UiT The Arctic University of Norway

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The Power of Literature

Mental health Education in the English Upper-Secondary Classroom

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Master's thesis in English Literature and Education, ENG-3983, May 2024

Abstract

This thesis investigates how and why English literature should be used in the upper-secondary classroom to increase awareness, knowledge and empathy in relation to mental health, for the purpose of decreasing the stigmatization of mental illness and mental health problems. This thesis conducts a literature analysis of the novel *Normal People* (Rooney, 2018) and the memoir *Reasons to Stay Alive* (Haig, 2015), focusing on stigmatization of mental illness and mental health problems (institutional stigma, public stigma and self-stigma). This thesis also includes the concept of normality and the debate on normal versus abnormal in relation to the mental health diagnostic system and stigmatization of those who are judged as different. Mental health is an important topic to include in the educational system because different studies and statistics show that a concerning high number of individuals in the younger generation experience problems or challenges with their mental health. The classroom is a safe and natural place to increase the student's mental health awareness, general knowledge about mental health and conduct stigma education with the help of *Normal People* and *Reasons to Stay Alive.*

Acknowledgments

I would like to thank my supervisor, Ruben Moi, for a good collaboration consisting of quick answers, helpful ideas, encouraging words, interesting conversations and a clear framework. Most of all I want to thank Ruben Moi for encouraging me to write about what I want and supporting my ideas and interpretations, as well as helping me see new perspectives in relation to this thesis.

I also want to thank all my fellow students at Lesehuset for being part of the social- and academical arena where I could get tips, discuss my ideas, or forget about the thesis for some hours. Thank you to everyone at Lesehuset who played ping-pong with me and made me a decent ping-pong player during these months.

Lastly, I would like to thank my friends and family for supporting me throughout these five years and always helping me when needed.

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1 Introduction

English literature surrounding the topic of mental health gives the reader insight into a world filled with diagnosis, hope and mastery, but also stigma, misery and misunderstanding. Where do we draw the line between disease, unwell-being and normality? How and Why? English literature involving the topic of mental health provides a possibility to facilitate reflection and discussion upon the topic of mental health, diagnosis and the stigma attached to the diagnosis. Reflecting and discussing the literary works about mental health can help students express their own feelings, thoughts and opinions, and provide the students with new perspectives that facilitate new ways of thinking and communicating, as well as mastering their own mind and life. Lastly, the new perspectives and knowledge can help break down the stigma of mental health problems and mental illness, replacing stigmatization with empathy, and affect how students perceives mental health in general. This thesis intends to see how the novel *Normal People* (Rooney, 2018) and the memoir *Reasons to Stay Alive* (Haig, 2015) can be used in the English upper secondary classroom to increase the students' knowledge about mental health in general and create a better understanding of how it is to live with a mental illness or mental health problem for the purpose of increasing empathy and decreasing stigmatization, as well as give the students' knowledge and tools to use when they meet a challenge in life. How literature affect humans is an interesting scientific field and Djikic, Oatley and Moldoveanu (2013) did a study on literature's potential to increase empathy and explains that:

> Since humans, as a species, are not born with cognitive empathy but develop it in middle childhood, it seems reasonable that there could be a potential of continuing to develop it throughout one's lifetime, and that fictional literature could be one means of doing this. While we have obtained some evidence for this relationship, in order to answer questions about the quality, speed, and mechanism of this development, it is necessary to conduct further experiments (p.23-24).

Cognitive empathy is how well we as humans can understand emotions of another human. It is reasonable to think that literature can help the development of cognitive empathy because literature naturally includes characters that express their feelings based on their situation and the characters give the reader a chance to go inside their mind; This helps the reader understand why the character feels the way they feel and how the characters actions and choices are connected to their feelings. Literature is a goldmine of perspectives, knowledge and experiences that individuals can learn from by walking in the shoes and minds of the

characters. Many of us have read books, novel, short stories or seen plays that made us sympathies with the character or feel empathy for their situation. William Shakespeare wrote *Hamlet* between 1599 and 1601, and still to this day the scholars debate about the mental state of the character prince Hamlet in relation to his own descriptions of his inner battles and mental distress caused by madness (mental health problems perhaps), grief and an ever-switching moral compass. *The Yellow Wallpaper* (1892) by Charlotte Perkins Gilman portrays a women's experience with mental illness from her own perspective as she declines into what at the time would be described as madness. The stream of consciousness used in the short story make you understand the struggles and hopelessness of the main character, evoking feelings of empathy and sympathy. Feelings as anger and sadness may also be evoked because of her treatment. Another author who touched many feelings of the public while making mental health relevant through her literature was Virginia Wolf. *Mrs. Dalloway* was published in 1925 and includes trauma, phycological introspection, feeling abnormal, shellshock (PTSD) and suicide. *Hamlet* written by William Shakespeare, Gilman's portrayal of a woman struggling with her mental health in a world where the ''man knows best'' (power structure) and Virginia Wolf's focus on underlying causes to mental health problems and mental illnesses, as well as conveying the seriousness and difficulty of living with a mental illness are examples that illustrate how literature and characters have affected the emotional register of the recipient for a very long time, but also that mental health has been a part of literature for a very long time. I also argue that these literary works support the idea that literature has the power to change and affect our perspective, thoughts and attitudes in regard to things in the real world. This thesis intends to show that by increasing the student's knowledge and awareness about mental health, through working with the fictional novel *Normal People* and the non-fictional memoir *Reasons to Stay Alive*, we hope to decrease the student's stigmatization of people with mental illness or mental health problems. We hope to replace the negative representations and misunderstandings connected to mental health in general and people with mental illness and mental health problems through empathy and a better understanding of how it is to live with mental illness and/or mental health problems. Replacing stigma with empathy, knowledge and humanity can also create introspective students who better understand their own feelings, how to express those feelings and more importantly how to deal with them; preparing the students for the small and bigger challenges that they will meet along their journey in life.

