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Mental Health Discourse: A Critical Discourse Analysis of Tiktok Video Narratives

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ABSTRACT
This study examined the construction, contestation, and circulation of clinical authority in TikTok mental health discourse through Critical Discourse Analysis, drawing on verbatim transcripts of fourteen purposively selected videos produced by both clinical and non-clinical creators. The social problem motivating the study was the systematic appropriation of clinical language by non-credentialed speakers theorised here as epistemic borrowing which produced authoritative mental health discourse for mass audiences in the absence of institutional grounding, with measurable consequences for public health, epistemic justice, and the global governance of medical knowledge. Grounded in Fairclough's (1992, 2001) three-dimensional CDA model and Foucault's (1972, 1980) theorisation of discourse as a site of power/knowledge production, the study interrogated how language performed clinical authority at the textual level and how algorithmic amplification functioned as a new regime of mental health truth at the sociocultural level. Four dominant discursive patterns were identified: the deployment of DSM-adjacent symptom lists as a normalised platform genre stripped of clinical qualification; the systematic use of assertive copular declarations, second-person diagnostic address, and constitutive intertextuality to perform clinical authority without credential; the instrumentalisation of personal testimony, neuroscientific framing, and psychological name-dropping as substitute epistemic warrants; and the emergence of metalinguistic counter-discourse by clinical creators that named and challenged the algorithmic ideology sustaining lay diagnostic authority. Crucially, the finding that an identified clinical professional adopted the same symptom-list genre as non-credentialed creators proved that the problem was structural rather than individual, with direct implications for governance design. The study introduced two original concepts: epistemic borrowing and digital diagnostic imperialism and concluded that TikTok mental health discourse constituted a linguistic crisis that applied linguistics was uniquely positioned to address. Recommendations were directed at scholars, clinicians, platform designers, and policymakers; educators and media literacy practitioners; and vulnerable young people whose epistemic protection is the study's most urgent social purpose.
Keywords: *Critical Discourse Analysis, TikTok, mental health discourse, epistemic borrowing, medicalisation, lay expertise, Fairclough, Foucault, algorithmic ideology, counter-discourse, self-diagnosis*
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1. INTRODUCTION

1.1 Background and Context

The global communicative ecology of mental health has undergone a transformation of historical significance, creating the conditions within which the problem this study addresses has emerged. Before identifying that problem, it is important to acknowledge the substantial contributions that existing scholarship has already made to this domain. Naslund et al. (2020) produced a landmark systematic review of social media's role in mental health communication, documenting its genuine capacity for destigmatisation, peer support, and help-seeking facilitation alongside its risks of inaccuracy and harmful content exposure. Alvarez-Mon et al. (2022) demonstrated empirically that over half of the most-viewed TikTok videos under mental health hashtags contained inaccurate or misleading information, establishing the scale of the problem with important quantitative precision.

Conrad (1992, 2007) provided the foundational theoretical account of medicalisation, the extension of medical categories to non-medical experience and identified its consumer-driven, media-facilitated forms as a defining feature of contemporary culture. KhosraviNik (2017) advanced the field of social media Critical Discourse Studies, positing that platform affordances are analytically co-constitutive of the discourses they host. These contributions have collectively proven that the problem exists, that it is consequential, and that it functions through social media in structurally predictable ways. They represent a robust foundation on which the present study builds.

What this scholarship has not yet provided, however, is a linguistically precise account of the mechanism through which the problem operates. Documenting that inaccurate content reaches large audiences does not explain how inaccuracy acquires the force of authority, how a non-credentialed speaker comes to be heard as a clinician, or how a numbered list of common behaviours comes to function as a diagnostic instrument. Content analysis classifies claims as accurate or inaccurate without examining the specific vocabulary, grammar, modality, and genre conventions through which inaccuracy is packaged as expertise.

Sociological accounts of medicalisation describe the social process without attending to the linguistic microstructure that enacts it utterance by utterance. The mechanism of harm is, at its core, a linguistic mechanism, and the discipline best positioned to examine it is applied linguistics. This is the gap the present study fills: it moves from the description of consequences to the demonstration of mechanisms. The gap is made both visible and theoretically addressable by the frameworks adopted here. Fairclough's (1992, 2001) three-dimensional Critical Discourse Analysis holds that ideology operates through naturalisation, the process by which ideologically saturated linguistic choices appear as common sense rather than interested construction. It is precisely because naturalisation functions at the level of vocabulary, grammar, and genre that prior scholarship which has not attended to these features has been unable to prove the mechanism of epistemic harm, even as it has documented its effects.

Foucault's (1972, 1980) power/knowledge theory demonstrates that the authority to name and classify experience is simultaneously the authority to govern it, and that what counts as authoritative health knowledge is always governed by institutional procedures rather than neutral truth. Applied to this corpus, these frameworks reveal that TikTok's algorithmic architecture has produced a new regime of mental health truth, one in which engagement metrics have displaced clinical credentialing as the arbiter of epistemic authority. The theoretical framework is therefore not selected to validate a predetermined conclusion but because it is the only framework that makes the specific gap this study addresses simultaneously legible and analytically tractable.

Against this background, the digital transformation of mental health communication takes on its full significance. What was once confined within the clinical consultation, the naming of illness, the attribution of diagnosis, the prescription of meaning for psychological distress has migrated into the algorithmically ordered feeds of social media users worldwide. At the epicentre of this transformation stands TikTok, commanding over 1.5 billion monthly active users globally (Statista, 2024), whose For You Page (FYP) delivers content based on engagement signals rather than declared interests (Bhandari & Bimo, 2022). The hashtag #MentalHealth alone exceeds 100 billion views. In the wake of the COVID-19 pandemic, which precipitated a global surge in anxiety, depression, and psychological distress (WHO, 2022), TikTok has become a de facto mental health resource for populations whose access to clinical services is constrained by cost, geography, and stigma. Drawing on fourteen TikTok video transcripts, this study demonstrates that TikTok mental health discourse constitutes an active site of discursive struggle where the power to define mental illness is exercised not through clinical credentialing but through language.

1.2 Statement of the Problem

The social problem at the heart of this study is both urgent and precisely defined: the systematic appropriation of clinical language by non-credentialed speakers on TikTok to construct authoritative mental health discourse for mass audiences and the measurable public health, epistemic, and social consequences of that appropriation. This problem operates across three interlocking dimensions, each of which makes the linguistic analysis this study provides indispensable.

The first dimension is clinical. The World Health Organisation (2022) estimates that one in eight people globally live with a mental health condition, yet treatment gaps remain catastrophic as fewer than 10% of those affected in low- and middle-income countries receive any form of care. TikTok fills this vacuum, but it does so through discourse governed by engagement logic rather than clinical ethics. When the language through which suffering is named, categorised, and validated is shaped by algorithmic amplification rather than clinical judgment, the

consequences are concrete and measurable: people make mental health decisions including whether to seek professional help and whether to pursue medication on the basis of content whose authority is performed rather than grounded. Videos 10 and 14 in the present corpus explicitly name this consequence, identifying a pipeline from TikTok self-diagnosis to inappropriate clinical encounters producing 'a lifetime of drugs' for incorrectly self-classified patients.

