejection of therapy without good reason calls your admission

into question.

Another finding concerns the omission of topics that could empower patients. They include information on the specific syndrome from which one suffers or on the triggers that may pre-empt a crisis, possible life stresses that one could alleviate, or how to draw up a safety plan. Mentioning such specific goals might make for a more structured therapeutic program and could help put to rest patients' minds when feeling ill at place in the crisis ward or doubting whether to leave or stay since they do not feel helped by, say, occupational or creative therapy which may serve mainly diagnostic purposes.

That the brochures tend to view patients as passive recipients of care has been pointed out above. When patients are considered active participants in the care process, this is very often, though not exclusively, in the context of getting one's daily life back on track, as appears from Excerpts 9 and 10 below, in which active verbs, such as *use, practice, regain, strengthen, look for, improve* or *cope* are used.

Excerpt 9

In occupational therapy you learn to discover your capabilities, limitations, interests. Then, through meaningful activities, you will use your talents optimally, while practi~~e~~sing your skills with the aim of regaining or strengthening them. With the social worker, you look for options for, among other things, daily activities - work, education or leisure - living, income and management, and professional support.

Excerpt 10

You develop skills to better understand your own psychological functioning, solve, improve or cope with your psychological problems.

Even if one could say that this is to be expected in the context of an acute psychiatric ward where one

of the goals is to discharge the patient as soon as possible, it is striking that a similar activating mindset tends to be lacking in ward brochures as far as patients well-being and psychological development are concerned.

Words that kill

Finally, we found that the brochures tend to show only limited awareness of the patient audience they work with. We want to address this question looking at what emotions or behaviours linguistic items can trigger when used in a text intended for an audience of mentally ill people. We are referring to lexical items, such as *group therapy, your care team, bodily experiences, occupational therapy, feeling, ECT, family,* or *self-help group.* Depending on previous autobiographic experiences, each of these words can activate very unpleasant memories which patients may be afraid of, and do not want to be confronted with or relive in nightmares for example. Thus, *bodily experiences* may re-activate sexual abuse memories, *family* violence or feelings of unsafety, *self-help group* forced disclosure, *group therapy* extreme social fear or fear of failure, and so on. When no proper explanation is given of jargon, such as *creative therapy* or *psychomotor therapy*, or when explanations are difficult to understand, patients cannot encoded the brochures in the way intended by the hospital. Rather, they may feel at a loss and hopeless, more so than before reading the brochure. The same may be true when sentences are complex and the information vague. Excerpt 11 may clarify this:

Excerpt 11

If you are struggling with a mental health vulnerability, it can interfere with your practical skills and interests and thus affect your daily actions. In occupational therapy you learn to discover your abilities, limitations and interests. An occupational therapist supports you in setting goals towards which you want to work, in the spirit of your desired future. Then you will use your talents in meaningful activities, while at the same time practi~~e~~sing your skills with the aim of regaining or strengthening them.

A phrase, such as *in the spirit of your desired future* may be painful for people who attempted to commit suicide and now stay in a psychiatric ward. These people may not have a future perspective for the time being and are now incited to work within the spirit of a desired future. Also, people may not see how they can *regain their strengths* as they may have been admitted because of a total lack of mental resilience and strength, and now read the suggestion that it will be easy for them to regain their

skills and strengthen them. A phrase, like *discover your limitations* is ill at place in a context where patients have lost their mental capabilities and feel nothing but limitation.

Discussion

The overall aim of the study was to shed light on whether hospital brochures used in crisis intervention centres in Flanders reflect the tenets of recovery-oriented healthcare, and on whether the encoded messages reflect the patients' perspectives and needs. The research was carried out against the background of the conviction that recovery-oriented care has to start in the psychiatric crisis intervention centre for it to be able to continue once the patients has been discharged.

Our findings on the basis of a corpus of Flemish crisis intervention ward brochures suggest that the answers to both questions are negative. This finding is unfortunate but not surprising, giving the fact that Belgium has held on to hospital-led crisis care and been slow in de-institutionalizing it, even if a number of hospital-specific mobile intervention teams are now fully operational. Yet, even within institutionalized care, a better uptake of patient-centred activating recovery-oriented care ideas might have been expected. Yet, as Egeland et al. (2021) has shown, mental health workers in Norway too have a relatively low orientation towards recovery (p. 5) despite year-long advocation.