There are many reasons for taking the battle against mental health stigmatization inside the upper-secondary classroom. The school is one of the arenas where adolescents spends most of their time and in Norway young people have the right to upper secondary school according to §3-1 *Right to upper secondary education and training for young people* in the *Act relating to Primary and Secondary Education and Training (the Education Act)* (1998) where it states that: ‘‘Young people who have completed primary and lower secondary education or the equivalent have, on application, the right to three years' full-time upper secondary education and training’’. The right to upper secondary school means that many adolescents attends the three-years of upper secondary school after completing the obliged primary and second lower school. The same young generation that has the right for upper-secondary school is in a struggle that the school system can help them with: ‘‘Between 15 and 20% of all young people in Norway have psychological problems that go beyond their own functional ability. Between 4 and 7% have such serious problems that they need treatment. Only 15-20% of young people with significant mental health problems have been in contact with mental health services the last 12 months’’ (Andersen, 2011, p. 6). 15-20% is a concerning high number and gives us the idea of how many students in the lower- and upper-secondary school that have psychological problems. 4-7% needs treatment, but this number is most likely higher based on the information that only 15-20% of young people with significant mental health problems have actually been given the opportunity to accept help. It is reasonable to think that stigma targeting people with mental health problems affects the 75-80% that chooses to not seek help from the mental health services, and it is also reasonable to think that a big percentage of the 75-80% attends school.

> It is a reasonable hypothesis that knowledge of such ailments and disorders - including the ability to recognize symptoms in one yourself and others - combined with knowledge of where to find help if problems arise, can contribute to increased coping skills and reduce the strength and extent of the problems. It is also reasonable to see the school as a good arena for providing young people with such knowledge and coping skills (Andersen, 2011, p. 45).

Andersen’s hypothesis is built upon the idea that knowledge about mental health, mental health problems and mental illnesses, as well as the symptoms for different mental health problems and mental illnesses, will affect how adolescents cope with their own problems and reduce the impact mental health problems and mental illness can have upon the individual. Anderson’s trust in the school-system to provide knowledge and coping skills support this thesis idea in respect to the school-system having a big responsibility, but not least, a big

opportunity and potential to help reduce one of the biggest public health challenges in Norway.

The adolescents in the upper-secondary classroom are one of the best groups to educate about mental health awareness and stigma for various reasons. First of all, Simmons, Jones and Bradley (2017, p. 30) are referring to Watson et al. (2004) and stating that ‘‘[…] more contemporary research also indicates that students are restricted in regard to mental health awareness within education, which in turn has a definite impact upon the individual's knowledge’’. Even though adolescents and the world in general have more information about mental health available now in 2024 than in 2004, I can still argue that this information is restricted within the educational system in Norway. Adolescents have limited knowledge about mental health awareness and there is a coherence between this lack of knowledge and negative perception on mental health, which leads to more stigmatization of individuals with mental health problems and mental illness. Secondly, Strassle refers to a meta-analysis done by Corrigan et al in 2012 and states that: ‘‘[…] literature favors contact as the best stigma reduction technique for adults but stigma education as the best stigma reduction technique for adolescents’’ (2018, p.352). Strassle further explains that Corrigan's et al. meta-analysis from 2012 had a hypothesis that: ‘‘[…] beliefs about mental illness may still be developing in adolescents and therefore may also be more malleable through stigma education’’ (2018, p.352). The individual's knowledge on mental health and mental health stigma is again empathized as a variable that plays a vital role in affecting the individual's attitudes and perspective on mental health problems and mental illness. The third reason is that the education of adolescents take place within the classroom where there is a clear framework and a natural opportunity where the students are expecting to learn something. The fourth reason is that adolescents and younger generations will have an impact on future generations in a fast moving and fast developing world. Mental health awareness and stigma are two concepts that I argue are transgenerational, which is supported by Bailey that confirmed comparable numbers between adolescents and adult samples in regard to mental health stigma (1999, p.109), because you will find lack of knowledge in regard to mental health and stigmatization of mental illness in all the generations alive today. In other words, by teaching adolescents in the upper-secondary classroom mental health awareness and start to decrease the stigmatization of people with mental illness and mental health problems; the students can influence the next generation on the topic mental health and affect the next generation's attitudes, perspectives and prejudices. Bailey, like Corrigan et al., also argues that: ‘‘Early

education about mental health and the facts of mental illness is critical if attitudes are to alter'' (p.109). One of the ways this generational battle could play out in the real world is an older generation correcting the younger generation in regard to negative representations of people with mental illness and mental health problems based on what they learned in the classroom when they were in upper-secondary school.

Using English literature to analyze, discuss, debate and reflect on the topic of mental health is something I argue as a reasonable strategy on the basis of governing documents and laws of Norwegian education. LK20, the core curriculum and the professional renewal that came in 2020 requires more interdisciplinarity between the subjects. To gain more interdisciplinarity the renewal added three interdisciplinary topics that must be integrated in the subjects: ''Health and life skills'', ''Democracy and Citizenship'', and ''Sustainable Development''. Other changes worth mentioning were fewer competence aims to facilitate deep learning and the progression in each subject must be increased (The Norwegian Ministry of Education, 2020). The interdisciplinary topic that is relevant for this thesis is ''Health and Life Skills''. LK20 (the core curriculum) defines the interdisciplinary topic ''Health and Life Skills'' as:

> The school's interdisciplinary topic health and life skills shall give the pupils competence which promotes sound physical and mental health, and which provides opportunities for making responsible life choices. In the childhood and adolescent years, the development of a positive self-image and confident identity is particularly important. […] Relevant areas within this topic are physical and mental health, lifestyle habits, sexuality and gender, drug abuse, media use and consumption and personal economy. Other issues that come under this topic are value choices and the importance of meaning in life and relations with others, the ability to draw boundaries and to respect others' boundaries, and the ability to deal with thoughts, feelings and relationships (Norwegian Ministry of Education, 2017, 15-16).

Especially interesting for this thesis are the relevant area of mental health and other issues explained as ''the importance of meaning in life and relations with others'' and ''the ability to deal with thoughts, feelings and relationships'', because these issues or variables affect the adolescent's mental health. Two paragraphs in the *Act relating to Primary and Secondary Education and Training (the Education Act)* (1998) cover the protection of student's well-being both physically and mentally. §9 A-2. *Right to a good physical and psychosocial school environment* states ''All pupils are entitled to a good physical and psychosocial environment

conducive to health, well-being and learning''. §9 A-3. *Zero tolerance and systematic work* states:

> The school must have zero tolerance for violations such as bullying, violence, discrimination and harassment. The school must work continuously and systematically to promote the pupils' health, environment and safety, so that the requirements in and pursuant to this chapter are being met. The head teacher must ensure that this takes place.