The second dimension is epistemic. The dissolution of the boundary between clinical knowledge and lay opinion in digital public discourse constitutes a crisis of epistemic justice who has the right to speak authoritatively about suffering, on what basis, and with what accountability. When lay speakers deploy the linguistic markers of clinical authority without the institutional infrastructure that normally warrants them, they do not merely misinform; they restructure the epistemic landscape of mental health knowledge in ways that delegitimise formal clinical institutions and privilege the most engaging rather than the most accurate voices. This is a power problem as much as an information problem.

The third dimension is social and global. TikTok's algorithmic architecture distributes content without regard for geographical or cultural context. The mental health discourse produced in this corpus is predominantly built on Western diagnostic frameworks, the DSM-5 system of psychiatric classification and circulates globally as if these frameworks were universal. In contexts with radically different epistemologies of distress including Nigerian, African, and other non-Western contexts reflected in Video 4's code-switching between Standard English and Nigerian Pidgin, this constitutes what this study terms digital diagnostic imperialism: the globalisation of culturally specific diagnostic categories through algorithmically amplified lay discourse, with consequences for how communities understand suffering in their own cultural terms.

1.3 Goal, Objectives, and Research Questions

The overarching goal of this study is to produce a linguistically rigorous and empirically grounded account of how clinical authority is constructed, circulated, and contested in TikTok mental health discourse, and to demonstrate the specific language-level mechanisms through which this construction functions and the social consequences it produces. Towards this goal, the study pursues five specific objectives:

1. To identify and describe the lexical, modal, and grammatical strategies through which TikTok creators both clinical and non-clinical construct or contest diagnostic authority in mental health content.
2. To examine the intertextual and generic conventions through which clinical knowledge is appropriated and transformed in lay TikTok mental health discourse.
3. To analyse the power relations, ideological interests, and sociocultural conditions reproduced by the dominant discursive patterns in the corpus.
4. To examine the counter-discourses produced by clinical professionals and assess their linguistic strategies, their capacity to contest lay clinical authority, and their structural position within the platform's discursive ecology.
5. To generate theoretically grounded and evidence-based recommendations for platform governance, public health communication, and educational policy that address the social problem the study identifies.

These objectives are operationalised through four research questions:

RQ1- What lexical, modal, and grammatical strategies do TikTok creators deploy to construct diagnostic authority, and how do these strategies differ between clinical and non-clinical speakers?

RQ2- How is clinical knowledge intertextually appropriated and transformed in lay TikTok content, and what generic conventions govern this process?

RQ3- What power relations, ideological interests, and sociocultural conditions are reproduced by dominant patterns of mental health discourse in the corpus?

RQ4- How do clinical counter-discourses engage with and challenge lay diagnostic authority, and what does their structural position within the platform's discursive ecology reveal about the governance of mental health knowledge on TikTok?

1.4 Specified Beneficiary Audiences

The study's findings and recommendations are directly relevant to three broad categories of audience, each positioned differently in relation to the discursive dynamics the study analyses. The first category comprises scholars, clinicians, and institutions concerned with the production and governance of mental health knowledge. Applied linguists and discourse analysts particularly those working in digital discourse, health communication linguistics, and critical discourse studies, will find in this study both theoretical resources (the concepts of

epistemic borrowing and digital diagnostic imperialism) and a replicable CDA protocol for TikTok transcript analysis that extends the field's capacity to address consequential digital communicative phenomena. Mental health clinicians and institutional health communication officers will find evidence-based analysis of why patients increasingly arrive at clinical consultations with pre-formed, social-media-derived diagnostic hypotheses, and practical models drawn from the counter-discourse strategies of Videos 10 and 14 for how credentialed clinical voices can communicate effectively on digital platforms without sacrificing epistemic accountability. Platform designers, digital regulators, and policymakers responsible for digital health communication governance will find a linguistically grounded analysis of the specific discursive features such as symptom-list genre, assertive diagnostic modality, credential-absent authority performance that constitute the mechanism of epistemic harm, enabling governance interventions more precise and more structurally effective than content-category removal or creator credentialing alone.

The second category comprises educators, curriculum designers, and media literacy practitioners. Those developing critical thinking, health education, and digital literacy curricula will find in the concept of epistemic borrowing a teachable and accessible descriptor for a discursive phenomenon their students encounter daily. The study shows, through the corpus evidence of Video 14, that the linguistic mechanisms of lay clinical authority can be identified and critiqued in language accessible to young people without requiring technical linguistic vocabulary, a finding with direct implications for classroom practice and curriculum design across secondary and tertiary levels.

The third and most urgent category comprises vulnerable young people themselves who are the primary consumers of TikTok mental health content and the population whose wellbeing is most directly at stake in the discursive dynamics the study analyses. Young people aged 16 to 29 constitute TikTok's dominant demographic (Statista, 2024) and are simultaneously the most likely to experience the onset of mental health challenges and the least likely to have access to formal clinical support (WHO, 2022). For this audience, the study's contribution is not theoretical but practical and protective: by naming the specific linguistic strategies through which lay creators perform clinical authority, the assertive copula, the second-person diagnostic address, the DSM-adjacent symptom list stripped of its clinical qualifications, the study equips young people, their caregivers, and the educators who serve them with a critical framework for evaluating the mental health content they encounter online. Understanding that 'that's anxiety' is not a clinical judgment but a performative speech act, and that a numbered list of five symptoms is not a diagnostic instrument but a normalised platform genre, constitutes a form of epistemic protection that is both linguistically grounded and socially urgent.

1.5 Relevance, Credibility, and Contribution to Knowledge

The study's relevance is established by three converging circumstances. The COVID-19 pandemic created an unprecedented global demand for mental health resources precisely when institutional mental health services were least accessible (WHO, 2022); TikTok emerged as the dominant short-form video platform during this same period, filling the vacuum with lay-produced mental health content at scale; and the academic study of this intersection while increasingly documented in public health and communication studies has not yet been examined with the linguistic precision that CDA provides. The problem is contemporary, consequential, and under-examined by the discipline most equipped to address it.

The study's credibility rests on three foundations. It draws on primary transcript data from actual TikTok videos rather than constructed exemplars; it applies a theoretically established and widely validated analytical framework (Fairclough's CDA, developed over three decades of scholarship); and it engages both the supporting and challenging voices in the corpus including clinical professionals who contest lay diagnostic authority rather than selecting only evidence that confirms a predetermined thesis. The corpus's inclusion of clinical counter-discourses (Videos 7, 8, 10, 11, 14) ensures that the analysis is genuinely comparative rather than one-sided.

The study contributes to knowledge in four distinct ways. Theoretically, it extends Fairclough's three-dimensional model to multimodal short-form digital video, a context for which the framework was not originally designed and demonstrates its continued analytical productivity in this unique environment. It introduces two original analytical concepts which are epistemic borrowing (the linguistic appropriation of clinical authority markers by non-credentialed speakers) and digital diagnostic imperialism (the algorithmic global circulation of culturally specific diagnostic frameworks as universal truths) that advance the vocabulary of critical discourse studies. Methodologically, it develops a replicable analytical protocol for TikTok-based CDA using primary transcript data, addressing the distinctive challenges of digital video research. Empirically, it produces the first CDA study of TikTok mental health discourse grounded in primary transcript evidence, with comparative analysis across the clinical/non-clinical divide that no prior study has performed.