The most striking finding has been the fact that all brochures foremost function as texts presenting and promoting the hospital and its therapeutic programme, and not as texts focusing primarily on and recognizing patients' experiences

and needs (information, support, comfort). In general, the texts appear to serve three functions, namely (1) promote the psychiatric wards as an exemplar of the high-quality care the hospital it is part of has to offer, (2) promote the discipline of psychiatry as a trustworthy discipline within the medical sciences, and (3) address patients and inform them about the biopsychosocial care they will receive. Some brochures also address a fourth function, namely to reassure home caregivers, such as family members, that the hospital takes good care of their beloved ones. Addressing these four functions adequately in one and the same brochure requires very skillful encoding of the message one wants to pass on. Three of the functions do not suffer from the encoder taking on a hierarchically dominant position and telling the world and home caretakers what it is they do, how their teams are composed, what their specialisms are, etc. The one group that suffers from this perspective are those who are admitted to the crisis intervention centre, namely the patients. They are not treated with full respect when they are addressed by the hospital in the same way as home caregivers are. They want to know what is happening to them, what they can do to get better, what the hospital has to offer, and they want to receive this information in a comprehensible way. Vague descriptions of what each kind of therapy involves but which do not tell patients how that therapy can assist their recovery are not

helpful. Patients need specific descriptions of their illness, specific goals, specific tools and specific steps to take to regain a grip on their minds and lives (Roosenschoon et al., 2016).

The second finding suggests that care in hospital wards is still focused on symptom reduction and on preparing patients to take up their daily lives after leaving the crisis ward. It is somewhat unfortunate that it is not made clear to patients that a longer recovery route is awaiting them. In physical healthcare, the recovery trajectory may indeed be confined to a couple of weeks or months after having left the hospital. By contrast, in psychiatric care, recovery may take much longer. Warning patients for too optimistic a curing perspective, yet also instilling hope and optimism about recovery, supported by their home community (Seikkula & Trimble, 2005), should be essential ingredients of any mental healthcare brochure.

The third finding clarifies and underlines just how important linguistic choices can be in imparting a certain message to certain audiences. As demonstrated by Pavlenko (2012), words can trigger both sensory images and physiological reactions. Personal autobiographies and ensuing individuals needs affect the way in which patients decode the encoded messages. Even if the message may seem objective to encoders, our findings suggest that word selection in psychiatric ward brochures may be crucial in imparting a message of safety, confidentiality and support to patients.

Overall, our findings show that the heuristic we have developed to study our corpus with respect to our two research questions seems appropriate and workable as an interpretative framework. Following Das and Ytre-Arne (2018), as a researcher, remaining on the side of the audience, which in our case are the patients, is not self-evident. In hospital brochures, patients tend to be viewed as decoders complying with the encoder’s message (Hall, 1973). Yet, in current times, this view of patients is outdated, and even patients with severe mental illnesses in a severe crisis have to be regarded and studied as individuals who interpret the messages imparted to them on the basis of their personal histories and current memberships of different social groups (Livingstone, 2018). This, however, may not release hospitals from the responsibility to put forward evidence-based therapies for the people trusted to them. Indeed, our findings point to common dilemmas in mental health services (Hansen et al., 2019) regarding how to combine professional expert knowledge with collaborative practices that emphasize shared decision-making and active roles on behalf of patients.

The current study is not without limitations. First, this is one of the first attempts to combine three theoretical frameworks into one heuristic to study a corpus of psychiatric hospital brochures, thus as yet proper validity remains to be established. Second, the size of the sample and the methodology used do not allow for generalizations. However, the fact that we found similar tendencies in all investigated brochures indicates that our conclusions may apply to other brochures too that were not included in this study. Further research is needed to establish whether our findings can be replicated in other or larger samples of brochures, in Belgium and in other countries.

The main implication of the current study is that a baseline description of psychiatric crisis intervention ward brochures has been provided, which can serve as a basis for studying other brochures, but also as a starting point for revising such brochures to better meet the needs of psychiatric patients admitted to crisis wards.

Conclusion

This small-scale qualitative study on the under-research population of psychiatric patients admitted to crisis intervention wards highlights the complexities involved in imparting helpful messages to the general public, home caregivers and patients via hospital brochures. Awareness of the issues involved in addressing patients in respectful and dignified ways and in ways to activate them and prepare them for taking up their further recovery in society after having left the hospital ward may build the starting point for writing less demeaning, more activating, concrete and more recovery-oriented brochures. Such brochures may help to destigmatize mental healthcare and mentally ill people, demonstrating that people are not merely flattened by medication when in a psychiatric hospital ward, but are guided towards an informed gradual but active uptake of different aspects of their social life and towards a higher level of well-being. Therefore, we hope this research may inform hospitals and their communication services to respond more appropriately to the needs of mentally ill people when writing hospital brochures.

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