The students are entitled to an environment that promotes health, well-being and learning. At the same time, the school must work systematically and continuously to make sure that these requirements are met. *The Education Act* and the interdisciplinary topic ''health and life skills'' mentions important factors that must be arranged for students to give them the best possible base for thriving both physically and mentally. These governing documents indicate how important the government in one of the happiest, richest and safest countries that have ever existed thinks mental health is, but the job their asking teachers to do is not an easy one.

The last governing document that we have to mention is the subject curriculum for English in the upper-secondary school and its competence aims. The Norwegian Ministry of Education (2019, p. 10-11) declare 18 different competence aims for the first year, but we will focus on three of them based of their relevance to the topic's literature and mental health. The first is ''explain the reasoning of others and use and follow up input from others during conversations and discussions on various topics''. This competence aim is included because it encourages students to reflect, discuss and debate interesting aspects and various topics in English literature, as well as reflection and consideration of other students' perspectives. The second aim states: ''read, discuss and reflect on the content and language features and literary devices in various types of texts, including self-chosen texts''. Like the first aim, the second aim is useful for the interpretation of literature as it implies that the writing, the descriptions and other language features can be discussed. Another important point to make is that I use a fictional novel and a memoir, which can be understood as two different texts on the same topic. The last competence aim is ''read, analyse and interpret fictional texts in English'', a general competence aim that must be included because it is the first step in understanding the literature the students are going to work with. The Norwegian Ministry of Education include resources to the competence aims and a definition of how to view the interdisciplinary topic ''Health and life skills'' integrated with the English subject.

> In the English subject, the interdisciplinary topic of health and life skills refers to developing the ability of the pupils to express themselves in writing and orally in English. This forms the basis for being able to express their feelings, thoughts, experiences and opinions and can provide new perspectives on different ways of thinking and communication patterns, as well as on the pupils' own way of life and that of others. The ability to handle situations that require linguistic and cultural competence can give pupils a sense of achievement and help them develop a positive self-image and a secure identity (The Norwegian Ministry of Education (2019, p.3).

This specified definition of ''Health and Life skills'' related to the English subject tells us what the school-system aims to achieve by working with the topic of mental health in the English subject. The ability to express feelings, thoughts, experiences and opinions in order to create new perspectives, and to connect the new perspectives to the adolescents own, as well as other people's life; foreshadows reflection, discussion and analyzing as tools that must be included in the teaching-sessions. Reflection, discussion and analyzing could facilitate deep learning of the topic the students are working on and is a good argument for why mental health should be included in the English teaching-sessions. Richmond (2014) argues, like Djikic, Oatley and Moldoveanu (2013), that literature can be one of the means to continue the development of an individual's cognitive empathy. While Djikic and his colleagues argues it to be a reasonable idea because we are not born with cognitive empathy but start developing it in middle childhood, Richmond takes it a step further by explaining how empathy fostered through young-adult literature can decrease stigmatization of mental health problems and mental illness. Richmond connects the development of empathy through literature to the mastery of other topics in school: ''The development of empathy can help high school and college students improve as peer responders in writing workshop and other cooperative learning activities in which perspective-taking is essential'' (2014, p. 20). What Richmond is conveying is argumentation for how a specified focus on mental health, mental health problems, mental illnesses and stigma, while working with YA-literature, is as an excellent way to cover the interdisciplinary topic ''Health and Life skills'' because it facilitates mastery in areas outside school, as well as other subjects in school where reflection, discussion, perspective, understanding and humanity are important abilities to achieve mastery.

In this thesis we will work with the theme mental health and experts are still debating what the best definition is for mental health as a term. The World Health Organization (WHO) has a general definition of the term mental health and other terms to categorize individuals struggling or having challenges with their mental health. WHO defines mental health as: ‘‘Mental health is a state of mental well-being that enables people to cope with the stresses of life, realize their abilities, learn well and work well, and contribute to their community’’ (2022). The definition given by WHO is vague and difficult to understand in respect to; what is mental well-being? What will it say to realize one’s abilities? I argue that the ability to learn and work well is influenced by countless factors that are not attached to mental health, such as where you are born in regard to opportunities, the individuals physical health and cognitive factors that influence how you learn and work. Galderisi, Heinz, Kastrup, Beezhold and Sartorius also criticize the definition given by WHO based on the definition identifying positive feelings and positive functioning as crucial factors for mental health.

> People in good mental health are often sad, unwell, angry or unhappy, and this is part of a fully lived life for a human being. In spite of this, mental health has been often conceptualized as a purely positive affect, marked by feelings of happiness and sense of mastery over the environment (Galderisi et al., p. 231,2015).

Galderisi and his fellow authors insists that WHO’s definition is too narrow-minded and is too easy to misunderstand. At the same time, they applaud the ‘‘new’’ definition for moving away from the old conceptualization of mental health just being a state where mental illness is not present (2015, p.231). Even though they applaud WHO for the small (but crucial) change in their definition they argue that the mental health of an individual is so much more than the feeling of happiness and the sense of accomplishment within the individual’s environment. One of their main arguments is how the modern world is shaped and how complicated the lives of different individuals are. If a minority group experiences discrimination, for example, the group would struggle to achieve a positive feeling of contributing to its society and working well, because they may never be given the opportunity. Galderisi and his fellow authors acknowledge that differences across different countries and different cultures (especially values and social background) makes it difficult to achieve an universal definition of mental health that we can agree upon (2015, p.231). With the critic of WHO and the acknowledgement of culture-differences as a starting point Galderisi and his colleagues proposed this definition of mental health:

> Mental health is a dynamic state of internal equilibrium which enables individuals to use their abilities in harmony with universal values of society. Basic cognitive and social skills; ability to recognize, express and modulate one's own emotions, as well as empathize with others; flexibility and ability to cope with adverse life events and function in social roles; and harmonious relationship between body and mind represent important components of mental health which contribute, to varying degrees, to the state of internal equilibrium (Galderisi et al., 2015, p.231-232).