1.6 New Outcomes the Study Discovers

Beyond what previous scholarship has established, this study discovers four genuinely new outcomes that constitute its original empirical contribution. First, it discovers that the TikTok symptom list is not merely a borrowed clinical format but a fully normalised platform genre that exerts discursive pressure on all content producers, regardless of credential demonstrated by the finding that Dr. Siya, an identified clinical professional (Video 11), adopts the same symptom-list format as non-credentialed lay creators. This is a discovery that complicates simple solutions based on credential-based content regulation. Second, it discovers the specific linguistic mechanism through which epistemic borrowing operates in verbal discourse: the conjunction of assertive copular diagnostic declarations ('that's anxiety,' 'it's a silent symptom of depression'), second-person diagnostic address, and constitutive intertextual appropriation of DSM-5 criteria format without clinical qualification. Third, it discovers that clinical counter-discourse on TikTok deploys a distinctive strategy of metalinguistic critique making the mechanism of lay diagnostic authority an explicit object of naming and analysis (Video 14: 'they're just listing general things... hoping that it will trick you to interact more with their video and boost up in the algorithm') — which constitutes a form of Foucauldian regime-of-truth denaturalisation enacted within the platform itself. Fourth, it discovers that code-switching between Standard English, vernacular registers (Nigerian Pidgin English, Video 4), and quasi-medical discourse functions as a dual ideological strategy: the vernacular establishes audience solidarity while the formal medical register constructs epistemic authority, combining social and epistemic dimensions of credibility in a single communicative performance that has no equivalent in the English-only lay subcorpus.

1.7 Expected Outcomes

The study expects to produce outcomes across three levels. At the theoretical level, Fairclough's three-dimensional CDA model is expected to demonstrate analytical productivity in the TikTok video context, with the textual dimension illuminating the specific linguistic strategies of epistemic borrowing, the discursive practice dimension revealing the genre normalisation of the symptom list, and the sociocultural dimension connecting these patterns to algorithmic ideology and global health knowledge governance. The concepts of epistemic borrowing and digital diagnostic imperialism are expected to prove analytically generative beyond this study's specific corpus, with applicability to any digital platform where non-credentialed speakers claim expertise through the appropriation of specialised discourse markers. At the empirical level, the analysis of fourteen transcripts is expected to yield a systematic, evidence-grounded account of the four dominant discursive patterns in TikTok mental health discourse identified in the abstract, with sufficient textual evidence to demonstrate each pattern's operation and sufficient comparative data to distinguish clinical from non-clinical discursive profiles. At the social level, the study expects to produce recommendations specific enough to guide concrete interventions: a linguistically informed creator credentialing framework for TikTok; a TikTok-native communication model for health institutions based on the counter-discourse strategies of Videos 10 and 14; a critical language awareness module for secondary and tertiary education; and a research agenda that extends the findings to multimodal, longitudinal, and cross-linguistic contexts.

2. THEORETICAL FRAMEWORK

2.1 Fairclough's Three-Dimensional CDA: Theory and Application

Fairclough's (1992, 2001) three-dimensional model conceptualises every discursive event simultaneously as text, discursive practice, and sociocultural practice, a tripartite structure that enables analysis to move between the word and the world without losing empirical grounding. At the textual level, formal linguistic features which includes vocabulary, grammar, cohesion, text structure are the surface at which ideology is produced and naturalised: made to appear as common sense rather than interested construction. In this study's application, the textual level is the site for analysing the specific vocabulary through which lay TikTok creators perform clinical authority (DSM-adjacent terminology, neuroscientific vocabulary), the epistemic modality through which diagnostic certainty is asserted or hedged, and the person deixis through which the viewer is grammatically positioned as a diagnostic subject. At the level of discursive practice, Fairclough's concepts of manifest and constitutive intertextuality are applied to reveal how clinical discourse conventions particularly the DSM-5 symptom list format are appropriated without attribution, and how the platform's generic norms (the symptom list as a TikTok genre) shape content production. At the sociocultural level, the analysis situates identified linguistic patterns within the political economy of TikTok's attention economy, the global mental health care gap, and the Foucauldian analysis of knowledge governance asking whose interests the dominant discursive patterns serve and with what social consequences.

2.2 Foucault's Power/Knowledge: Theory and Application

Foucault's (1972, 1980) theorisation of discourse as constitutive rather than merely reflective provides the macro-political anchor. Discourse does not describe the world; it produces the objects it appears to describe delimiting what can be said about mental illness, by whom, in what form, with what authority. His concept of power/knowledge captures the argument that the authority to classify and explain experience is simultaneously the authority to govern it. Applied to this corpus, Foucauldian analysis asks: what new regime of mental health truth is being produced on TikTok? What institutional interests does this regime serve? How does algorithmic amplification function as a power/knowledge apparatus that determines which mental health knowledge claims acquire social force? The concept of regime of truth is applied specifically to the comparison between clinical counter-discourse (Videos 10, 14) and lay diagnostic discourse (Videos 3, 9, 12, 13): the clinical creators who challenge lay diagnostic authority are performing a Foucauldian denaturalisation making visible the power apparatus that governs TikTok's mental health knowledge regime rather than operating within it.

2.3 Integration of Frameworks

Fairclough (1992) explicitly acknowledges Foucault's foundational influence, describing his framework as developing Foucauldian discourse theory with greater attention to formal linguistic features. The integration here is therefore not eclectic but a continuation of a theoretically coherent development: Foucault accounts for why clinical language carries the authority it does and how that authority is being transformed in digital spaces; Fairclough provides the micro-analytical tools to demonstrate precisely how that transformation is enacted word by word, clause by clause, in specific video transcripts. Neither framework alone is sufficient: Foucault without Fairclough produces macro-political analysis ungrounded in textual evidence; Fairclough without Foucault produces textual description without political account. Together, they ensure that the analysis is simultaneously accountable to the words on the screen and to the historical and institutional conditions that give those words their social force.

3. ASPECTS OF LINGUISTICS ENGAGED BY THIS STUDY

This study is emphatically and comprehensively linguistically focused. It draws on five distinct sub-disciplines within linguistics and applied linguistics, each of which contributes specific analytical tools to the investigation of a different dimension of the corpus.

Critical Discourse Analysis is the primary analytical framework. As the discipline that examines discourse as social practice attending to how language reproduces or challenges power asymmetries. CDA provides the overarching structure for the entire study. The choice of CDA is not arbitrary but epistemologically motivated: the social problem being addressed is fundamentally a linguistic one, and only linguistic analysis can demonstrate how it operates at the level of specific utterances, grammar, and genre.