This definition is closer to actually conveying human life experience, because the definition touches upon the variety of emotions and mental states a human feels and encounters in their lifespan. Life will bring joy, happy moments, love and euphoria, but life will also bring sorrow, heartbreak, challenges and hardship in a human's lifespan. In addition to a realistic view of a fully lived human life, Galderisis et al. also takes into consideration the possibility of living a fulfilling life after recovering from a mental illness: ''[…] by building on the functions spared by the illness, in spite of the fact that other functions have been impaired (2015, p.233).

Now that this thesis has defined the term mental health, I need to define what challenges, struggles or problems with mental health is defined as. WHO uses three different terms to explain different mental challenges based on how severely the challenges impact an individual's life. WHO defines mental disorders as: ''A mental disorder is characterized by a clinically significant disturbance in an individual's cognition, emotional regulation, or behaviour. It is usually associated with distress or impairment in important areas of functioning'' (2022). Another term being used is mental health conditions: ''The latter is a broader term covering mental disorders, psychosocial disabilities and (other) mental states associated with significant distress, impairment in functioning, or risk of self-harm'' (World Health Organization, 2022). When we take a look at the passage described as; ''The determinants of mental health'' WHO use the term mental health problems: ''Individual psychological and biological factors such as emotional skills, substance use and genetics can make people more vulnerable to mental health problems'' (2022). Mental health problems are, from my understanding, concerns and problems in regard to an individual's mental health that can evolve into a mental health condition if it persists over a substantial period of time. To summarize, when WHO mentions mental disorders, they refer to diagnosed disorders such as depression, anxiety, bipolar disorder, eating disorders etc. The term mental health conditions are more of an umbrella term covering both mental disorders and other mental

states. The usage of ‘‘other mental states’’ is vague and general but the WHO refers to psychosocial disabilities, impairment in functioning and risk of self-harm, but I still find it hard to see a clear line that separates the terms mental disorder and mental health conditions.

This thesis has mentioned several different terms in regard to mental health, but the one I will use to refer to the pre-diagnostic phase of a diagnosed mental illness is the term mental health problems; defined as concerns and problems in regard to an individual’s mental health that can evolve into a diagnostic mental illness if it persists over a substantial period of time. The key aspect is that a mental health problem is the pre-diagnostic phase of a possible mental illness and therefore the mental health problem can be solved and treated before the mental health problem evolves into a diagnosis of mental illness. In this thesis I will not use the terms mental disorder or mental health conditions (both used by WHO) to refer to a diagnosed state of mental illness. Mental health conditions is not a suited term because the term is vague and ambiguous in regard to what can be classified as a condition. Mental health conditions can be understood as less serious because of the usage of the term ‘‘condition’’, unlike illness which conveys seriousness and sickness. I also argue that mental health conditions as a term doesn’t have the same natural connection to the idea of medicalization that the term mental illness has and that the lack of natural connection affects the seriousness, especially in regard to treatment. Mental disorder as a term for the diagnostic stage is even worse than mental health conditions because of the usage of the term ‘‘disorder’’. The term disorder is often stigmatizing and refers to abnormality or dysfunctions which can contribute to stigmatization of individuals with mental illnesses, especially in relation to the stigmatization connected to labeling individuals with a diagnosis. Mental disorder is, like mental health conditions, vague in the matter of what can be classified as a disorder. The American Psychiatric Association uses the term mental illness (instead of mental disorders or mental health conditions) and defines mental illness as an umbrella term for all diagnosable mental disorders and/or mental health conditions involving ‘‘Significant changes in thinking, emotion and/or behavior’’ and/or ‘‘Distress and/or problems functioning in social, work or family activities’’ (2022). The key difference between the two terms we will use, mental illness and mental health problems, is that mental illness affects the individual’s life to a more severe degree; to the point that a diagnosis of a mental illness will be made and the individual needs help and treatment. A mental health problem is the pre-diagnostic phase where a mental illness may form if the mental health problem isn’t dealt with in the correct manner. The term mental illness acknowledges that we are dealing with illness and sickness that affects the individual

to a severe degree, which influence how we interpret the term mental illness and the individual attached to the term. Amzat and Razum defines illness as the manifestation of an impairment, defect or disability. Illness is to be understood as the live-experience of a diseased condition. Furthermore, Amzat and Razum specifics that illness is both a ‘‘presentation of a medical condition in a way that limits the functional capability of an individual in society’’ and ‘‘it is a situation when an individual consciously feels that he/she is unhealthy, sometimes as a result of discomfort and pain’’ (2014, pp. 28-29). By using Amzat and Razum’s definition of an illness I support the understanding of the term mental illness as a state of being connected to the live-experience of a diseased condition and the presentation of a medical condition on the same basis as a physical illness. Therefore, the term mental illness acknowledges that mental illnesses have the same broad spectrum as physical illnesses, in regard to variety in symptoms and variety in degree of severity. The term mental illness also acknowledges a broad spectrum of different diagnosis that affect people in different ways. The most important acknowledgment however is that the term mental illness, in relation to physical illness, indicates that the diagnosis or illness is not the individual’s identity.

Stigmatization of individuals suffering from mental illness and mental health problems are unfortunately common and universal. Stigma is defined as a source of negative phycological distress that has social and political consequence for the people stigmatized and is potentially detrimental for them (Simmons, Jones & Bradley, 2016, p.26). Stuart conveys in her article ‘‘The Stigmatization of mental illness’’ that: ‘‘[…] people who have a mental illness still experience society’s negative response to them as more devastating, disabling, and life-limiting than the illness itself’’ (2012, p. 455). Stuart’s message cannot be exaggerated enough. For someone with mental illness to say that the stigma attached to the mental illness is more devastating, disabling and limiting than the illness itself tells us how extremely damaging stigma is for a group that already is struggling. Stigmatization of individuals with mental health problems and mental illness is clearly affecting the individuals to a severe degree and confirms how important it is to challenge the established stigma in our society. Stuart is convinced that the world is not doing enough to break down stereotypes and stigma aimed at people with mental illness, also specifying that stereotypes and stigma are highly resistant to change when they first have established themselves (2012, p.455). There are three different types of stigma in relation to mental illness and mental health problems that we can argue have established themselves in our modern societies. The first one is public

stigmatization, which is the negative or discriminating attitudes that other people have towards people with mental illnesses. An example of this can be that people view individuals with mental illness as unpredictable or dangerous. The second one is self-stigma, and an example of self-stigma is that an individual with mental illness tells him- or herself that he/she is dangerous or unpredictable because of the illness (internalizes the negative stigma). The last one is institutional stigma, which can be both intentional and unintentional. Policies in the government, policies within private organization or within different cooperation's can intentionally or unintentionally stigmatize people with mental illness (American Psychiatric Association, 2020). An example of institutional stigma is that people with mental illness struggle to find a job because of deep screenings by employers, but one of the most common examples of institutional stigma is actually the difference between the budget of physical health and the budget of mental health within the health care system of a country, conveying the message that physical health is more important than mental health from a government perspective. In other words, many people struggle in silence and refuse to seek help because they are worried of getting thrown after them negative stereotypes and labels when they get a diagnosis or admit that they have problems with their mental health.

Stigma targeting the mentally ill and individuals with mental health problems is not something new, but societies attitudes towards the mentally ill and individuals with mental health problems, as well as how society chooses to deal with these two groups have varied throughout history. Foucault portrays the journey of madness in his book *Madness and Civilization* (1965) and how madness is a historical construction influenced by culture and social factors. He explains how the mentally ill or ''madmen'' were allowed to roam the countryside by themselves or given away to ''mad ships'' where they roamed the seas without creating too much trouble in the towns. ''Scarcely a century after the career of mad ships, we note the appearance of the theme of the ''Hospital of Madmen'', the ''Mad house''. Here every empty head, fixed and classified according to the true reason of men, utters contradiction and irony, the double language of wisdom (1965, p.35). The ''Hospital of madmen'' introduces us to the development of the modern institutions in today's society. Why did we suddenly feel the need to control, manage, cure and confine the individuals that drifted too far outside the social norm? Foucault goes on to explain that while these institutions were put in place; more and more labels came along: ''mad drunkards, madmen deprived of memory and understanding, madmen benumbed and half-dead, the madmen of giddy and empty heads'' (1965, p. 36) and explains these labels as: ''All this world of

disorder, in perfect order, pronounces, each in his turn, the Praise of reason. Already, in this ‘‘Hospital’’ confinement has succeeded embarkation’’ (1965, p.36). The hospitalization of the mentally ill and the labels that came along with the institutions can be understood as a new way of dealing with the mentally ill; a new way that marginalizes and excludes the mentally ill, and at the same time confines them. I argue that the historical shift happening in the 17th and 18th century in regard to societies attitudes towards the mentally ill and the systematic approach to confine and treat them, as well as label them, have contributed to the creation and evolution of the stigma experienced by individuals with mental illness and mental health problems in the modern world. The historical switch is interesting for my thesis because Foucault's explanation of the historical construction of madness and social attitudes towards mental illness touches upon the question of normality versus diagnosis, as well as the question of treatment; all in the light of cultural, social and historical context. There is no debate in regard to the severity of mental illness in today's society, but how does culture, social factors and the time we live in contribute to how we talk about the mentally ill versus what we deem ‘‘normal’’, and also how culture, social factors and historical context influence our experts; doctors, psychiatrists and psychologists in how they draw the line between normality and diagnosis? When do you differ too much from the social norm that you need professional help from someone else to once again thrive in the eyes of society?

The World Health Organization (WHO) is one of, if not the most, powerful and influential organization in regard to deciding where we draw the line between normal and abnormal, and where we should draw the line between mental health and mental health problems, as well as mental illness. The diagnostic system WHO is involved with is called the International Classification of Diseases (ICD) and contains both health conditions and mental illnesses (referred to as mental disorders in the ICD). ICD is a vital tool for experts within the health care system and is used globally for various reasons. The ICD included mental illnesses in their 6th version published in 1949 and the ‘‘ICD–6 was heavily influenced by the Veterans Administration classification and included 10 categories for psychoses and psychoneuroses and seven categories for disorders of character, behavior, and intelligence’’. The Veterans Administration, alongside the U.S. Army, wanted ‘‘[…] to better incorporate the outpatient presentations of World War II servicemen and veterans (e.g., psychophysiological, personality, and acute disorders)’’ (American Psychiatric Association, 2024). In other words, ICD's incorporation of mental illnesses was motivated by the many soldiers and veterans that came back from war with non-visible war wounds. These veterans needed treatment and there

was a wish to get control over the situation in terms of what kind of symptoms the veterans had and the number of the veterans that came back with non-visible war wounds. Like it is stated by the American Psychology Association, ICD-6 included two different mental illness groupings: *psychoses and psychoneuroses*, as well as *disorders of character, behavior, and intelligence*. ICD-11 (the newest version) contains: ‘‘The ICD-11 MBND chapter contains 21 disorder groupings compared with 11 disorder groupings in ICD-10’’ (Gaebel, Stricker & Kerst, 2019, p.8). ICD-10 was released or introduced in 1994, while ICD-11 took ICD-10’s place in 2022. The two versions are 28 years apart and, in that time, 10 new disorder groupings have been incorporated into the system. It is reasonable to think that there would be new disorder groupings based on how the world has changed between 1994 and 2022, as well as the attention given to mental health the last 15 years. The question is then if the new diagnosis and disorder groupings make sure that more people get the treatment they need or if the new diagnosis and disorder groupings contribute to more individuals being labelled and stigmatized? The ICD and the WHO have moved far away from their first mission of treating war-veterans and are now treating and diagnosing, among others, individuals with ‘‘gaming disorder’’ defined as: ‘‘A pattern of persistent or recurrent gaming behaviour (“video gaming”)’’ (Gaebel et al., 2019, p. 10). ‘‘Gaming disorder’’ is a perfect example on how the world of technology and the worlds development in general has affected young individuals and the WHO takes on themselves the task of setting the boundaries for what is a normal and healthy relationship to gaming and what is unhealthy and abnormal behavior in relation to gaming. It is crucial that individuals that needs help with a ‘‘gaming disorder’’ gets the help they need and that a professional has something like the ICD-11 to actually decide if the individual has an unhealthy/abnormal relation to gaming, but at the same time, do we need a label for everything we judge as abnormal? Should an illness that is connected to gaming be a part of the same diagnosis-system that decides if war-veterans suffer from PTSD? Is a ‘‘gaming disorder’’ even relevant outside the western world? Isn’t this a job for the parents of the child? We should be cautious with the idea of removing and treating all the things that fall outside of what is deemed ‘‘normal’’ in the eyes of society. Gaming is quite a new trend in relation to gaming inside your own house while communicating with friends from all over the world; are we even sure we understand the concept of gaming before we throw labels around and decide to tell a young person that they are mentally ill based on their relationship to gaming? If this child became a professional E-sport athlete and succeeded in gaming; would we still label them mentally ill or would we say that this individual has a passion for gaming? Where do we draw the line? The world is becoming more complex and advanced for every