Systemic Functional Linguistics (Halliday, 1985; Halliday & Matthiessen, 2004) contributes the analytical apparatus for the textual dimension of the CDA. Halliday's three metafunctions, ideational (how language constructs representations of the world), interpersonal (how language constructs social relationships and positions), and textual (how language organises information) are applied directly in the analysis. The interpersonal metafunction is particularly central: the epistemic modality markers that pervade the non-clinical subcorpus are precisely the grammatical resources through which the creator-viewer relationship and the clinical authority of the creator over the viewer-as-diagnostic-subject is encoded. 'That's anxiety' is not merely a statement about the world (ideational); it is a statement about who the speaker is in relation to the listener (interpersonal) a clinician to a patient.

Pragmatics (Austin, 1962; Searle, 1969) provides the speech act framework for analysing the performative dimension of diagnostic claims. When a non-clinical creator asserts 'that's a silent symptom of depression,' the utterance is not a report but a performative speech act, an illocutionary assertion that attempts to bring about the situation it names: the viewer's recognition of herself as depressed. Analysing TikTok diagnostic discourse as a system of performative speech acts whose illocutionary force is the construction of the viewer as a clinical subject is essential to answering RQ1.

Sociolinguistics (Gumperz, 1982; Myers-Scotton, 1993) is engaged specifically for Video 4's code-switching between Standard English, Nigerian Pidgin English, and quasi-medical discourse. The analysis applies Myers-Scotton's (1993) markedness model to demonstrate that the code-switches in Video 4 are motivated choices that simultaneously manage the social dimension of the creator-viewer relationship (solidarity, relatability through

Pidgin) and the epistemic dimension of the creator's authority claim (credibility through Standard English medical register). Code-switching here is not incidental but ideologically strategic.

Health communication linguistics (Mishler, 1984; Coupland, Giles, & Wiemann, 1991) provides the framework for understanding the clinical consultation as the discursive archetype from which TikTok mental health creators borrow. Mishler's (1984) distinction between the 'voice of medicine' (technical, decontextualised, diagnostic) and the 'voice of the lifeworld' (personal, contextual, experiential) illuminates the discursive strategy of TikTok lay creators who blend the voice of medicine's diagnostic vocabulary with the voice of the lifeworld's personal testimony producing a hybrid discourse that is clinically formatted but experientially grounded, and thereby both authoritative and relatable.

4. LITERATURE REVIEW

The literature reviewed here spans six interconnected domains. The review adopts an evaluative rather than merely descriptive posture: identifying what each body of scholarship contributes, where it is limited, and precisely how the present study advances beyond it.

4.1 Intellectual Architecture of CDA

CDA emerged from critical linguistics (Fowler, Hodge, Kress, & Trew, 1979), demonstrating that grammatical and lexical choices encode ideological perspectives that naturalise particular social arrangements. Fairclough (1989, 1992, 2001) systematised this into the three-dimensional framework that anchors this study. Van Dijk (1993, 2001) extended it sociocognitively: his concept of the abuse of power, the illegitimate exercise of social force through discourse is directly applicable to lay creators asserting diagnostic conclusions that carry real social force among vulnerable audiences without clinical grounding. Wodak's (1995, 2001) discourse-historical approach insists on historical situations, informing this study's attention to the historical formation of clinical psychiatric authority from which TikTok creators borrow. What CDA scholarship did not foresee and what this study addresses is the application of these tools to algorithmically curated short-form video content, where the conditions of text production, distribution, and reception differ fundamentally from those of print and broadcast media.

4.2 Digital CDA and Social Media

Herring (2007) established the structural features of digital discourse — asynchronicity, persistence, searchability — as analytically significant. KhosraviNik's (2017) Social Media Critical Discourse Studies (SM-CDS) foregrounded platform affordances as analytically co-constitutive: TikTok's FYP, short-form video format, and hashtag architecture are not merely medium but discursive condition. Bou-Franch and Garcés-Conejos Blitvich (2014) developed CDA protocols for polylogic digital contexts; Page (2012) examined identity in social media self-presentation; KhosraviNik and Unger (2016) extended CDA to social media power dynamics. Despite this rich tradition, TikTok specifically has received no systematic CDA treatment, a gap this study fills with primary transcript evidence.

4.3 Mental Health Communication in Digital Spaces

Naslund et al.'s (2020) systematic review documented social media's dual function in mental health communication: destigmatisation and peer support alongside information inaccuracy and harmful content exposure. Alvarez-Mon et al. (2022) found that 52% of the 100 most-viewed #ADHD TikTok videos were inaccurate, with no significant correlation between creator credentials and content accuracy precisely the decoupling of authority from credential that epistemic borrowing names. Merchant et al. (2020) identified the structural tension: platforms most accessible to health information-seekers are least regulated. De Choudhury et al. (2014) demonstrated that language and mental health experience are systematically related in digital contexts. Crucially, all these studies document the phenomenon or its consequences; none examines the linguistic mechanisms through which inaccuracy acquires the force of authority. That linguistic examination is this study's contribution.

4.4 TikTok: Platform Architecture and Discursive Ideology

Bhandari and Bimo (2022) theorise 'algorithmic publics' communities formed by shared algorithmic exposure rather than declared interests which explains why TikTok users encounter diagnostic content without seeking it, and why the algorithm's engagement-maximising logic systematically rewards content that generates self-identification. Zulli and Zulli (2022) theorise 'imitation publics,' explaining how successful content formats are replicated directly evidenced in the near-identical Videos 3 and 12 of the present corpus. Cunningham and Craig

(2019) illuminate the creator economy's logic: algorithmically successful formats are monetisable, creating market incentives for the replication of epistemically aggressive diagnostic content. These studies establish the structural context within which the discursive patterns this study analyses are produced and circulated.

4.5 Medicalisation, Lay Expertise, and Epistemic Authority

Conrad (1992, 2007) theorised medicalisation as the extension of medical categories to non-medical experience, identifying its shift toward consumer-driven, media-facilitated forms that anticipate TikTok's manifestation. Hardey (1999) documented how online health information produces patients who arrive at consultations with pre-formed diagnostic hypotheses. Caron and Light (2022) described 'diagnostic borrowing' in online communities. The present study develops this into the more linguistically precise concept of epistemic borrowing: the appropriation of the specific discourse markers of clinical authority terminology, genre form, epistemic modality, and relational grammar to perform expertise indexed by language rather than grounded in institutional credential. This conceptual development is necessary because it shifts the analytical focus from the sociological practice of self-diagnosis to the specific linguistic mechanics through which that practice is enabled which is the precise contribution applied linguistics makes.

4.6 Language, Power, and the Social Construction of Mental Illness

Scheff (1966) established that diagnostic naming is a social act with real consequences. Rose (1998, 2007) demonstrated how psy-discourse historically produces subjectivities ways of understanding the self through psychological language and how neurological discourse reframes social and existential distress as brain pathology. Videos 6 and 13 in this corpus precisely enact this reframing: 'neurological patterns,' 'depression lives in the nervous system.' Wiggins (2017) documented diagnostic identity claims in online forums assertions of mental health identity through clinical language which the explicit engagement solicitations of Videos 3 and 12 ('drop it in the comments') anticipate and elicit. These studies confirm the social stakes of the linguistic analysis this study performs: the language of diagnosis is not descriptive but constitutive, and its unauthorised deployment has the same constitutive effects as its authorised use, regardless of the speaker's credential.