day that goes by and the box between what we label as normal and abnormal is expanding. The distinction between normal and abnormal is becoming even harder to decide because of this expansion and it is a dangerous route to label and treat all the ‘‘new problems’’ that pops up in our younger generations. Maybe we should look more to how our institutions are run then the problems with the people not able to succeed within those very institutions. The world outside the classroom has changed dramatically in the last 50 years, but the classroom hasn’t. We are asking children to sit still in a development stage where their bodies are meant to move, and if they don’t confine to this, they have special needs, concentration difficulties or behavioral difficulties. To label something isn’t going to solve the problem. Those who need treatment should definitely get the treatment they need, but are the diagnosis-system working as it should when:

> Now a new additional survey, defined according to international diagnostic criteria, shows that mental disorders are also generally widespread in the student population. 57.3% of the female and 42.5% of the male students fulfilled the criteria for a mental disorder during the last year (Rådet for Psykisk Helse, 2023, par. 3)

The numbers above are referring to Norwegian students and the survey is done by SHoT. Using international diagnostic criteria, they revealed that over half of the female students and right below half of the male students fulfilled the criteria for a mental disorder during the last year. The numbers are unbelievable high and should raise eyebrows in terms of the international criteria used to diagnose mental illnesses. Could close to half of the students in Norway suffer from a mental illness while studying? If that was the case, then many universities should have reported dramatic drop out rates; instead, we are seeing a growth of higher education in Norway. It is perfectly normal to have a tough period within a year and for a short period of time experience uncomfortable feelings that also can be found on the symptom-list of mental illnesses such as depression and anxiety. The truth is that everybody can recall a period where they felt sad or stressed or some other uncomfortable feeling that affected their day-to-day life. Some people will indeed need professional help for such a period, but I refuse to believe that almost 50% of students in Norway needed professional help at some point of time in the last year. The reason for me being so firm in my opinion is that the diagnosis-system must have improvement potential in relation to where they draw the line between what is normal and what is abnormal for a healthy human being. At the same time, I would argue that the statistics from SHoT gives us a glance on how young people and students talk and reflect around their own mental health, as well as the the misusage of mental

illnesses such as depression, anxiety and OCD in everyday speech; which contributes to the underestimation of how severe these mental illnesses in reality affects an individual's life, as well as increase the stigma associated with mental illnesses and the possibility for self-diagnosis.

ICD is available to everybody with an internet-connection and is free of charge. I argue that an accessible ''checklist'' for mental illnesses is problematic if misused by unprofessional individuals outside the various healthcare sectors. The main issue and danger with easily accessible symptoms and criteria on mental illness in relation to adolescents is that the younger generation lacks knowledge on mental health awareness and knowledge about mental health, and at the same time the data from SHoT is evidence on how they feel, or what they report they feel when they reflect on their emotions and mental state, and what they report resonates with the criteria's and symptoms listed in ICD. The data from SHoT has extremely high numbers of individuals suffering from mental health problems and mental illness according to international criteria like the ICD. These two factors, young individuals lack of knowledge on mental health and a fallible diagnosis system that abnormalizes almost 50% of the Norwegian student population, facilitates self-diagnosing by confirmation-bias in relation to symptoms listed on the different mental health problems and mental illnesses in the ICD. I argue that the SHoT data implies that a high number of students could go to ICD's lists of symptoms and criteria and recognize oneself in the descriptions, because whatever they self-reported must have resonated with the international diagnosis criteria. Another important point to make is how damaging a list like the ICD can be for a confused and vulnerable adolescent looking for answers in relation to how they feel. Self-stigma is relevant for adolescents looking for answers on how they feel and through confirmation-bias attach the symptoms to their identity, but also adolescents who already have a diagnosis and can go to the ICD and read every single symptom that is connected to their diagnosis and label. To read how society (public-stigma) separates you from the rest can increase the self-stigmatization but more concerning is the danger of using the symptom list to describe oneself; to tie the symptoms, diagnosis and label to their own identity. It is damaging for an adolescent, as well as an adult, to read and get told how you are negatively different from the rest of society and that this abnormality has a label attached to it. The numbers given on Norwegian student's mental health also gives us an indication on how the international criteria of diagnosing a mental illness can be attached to a staggering high number of ''normal'' individuals, which can be interpreted as an argument for how easily an individual behind a screen can identify

with the symptoms and criteria used to describe a diagnosis of a mental illness. From a more general perspective, a diagnostic system like the ICD has the power to influence the perspective and attitudes towards mental illness and mental health problems of populations worldwide and therefore the ICD could be misused as a general ‘‘checklist’’ for what should be deemed abnormal for a healthy functional human being. The ICD could in the worst-case scenario create two fictional boxes; where the first box is everything that we should view as normal behavior and box number two is abnormal behavior, and by doing so the ICD blurs every behavior that's in-between the two boxes (the differences that makes us human). In other words, the ICD and WHO can easily be misused as tools to increase institutional stigma and directly influence the increasing self- and public stigmatization of people with mental illness and mental health problems. Lastly, the international diagnostic system in general (both ICD and DSM) can be criticized by the social ideas of Foucault, because it generalizes different data from all over the world and Foucault would be concerned about how differences within culture, social and historical factors would be diminished and lost in the data; resulting in treatments being generalized and not taking into consideration the differences in culture, social and historical factors. An example can be how the ICD and the WHO are influenced by western cultures and ideas, and therefore their diagnosis-system is built around western way of living. Does this influence how mental health problems and mental illnesses are diagnosed and treated in countries outside the western world? Can a professional psychologist use the same criteria for diagnosis on an individual in Norway and one individual in Congo? Is it the same availability for treatment in Norway and Congo? Of course, it depends on what kind of diagnosis we are talking about, but most likely there will be different approaches to what the society in Norway and the society in Congo would describe as abnormal behavior and how the abnormal behavior is treated, and I am skeptical to this difference being incorporated in the huge diagnosis system of the WHO.

In this thesis I will use two literary works as my primary source to explore the thesis; *Reasons to Stay Alive* (2015) by Matt Haig and *Normal People* (2018) by Sally Rooney. *Reasons to Stay Alive* is Haig's own story of battling depression and anxiety from the age of 24 years old. We follow him as he hits rock bottom on the party island of Ibiza, and is ready to commit suicide, instead he starts his life over again in his childhood home with his parents, before he eventually finds his own mental balance place. He goes through all of these mental challenges with his loyal girlfriend by his side, a woman that played an important and patient role while Haig fought his inner demons. This novel gives us a look into the mind of someone with

depression, anxiety, panic attacks and everything that accompanies these mental illnesses, as well as Haig's own reflection around his earlier signs of mental health problems. The memoir also contains lists of his physical and phycological symptoms, as well as a hopeful list of reasons to stay alive. *Reasons to Stay Alive* is not just relevant because of the theme mental health, but Haig's detailed descriptions of how it is to live inside the mind of someone with a mental illness, his lists of physical and mental symptoms, and his message of hope in the darkness creates a good platform for reflection. Haig starts the whole memoir with ''a note, before we get fully underway'' that I feel is important to understand why I chose this memoir:

> MINDS ARE UNIQUE. They go wrong in unique ways. My mind went wrong in a slightly different way to how other minds go wrong. Our experience overlaps with other people's, but it is never exactly the same experience. Umbrella labels like 'depression' (and 'anxiety' and 'panic disorder' and 'OCD') are useful, but only if we appreciate that people do not all have the same precise experience of such things (2015, p.11).

What Haig is questioning from the very start are labels and diagnosis as umbrella terms that are supposed to capture everybody with that particular mental illness. Haig is also normalizing the idea of a ''mind going wrong'' and recognizes the understanding of how everyone has their own experience of how it is to live with mental illness. Why is this important? Because his message is stigma-education from a contact perspective with someone that have experienced mental illness. Matt Haig wanted to tell his story for two main reasons:

> Ever since I realised that depression lied about the future I have wanted to write a book about my experience, to tackle depression and anxiety head-on. So this book seeks to do two things. To lessen that stigma, and – the possibly more quixotic ambition – to try and actually convince people that the bottom of the valley never provides the clearest view. I wrote this because the oldest clichés remain the truest. Time heals. The tunnel does have light at the end of it, even if we aren't able to see it. And there's a two-for-one offer on clouds and silver linings. Words, just sometimes, can set you free (2015, p.10).

He intends to lessen the stigma associated with mental illness, in his case depression and anxiety, and Haig wants to help people by giving them hope with his own story. Another thing that Haig mentions that is relevant for this thesis is the power of words and his intention to use his words to lessen stigma by (he may have intended this or not) increasing knowledge on mental illness and offer stigma education to his readers. Earlier in the thesis I referred to Strassle (2018) for evidence that supports stigma education as the best stigma reduction

technique for adolescents, most likely because adolescents' beliefs and attitudes about people with mental health problems or mental illness are still developing and can therefore be influenced and altered through education and knowledge. Like I mentioned earlier, I argue that Haig's memoir is a good platform for stigma education because of the detailed stream of consciousness and how Haig goes into detail with every choice he makes; choices as going to the store while battling anxiety described as a stream of consciousness is perfect to replace the stigma and lack of knowledge with empathy and understanding for his situation. I would also argue that *Reasons to stay Alive* is a form of contact without actually meeting the individual with mental illness or mental health problems in the physical world.

At the same time, it is important to create awareness to the students and readers that *Reasons to Stay Alive* is Matt Haig's own story written in his own words from a period he describes as hell: ''And there was no way anyone seeing me in that villa could have known what I was feeling, no way they could have appreciated the strange hell I was living through, or why death seemed such a phenomenally good idea'' (2015, p.14). Therefore, one should be critical towards generalizing Haig's experience and include cultural, social and historical context to the reflection on *Reasons to Stay Alive.* Matt Haig's memoir also got a lot of positive feedback and recognition:

> Although it's a given that this book will benefit sufferers of depression, it is equally as beneficial to the wider public as it will help with demystifying mental illness. But the book's real strength lies in its ability to enable physicians to better understand depression: the pages are a canvas of honesty, raw emotions and, at times, chaotic and disorganised thoughts, beautifully demonstrating the endless ruminations often experienced by individuals with depression (Mahmood, 2015, p.657).

Mahmood praises the honesty, raw emotion and the stream of consciousness coming to life through Haig's writing, but it is important to remember that the honesty, the raw emotions and the stream of consciousness is built solely on Haig's own experience and thoughts about his own illness. This is one of the main issues if we want to be critical towards *Reasons to Stay Alive;* an individual story that lacks representation of different perspectives, diverse backgrounds and therefore cannot be generalized or fully represent the range of possible challenges an individual with mental illness or mental health problems can come across in the modern world. I also argue that Haig's personal journey with lifestyle changes, refusing to take medicine in form of pills and instead copes with the problems on his own, downplays the

importance of getting professional help, but the critique of downplaying professional help is very interesting for us because refusing professional help is often connected to self- and public stigmatization of mental illness and mental health problems. Another critique that is interesting to reflect on is Haig's downplay of his background as a party-boy; drinking and using drugs that can affect the brain and increase the risk of both mental health problems and mental illness. The downplay of his background can also be seen in correlation with stigma in regard to self-stigma and self-blame, as well as the public stigma or public opinion of himself being responsible for getting a mental illness. The first critic and question mark I wrote down when reading *Reasons to Stay Alive* was Haig's multiple lists of symptoms, as well as his last list containing reasons to stay alive. Firstly, the lists of symptoms are a good tool, if used correctly. If we compare Haig's list to the ICD, they both offer knowledge and an understanding of what kind of symptoms an individual can experience when having a specific mental illness. Like the ICD, the problem arrives when we acknowledge that the lists can promote stigma in terms of self- and public stigma by the readers. The memoir and the ICD will undoubtedly get the attention of someone with an interest in mental health and some of those will be looking for answers, consequently being uncertain and vulnerable. Again, like the ICD, Haig's lists can create confirmation-bias where readers self-confirm and identify themselves with different symptoms from the lists and connects the various symptoms to themselves having a mental illness, even though they may not have gotten a diagnosis from a professional. To summarize, *Reasons to Stay Alive* is extremely interesting for this thesis because the memoir can be used as a good tool to learn and connect with an individual reflecting about his own journey with mental illness and mental health problems, but the memoir also facilitates a debate and reflection concerning how the memoir can be misused and actually create more misunderstanding to a generation that is already restricted in mental health awareness and knowledge. *Reasons to Stay Alive* also facilitates a discussion in respect to the memoirs ability to increase stigma and contribute to more self-diagnosis on the same basis as the ICD, through symptom-lists and Haig's own descriptions of what could be understood as abnormal behavior. In a society where everybody wants to be normal and accepted, it can be dangerous to give people examples on what ''different'' looks like without understanding why: ''[…] to borrow Michel Foucault's favourite word – is being safely neutered in a society which demands we be normal even as it drives us insane'' (Haig, 2015, p.27).