4.7 How This Study Differs from Previous Work and Gaps Filled

This study is distinguished from prior scholarship by five specific features. First, it uses primary transcript data as the analytical object, no prior CDA study has analysed actual TikTok video transcripts for mental health discourse. Second, it analyses the full discursive spectrum of TikTok mental health content, including clinical counter-discourses, enabling comparative analysis no prior study has performed. Third, it introduces epistemic borrowing as a theoretically precise descriptor that is more analytically specific than existing concepts (lay expertise, health misinformation, medicalisation). Fourth, it introduces digital diagnostic imperialism to name the global, algorithmically amplified reproduction of Western diagnostic frameworks, a dimension absent from all prior digital health communication scholarship. Fifth, it demonstrates through the case of Dr. Siya (Video 11) that genre normalisation colonises clinical communication, a finding with direct implications for governance that has not previously been empirically demonstrated. The tripartite gap it fills, health communication's lack of linguistic analysis; digital CDA's lack of TikTok application; medical sociology's lack of discourse-analytical specificity is addressed simultaneously.

5. METHODOLOGY

5.1 Research Design and Data Source

This study adopts an interpretive, qualitative research design grounded in CDA's epistemological commitments. The interpretive paradigm is appropriate because the study's concern, the ideological functions of language in digital mental health communication requires hermeneutic engagement with texts as socially situated practices. Fairclough (2001, p. 19) articulates CDA's emancipatory commitment as making 'visible the dialectical relationships between discursive practices and wider social and cultural developments'; this commitment motivates both the analytical design and the study's practical recommendations. The primary data consist of verbatim transcripts of fourteen TikTok videos, produced through a systematic transcription process in which each video was viewed repeatedly by the researcher and its full spoken verbal content rendered in written form, retaining all false starts, colloquialisms, code-switches, incomplete sentences, and informal grammatical constructions as analytically significant features of the spoken discourse. Transcription accuracy was verified through a minimum of three full listenings per video against the completed transcript, with particular attention to passages containing code-switching (Video 4), suspended or incomplete utterances (Video 9), and dual-voice formats (Video 11). Transcription followed the conventions of discourse-focused spoken language transcription as established in CDA research practice (Fairclough, 2001; Mishler, 1984), prioritising the preservation of

authentic verbal form over orthographic standardisation. TikTok is selected as the site of investigation because: its FYP algorithm distributes mental health content to users who never sought it, creating discursive conditions uniquely consequential for public health; its demographic profile concentrates impact among young adults aged 16 to 29 (Statista, 2024), the population most vulnerable to mental health challenges; and it hosts the largest volume of mental health discourse of any short-form video platform. The corpus contains both clinical and non-clinical creators, enabling the comparative analysis that constitutes one of this study's original contributions.

5.2 Corpus Construction: Sampling Criteria and Rationale

The fourteen videos were purposively sampled, the strategy when research goals require information-rich cases that illuminate a phenomenon rather than statistical representativeness (Patton, 2002). The corpus was constructed to achieve three specific sampling goals: discursive range, covering the full spectrum from lay advocacy through pseudo-psychological content, symptom lists, faith-inflected narratives, and clinical advisory content to direct counter-discourse against social media self-diagnosis; credential diversity, including identified clinical professionals (Videos 7, 8, 10, 11, 14) and non-clinical lay speakers (Videos 1, 2, 3, 4, 5, 6, 9, 12, 13) to enable comparative analysis; and topical breadth, spanning depression, anxiety, mental-physical correlations, psychological lay-theorising, physician wellbeing, and self-diagnosis warnings.

5.3 Limits, Boundaries, and Justification of Selection

Each delimitation of this study reflects a principled scholarly decision rather than a methodological limitation, and each requires explicit justification.

The corpus is restricted to verbal transcript content that is, spoken words only without incorporating visual text overlays, background music, editing patterns, or other multimodal elements. This delimitation is justified on three grounds: it ensures analytical consistency across all fourteen videos, since visual and musical elements vary in availability and interpretability; it maintains focus on the study's central concern, the linguistic construction of epistemic authority which is enacted primarily through verbal choices; and it produces a clearly bounded analytical object that supports replication. The limitation this creates is that the full multimodal meaning-making of TikTok content is not analysed, this is explicitly acknowledged and identified as a priority for future multimodal CDA research.

Fourteen videos constitute the corpus rather than a larger sample. This number is justified by the interpretive, depth-oriented design of the study: CDA requires close reading of individual texts rather than surface-level analysis of large corpora, and fourteen videos with full transcript evidence provide sufficient analytical depth to demonstrate the full range of discursive patterns while remaining manageable for the level of close reading the methodology demands. The corpus achieves saturation by Video 13, no new discursive patterns were being identified which is the appropriate criterion for adequacy in purposive qualitative sampling (Patton, 2002).

The corpus is restricted to English-language content, justifying analytical consistency and cross-video comparability. Video 4's Nigerian Pidgin English code-switching is retained rather than excluded because it operates within an English-based linguistic system and its code-switching patterns are analytically productive for the sociolinguistic dimension of the study. Excluding it would have eliminated the only corpus instance of African vernacular discourse, impoverishing the cross-cultural dimension of the analysis.

The corpus includes both clinical and non-clinical creators rather than restricting itself to one group. This is justified by Objective 4, which requires comparative analysis of clinical counter-discourse. A corpus restricted to non-clinical creators would produce a more homogeneous but analytically less revealing dataset; the inclusion of clinical voices particularly the counter-discourses of Videos 10 and 14 and the genre-normalisation case of Video 11 generates the study's most theoretically consequential findings.

The study does not include TikTok comment sections. This is justified by the need to keep the analytical object clearly defined and bounded within the fourteen transcripts; comment section analysis would require a separate analytical protocol and would significantly expand the scope beyond what is appropriate for a single study. Comment section dynamics are identified as a productive avenue for future research.

5.4 Corpus Overview: Transcript Catalogue

Video	Creator Type	Topic	Primary Analytical Significance
1	Non-clinical (lay-religious)	Depression: causes, coping, spiritual reframe	Anaphoric escalation; biblical intertextuality; sermon-register authority construction
2	Non-clinical (advocacy)	Mental health validity; anti-stigma	Bomb metaphor; assertive declaration; lay peer-support advice without clinical basis
3	Non-clinical (content creator)	Five-sign symptom list: anxiety/depression	DSM-adjacent numbered list; 2nd-person diagnostic address; engagement call-to-action
4	Non-clinical (lay health educator)	Mental-physical correlation; religion; body	Statistical assertion; code-switching (Nigerian Pidgin/English); dual authority strategy
5	Non-clinical (pseudo-psychological)	Attachment; absent parent; relationships	'According to psychology' borrowing; 3rd-person generic as diagnostic positioning
6	Non-clinical (advocacy)	Biomedical legitimisation of mental illness	Highest biomedical vocabulary in lay subcorpus; counter-folk-dismissal discourse
7	Clinical (physician)	Medical vocation; physician wellbeing	Credential contrast; hedged advisory modality; absence of diagnostic claims
8	Clinical (physician/resident)	Specialty selection; personal fulfilment	Personal-experience warrant; hedged modality; professional identity discourse
9	Non-clinical	Seven signs of mental exhaustion	Suspended diagnostic climax — algorithmic suspense as engagement device
10	Clinical (psychiatrist/physician)	Counter-discourse: social media self-diagnosis	Names influencer-diagnosis mechanism; critiques pill-and-psych commercial system
11	Clinical (Dr. Siya)	(A) Poetic emotional content; (B) sign list	Genre normalisation: credentialed clinician adopts TikTok symptom-list format
12	Non-clinical	Five-sign list (near-identical to Video 3)	Content replication — evidence of imitation public culture (Zulli & Zulli, 2022)
13	Non-clinical	12-item depression behaviour inventory	Largest behaviour list; 'depression lives in the nervous system'; ordinary life medicalised
14	Clinical (health professional)	Counter-discourse: Gen-Z self-diagnosis warning	Explicitly names algorithm; identifies ordinary behaviour medicalisation; most direct counter

Table 1: Corpus Transcript Catalogue

5.5 Analytical Procedure and Ethics

Each transcript was subjected to Fairclough's three-dimensional protocol. At the textual level: lexical analysis tracking vocabulary across a three-point spectrum from general emotional to lay clinical to DSM-adjacent technical; epistemic modality coding from assertive high-certainty to protective hedging; person deixis analysis examining how 'you'/'your' constructs the viewer as diagnostic subject; rhetorical structure analysis of numbered lists, anaphora, and engagement calls; speech act classification of diagnostic utterances as performatives, constatives, or directives. At the discursive practice level: manifest intertextuality analysis of named sources (biblical, psychological, statistical); constitutive intertextuality analysis of unnamed DSM-5 format appropriation; genre analysis of the symptom list, testimonial narrative, and counter-warning; code-switching analysis (Video 4); counter-discourse analysis (Videos 10, 14). At the sociocultural level: situating patterns within TikTok's political economy (Bhandari & Bimo, 2022), the global mental health care gap (WHO, 2022), and Foucauldian regimes of truth. Data are publicly available; non-prominent creator anonymity is preserved;

Dr. Siya's credential is retained as analytically significant. Study adheres to AoIR ethical guidelines (Franzke et al., 2020).

6. ANALYSIS AND DISCUSSION

The analysis proceeds through Fairclough's three dimensions, grounded throughout in direct transcript evidence. Analytical claims are accountable to specific verbal quotations, with each quotation followed by an analytic note showing the application of the theoretical framework. Comparative analysis across the clinical/non-clinical divide is integrated throughout, addressing all four research questions.

6.1 Textual Dimension: Lexical Choice, Modality, and Deixis

6.1.1 Epistemic Borrowing Through Lexical Escalation and Biomedical Vocabulary

Video 1 (Non-clinical, lay-religious) — Anaphoric escalation:

'It started as disappointment. It started as failure. It started as hopelessness. It started as helplessness. It started as fatigue... And then gradually it descends to despair and then to depression.'

Fairclough's textual analysis: The nine-stage anaphoric escalation mimics the clinical developmental typology of depressive disorders. The verb 'descends' borrows clinical metaphor; 'checked' imports the language of clinical monitoring. Clinical authority is performed through sequential causal logic, not diagnostic credential constituting epistemic borrowing at the level of rhetorical structure.

Video 6 (Non-clinical advocacy) — Neuroscientific vocabulary:

'There are actual chemical shifts, nervous system responses, and biological processes that are involved... As if a walk, a smoothie, or a good attitude can rewrite neurological patterns.'

SFL interpersonal metafunction: 'chemical shifts,' 'nervous system responses,' 'neurological patterns' deploy neuroscientific vocabulary without attribution. 'Rewrite neurological patterns' borrows from neuroplasticity discourse, a contextually complex scientific field to assert general biological intractability, performing scientific authority with considerable rhetorical force in the complete absence of scientific grounding.

6.1.2 The Grammar of Diagnostic Certainty: Epistemic Modality

High-certainty assertive modality — Videos 3 and 12 (Non-clinical):

'You second guess every choice... That's anxiety. Whispering you can't handle life.' / 'That numbness, it's a silent symptom of depression.'

Speech act analysis: 'That's anxiety' and 'it's a silent symptom of depression' use the copula 'is' to perform a speech act of classification, not to describe but to constitute. In clinical discourse, such declarations are preceded by comprehensive assessment and qualified by differential diagnosis. Their deployment by a lay speaker produces the illocutionary force of clinical diagnosis without any of its epistemic grounding.

Protective hedging — Video 10 (Clinical counter-discourse):

'Be really careful about self diagnosing yourself because many doctors out there will not stop you from giving yourself this incorrect diagnosis.'

Modal contrast: 'Be really careful' shifts to protective directive modality, intensifying warning rather than claiming diagnostic truth. This is the linguistic mark of epistemic accountability systematically absent from the lay subcorpus. The contrast with 'that's anxiety' (Video 3) demonstrates the clinician/lay divide at the level of modal grammar.

Metalinguistic critique — Video 14 (Clinical counter-discourse):

'All those videos... are lying to you... they're just listing general things that like almost everyone in the population does hoping that it will trick you to interact more with their video and boost up in the algorithm.'

Foucauldian application: This is the corpus's most politically significant utterance. The creator performs regime-of-truth denaturalisation making the power apparatus of lay diagnostic authority (algorithmic amplification, engagement incentive) an explicit object of naming. 'Lying to you' deploys the certainty modality of the lay subcorpus in the service of epistemic critique rather than diagnostic assertion.

6.1.3 Person Deixis: Constructing the Diagnostic Subject

Video 1 — Conditional as diagnostic entry point:

'If you are someone who has experienced trauma... it's almost like you descend into this pit of despair... You're battling depression.'

SFL interpersonal metafunction: The conditional 'if you are someone who' opens a diagnostic inquiry that 'you're battling depression' immediately converts into assertion. The conditional provides deniability while the second-person declaration delivers the diagnosis, a grammatical strategy that performs clinical intimacy while avoiding the qualification that genuine clinical assessment would require.

6.2 Discursive Practice: Intertextuality and Genre Replication

6.2.1 Manifest Intertextuality: Named Authority Without Epistemic Substance

Video 1's biblical intertextuality (David, Jeremiah, Elijah as typological figures of depression) performs a dual ideological function: legitimising depression as spiritually serious while positioning scriptural exegesis as clinical authority, a distinctly African/Nigerian epistemic move in which faith functions as the primary credentialing system. Video 4's 'Studies have proven' deploys the discourse marker of scientific authority without citation, the form of scientific reference without its epistemic substance. Video 5's 'According to psychology' borrows an entire academic discipline as monolithic authority, appropriating simplified attachment theory (Bowlby, 1969) without naming any specific theorist, study, or finding resisting verification while claiming scientific grounding.

6.2.2 Constitutive Intertextuality: The Symptom List as Platform Genre

Videos 3 and 12 (Non-clinical — near-identical content):

'1. your sleep is all over the place... 2. you get upset over nothing... 3. your self esteem is gone... 4. you've stopped caring about things you once loved... 5. you can't live in the moment.'

Fairclough's constitutive intertextuality: The numbered format replicates the structural logic of DSM-5 diagnostic criteria without attribution. Crucially, DSM-5 criteria include temporal specifications ('most of the day, nearly every day, for at least two weeks') and contextual qualifications (significant distress or impairment). Both are entirely absent, stripping clinical criteria of their evidential grounding while retaining their epistemic form. The near-identical content across Videos 3 and 12 demonstrates Zulli and Zulli's (2022) imitation public culture: the genre spreads through platform-normalised replication, not individual creativity.

Video 13 — 12-item depression behaviour inventory:

'many people live like this for years blaming themselves for laziness or thinking it's just low energy... depression doesn't live in words it lives in the nervous system'

Sociocultural analysis: The reframe from 'laziness' to unrecognised depression converts self-attribution into clinical attribution, Conrad's (2007) consumer-driven medicalisation at the level of specific lexical substitution. The neuroscientific claim 'depression lives in the nervous system' deploys Rose's (2007) neurological subject discourse without any scientific basis, reducing a complex biopsychosocial phenomenon to a single anatomical location.

6.2.3 Genre Normalisation Across the Credential Divide

Video 11 — Dr. Siya (Clinical professional):

[Part B, Dr. Siya:] 'Signs that you are struggling. Mood swings. Avoiding. No sleep. Thinking too much. Easily annoyed. Always tired.'

This is the corpus's most theoretically consequential finding. Dr. Siya, an identified clinical professional deploys the exact symptom-list genre form, with clipped single-clause items and zero epistemic hedging, that characterises non-clinical lay content. Fairclough's concept of generic colonisation explains this: TikTok's order of discourse exerts normalising pressure on all content producers regardless of their credential level. The governance implication is significant: credential-based content regulation alone cannot solve the problem the study identifies, because the genre itself not merely unqualified speakers is the vehicle of epistemic harm.

6.3 Sociocultural Practice: Algorithmic Ideology and Medicalization

The discursive patterns identified in Sections 6.1 and 6.2 are embedded in a specific configuration of power relations intersecting algorithmic architecture, the global mental health care gap, and the commodification of

psychological suffering. Algorithmic ideology, TikTok's engagement-maximising architecture functioning as an ideological selection mechanism, systematically rewards the most epistemically confident and emotionally resonant content. The numbered symptom list is algorithmically optimal: it generates watch-time completion, self-identification engagement, and affective resonance. Clinical counter-discourse is structurally disadvantaged: protective warnings generate lower engagement than diagnostic validation. The platform does not deliberately amplify misinformation; its engagement logic produces this effect systematically and structurally.

Conrad's (2007) consumer-driven medicalisation is enacted textually throughout the corpus, ordinary experience (decision-avoidance, sleep irregularity, binge-watching) reframed as clinical pathology. Rose's (2007) neurological subject is produced through the vocabulary of Videos 6 and 13. Video 4's code-switching between Standard English, Nigerian Pidgin ('Na science talk am o' meaning it is 'It's science that says so, not me'), and quasi-medical register performs a sophisticated dual ideological strategy: Pidgin establishes solidarity with a Nigerian audience while the formal medical register claims epistemic authority. This is the only corpus instance of African vernacular deployed in the service of lay clinical authority, and its analysis demonstrates that digital diagnostic imperialism operates not only through Western creators addressing global audiences but also through local creators who adopt Western diagnostic frameworks and reproduce them in vernacular-inflected content for regional audiences.

6.4 Counter-Discourse: Clinical Voices in Resistance

Video 10 constitutes the corpus's most analytically significant clinical intervention. The creator identifies three mechanisms of social media self-diagnosis which are influencer symptom-display, viewer identification, and commercial clinical legitimisation and challenges all three. The phrase 'a long way ticket to a lifetime of drugs' critiques the commercial incentive structure implicating systemic institutional failure: the problem is not merely lay creators performing clinical authority but a clinical marketplace that accommodates the self-diagnoses those performances produce. Video 14 deploys direct audience targeting ('especially GenZ, especially if you're self-diagnosing through TikTok'), names the symptom-list format specifically, identifies specific medicalised ordinary behaviours ('biting your lip,' 'talking really fast,' 'liking to wake up late'), and explicitly names the algorithmic mechanism performing within the platform the same denaturalising analysis this study performs in the academy. Videos 7 and 8 provide credential contrast through hedged, first-person, experience-based modality ('you may fail,' 'from my experience'), demonstrating epistemic accountability as the linguistic signature of credentialed clinical communication.

6.5 Cross-Corpus Comparative Summary

Feature	Non-Clinical Lay Subcorpus (V.1–6, 9, 12–13)	Clinical Subcorpus (V.7, 8, 10, 11, 14)
Epistemic modality	Overwhelmingly assertive high-certainty	Hedged advisory (7,8); protective warning (10,14); genre-normalised list (11)
Diagnostic claims	Frequent, explicit, named; no clinical qualification	Absent (7,8); explicitly cautioned against (10,14); form-adopted without claims (11)
Intertextual sources	Unnamed: 'studies show,' 'according to psychology,' implied DSM-5 format	Named personal experience (7,8,10); algorithmic mechanism explicitly named (14)
Genre form	Symptom list, testimonial narrative, escalation sequence, pseudo-psychological profile	Career advisory, clinical warning, metalinguistic commentary on platform discourse
Authority warrant	Lived experience, name-dropping, religious/statistical assertion, neuroscientific framing	Professional credential; personal clinical experience; metalinguistic expertise
Engagement solicitation	Explicit: 'drop it in the comments, like, share and follow' (3,12)	Absent in all five clinical videos

Table 2: Comparative Discursive Profile — Clinical vs. Non-Clinical Subcorpora

7. FINDINGS

Objective / RQ	Principal Finding	Theoretical Frame Applied
Obj.1 / RQ1: Lexical, modal, grammatical strategies	Epistemic borrowing enacted through: DSM-adjacent symptom lists; assertive copular diagnostic modality ('that's anxiety'); 2nd-person diagnostic address; constitutive intertextuality appropriating clinical genre without qualification. Clinical speakers deploy hedged, advisory, first-person modality in contrast.	Fairclough textual; Halliday interpersonal metafunction; Austin/Searle speech acts
Obj.2 / RQ2: Intertextual appropriation and genre conventions	The TikTok symptom list is a normalised genre that eliminates DSM-5's temporal and contextual qualifications. Content replication (V.3/V.12) demonstrates imitation public culture. Manifest intertextuality deploys named disciplinary authority without epistemic substance.	Fairclough discursive practice; Zulli & Zulli 2022; Bowlby/DSM contrast
Obj.3 / RQ3: Power relations and ideological interests	Algorithmic ideology selects for epistemic confidence over accuracy. Ordinary experience is systematically medicalised. Code-switching (V.4) deploys vernacular solidarity alongside clinical register for dual authority. Digital diagnostic imperialism circulates Western frameworks globally.	Foucault power/knowledge; Conrad 2007; Rose 2007; Cunningham & Craig 2019
Obj.4 / RQ4: Clinical counter-discourse strategies	Videos 10 and 14 deploy metalinguistic critique and explicit algorithmic naming — regime-of-truth denaturalisation within the platform. Genre normalisation colonises credentialed communication (V.11 Dr. Siya). Credential-based regulation alone is insufficient.	Foucault regime of truth; Bhandari & Bimo 2022; Fairclough generic colonisation
Obj.5 / New Outcomes: Generating recommendations and original discoveries	Four evidence-based recommendations were generated: platform-level genre governance (not merely creator credentials); TikTok-native communication strategies for health institutions modelled on Videos 10 and 14; critical language awareness integration into curricula; and a cross-linguistic, multimodal, longitudinal research agenda. Original discoveries beyond prior work include: genre normalisation across the credential divide (Dr. Siya, Video 11); the specific three-part linguistic mechanism of epistemic borrowing (assertive copula + 2nd-person deixis + constitutive intertextuality); metalinguistic counter-discourse as platform-internal Foucauldian denaturalisation; and the dual ideological function of vernacular code-switching (Video 4).	Original contribution — no prior study demonstrates these findings

Table 3: Principal Findings Against Objectives and Research Questions

8. RECOMMENDATIONS

Four evidence-grounded recommendations follow directly from the corpus analysis, organised across the three beneficiary audience categories identified in Section 1.4. The first two recommendations address the first category which are scholars, clinicians, institutions, and governance actors. The third addresses educators and media literacy practitioners. The fourth addresses the research community whose future work will extend the study's reach, including into the non-Western and multilingual contexts where vulnerable young people face the consequences of digital diagnostic imperialism most acutely. First, for platform designers, digital regulators, and policymakers: TikTok should institute linguistically informed content classification that renders creator credentials visible at the point of consumption. Because even credentialed creators adopt the symptom-list genre (Video 11), governance must function at the genre level flagging the symptom-list format itself as a potential epistemic risk indicator not merely at the creator credential level. TikTok's algorithmic architecture should be

independently audited for systematic amplification of epistemically aggressive diagnostic content, with modifications that balance engagement incentives with epistemic accountability.

Second, for mental health clinicians and institutional health communication officers: Videos 10 and 14 demonstrate that clinical communication can be TikTok-native without sacrificing epistemic responsibility. Direct audience targeting, explicit algorithmic naming, and linguistically specific critique of symptom-list content constitute an engaging and credible model that health institutions should study and adopt. The absence of credentialed voices from algorithmically dominant TikTok mental health content is not inevitable but a communicative failure that can be strategically addressed.

Third, for educators, curriculum designers, and most directly vulnerable young people themselves: Critical language awareness (Fairclough, 1992; Hawkins, 1984) specifically, awareness of epistemic modality markers, genre conventions, and the authority-constructing discourse strategies documented in this corpus should be integrated into secondary and tertiary curricula as a component of digital health literacy. The concept of epistemic borrowing provides a teachable, accessible framework for a discursive phenomenon that young people encounter daily in their social media feeds; Video 14's creator demonstrates that this framework can be communicated in language accessible to Gen-Z audiences without technical linguistic vocabulary. For young people navigating mental health challenges without access to formal clinical support, the capacity to recognise that a numbered symptom list is a platform genre rather than a diagnostic instrument and that 'that's anxiety' is a performative speech act rather than a clinical assessment constitutes a form of epistemic self-protection with direct implications for whether they seek appropriate professional help or accept a lay-produced label as sufficient.

Fourth, for researchers: Priority research directions include multimodal TikTok CDA incorporating visual overlays and music; comparative platform studies across TikTok, Instagram Reels, and YouTube Shorts; longitudinal discourse analysis of TikTok mental health content over multi-year periods; and cross-linguistic investigation particularly in Yoruba, Igbo, Swahili, Hindi, and other non-Western-European language contexts where digital diagnostic imperialism is most consequential and least studied.

9. CONCLUSION

This study demonstrated that TikTok mental health discourse constituted a discursive crisis whose depth and mechanisms could only be illuminated through the analytical precision of Critical Discourse Analysis. Applying Fairclough's three-dimensional framework in integration with Foucault's power/knowledge analysis to fourteen primary video transcripts, the study produced a rigorous, evidence-grounded account of how clinical authority was constructed, contested, and circulated in digital short-form video without clinical credential and of the specific linguistic mechanisms through which this construction operated word by word, clause by clause, and genre by genre.

The social problem the study addressed was precisely defined: the appropriation of clinical language by non-credentialed speakers, amplified algorithmically to over 1.5 billion users, with direct and measurable consequences for how vulnerable populations name, understand, and respond to their psychological suffering. The study demonstrated that this problem is not merely informational, a matter of inaccurate health facts circulating online, but fundamentally linguistic and structural: a problem of epistemic authority exercised discursively in the absence of institutional grounding and systematically rewarded by the very architecture of the platform that hosts it. The finding that a credentialed clinical professional (Dr. Siya, Video 11) adopts the platform's symptom-list genre shows that the structural dimension of the problem functions beyond individual speaker irresponsibility.

The two original concepts introduced are epistemic borrowing and digital diagnostic imperialism which offer applied linguistics a precise and generative vocabulary for a category of discursive phenomena that will only grow in consequence as digital platforms continue to displace formal institutions as primary sites of health, legal, and scientific knowledge production. What can be deduced from this study is equally precise: that the governance of digital mental health discourse cannot be achieved through content moderation or creator credentialing alone, because the mechanism of harm is not the individual speaker but the genre, the normalised linguistic form through which clinical authority is performed without institutional grounding, and which exerts discursive pressure on credentialed and non-credentialed creators alike. This deduction has direct implications for platform architecture, public health communication policy, and educational practice that no amount of epidemiological or sociological analysis could have generated, because the mechanism it identifies is irreducibly

linguistic. The study's contributions are theoretical, methodological, empirical, and social and its argument is for the irreplaceability of applied linguistics in the analysis of social problems whose surfaces appear informational and epidemiological, but whose structure is fundamentally linguistic, ideological, and consequential. TikTok has given millions of people a language for their suffering. This study argued that the language it gives them is not neutral, not unmediated, and not without consequence and that naming its mechanisms with linguistic precision is the indispensable first step toward addressing them.

APPENDIX

Video 1- https://vt.tiktok.com/ZSuSam4J2/

Video 2- https://vt.tiktok.com/ZSuSay9Cu/

Video 3- https://vt.tiktok.com/ZSuSagdUJ/

Video 4- https://vt.tiktok.com/ZSuSm3G3U/

Video 5- https://vt.tiktok.com/ZSuSmvspy/

Video 6- https://vt.tiktok.com/ZSuSmqGf2/

Video 7- https://vt.tiktok.com/ZSuSm9Rfv/

Video 8- https://vt.tiktok.com/ZSuSmxRbw/

Video 9- https://vt.tiktok.com/ZSuSuFDdq/

Video 10- https://vt.tiktok.com/ZSuSuN2uU/

Video 11- https://vt.tiktok.com/ZSuSuFJhr/

Video 12- https://vt.tiktok.com/ZSuSuBpDV/

Video 13- https://vt.tiktok.com/ZSuSu8N7B/

Video 14- https://vt.tiktok.com/ZSuSuPLH4/

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