Normal People (2018, Rooney) is about the relationship between two teenagers named Connell and Marianne. They go to the same secondary school but live very different lives. Connell is the smart, handsome and popular football player, while Marianne is the unpopular, intimidating rich kid that no one really knows. They start a relationship outside of school because Connell's mother works as the cleaner for Marianne's mother. Connell keeps the relationship a secret from his friends and the rest of the school, because of his shame of being intimate with Marianne as well as avoiding people finding out about his mother's job. Connell is in a personal conflict between his feelings for Marianne and the social consequences of making those feelings public, making him live two different lives and searching for his own identity and a feeling of belonging. The on and off relationship follows them to Trinity university where Marianne becomes the popular one and Connell is struggling for the first time in his life to fit in. Their relationship displays a tight bond that doesn't seem to go away no matter what happens between them or what life throws at them. Through their journey we learn about their traumas and insecurities and how they deal with them as individualists and as a duo. *Normal People* portrays how central themes as social-economic status (social, cultural, and historical factors), mental violence and domestic violence affects an adolescent's mental health and behavior, but also more specific themes to the age-group in question, such as identity, falling in love, abandonment and heart break, affiliation and recognition. Both Connell and Marianne suffer from mental health problems, and after a while, Connell gets diagnosed with depression and has suicidal thoughts, therefore he falls into the category of having a mental illness. Marianne never gets diagnosed with a mental illness in the novel, but she struggles with her mental health from severe traumas connected to domestic violence, both physically and mentally, as well as sexual assault; and as a result, Marianne is self-diagnosing and labeling herself as someone with depression and anxiety, partly in relation to her self-destructive behavior sexually. Both Connell and Marianne facilitate reflection on how to deal with mental illness and mental health problems, especially in terms of self-stigma, public stigma and how mental illness and mental health problems affects one's behavior. I argue that both of them are a type of ''silent struggler'' because of stigma and not knowing how to deal with their emotions; resulting in behavioral patterns and choices that reflects how they feel on the inside. Marianne and Connell are influenced by stigma in different ways; Marianne is viewed by her classmates as an abnormality to society, which is a type of public stigma: ''She's probably just being glib and not suggestive, but if she is being suggestive it's only to degrade him by association, since she is considered an object of disgust'' (Rooney, p.3). One of the first things we learn about Marianne is that she is considered an object of

disgust by her peers and Connell implies that there is a social consequence in form of degrading if you are associated with Marianne. Connell is so afraid of this association that he says: ‘‘Don’t go telling people in school about this, okay?’’ (Rooney, 16) after their first kiss. The public stigma along with Marianne’s self-image and self-stigma makes her think that she actually is an abnormality to society and that she is unlovable. Connell also struggles with self-stigma and understanding of his emotions and thoughts. He often blames himself because he can’t understand or justify his feelings and thoughts, especially in relation to being intimate with Marianne. This affects his relation to Marianne, and even though she is his safe haven, he struggles to express feelings and be honest with her. The public stigma affects Connell in an interesting and intense way because of his nature. He cares a lot about how people perceive and treat him; this makes it even more difficult to open up about his problems because he wants to avoid everything that makes others judge him as different, weak or unstable. His first big challenge in relation to fit in socially takes a toll on his self-esteem and increases his self-stigma, as well as makes it even harder for him to open up to someone. The inner monologue (like *Reasons to Stay Alive)* acts as a stream of consciousness and gives the reader a brilliant chance to get to know the inner demons of Marianne and Connell, and a brilliant chance to understand how their inner demons affect what they do, and even more interesting, what they chose not to do. Their situation facilitates a good debate and reflection on how stigmatization affects adolescents with mental illness and mental health problems, as well as a debate and reflections on the ‘‘normal’’ universal youth problems; how all of us wants to belong, wants affiliation, wants recognition and feel that we have something good to offer to others in this world. *Normal People* doesn’t just offer knowledge about mental health from an adolescent’s perspective, but Rooney’s novel can be used proactively by giving students tools, knowledge and awareness on how to deal with life when the challenges arrive.

Rooney herself and *Normal People* have gotten a lot of praise for how mental illness and mental health problems are portrayed, and this praise became even stronger after the novel became a tv-series. Muller (2023, par.3) argues that: ‘‘Rooney’s novel depicts mental illness in its actuality, the melancholic tone of the novel allows you to feel deeply for the characters while also giving the reader space to reflect on their own experiences. Her style of writing feels like watching your memories and heartbreak play out in words’’. The blog called ‘‘The Insecure Girls’s Club’’ (with a worldwide audience) describes the novel as different:

> But Normal People is different: it depicts mental illness as it is - debilitating, suffocating, isolating. It doesn’t glamourise it, nor does it exaggerate it; it portrays it for what it is - hard

> and painful, but also moralising and grounding. The main characters of Normal People, Marianne (Daisy Edgar-Jones) and Connell (Paul Mescal), lead us through a journey of growth and evolution, taking us through their struggles of becoming young adults. Their on-again-off-again relationship is the central plot throughout the series, but it's their struggle with mental illness, self-hatred and belonging that lodges itself into your heart (Cooke, 2020, par. 2).

Even though this review is written after reading the book and watching the tv-series, and is not a peer-reviewed article, both Cooke and Muller convey two important messages. Firstly, they are left with the feeling of mental illness finally getting an authentic description and voice. Secondly, they convey how the novel and tv-series have affected them emotionally in terms of reflecting around own experiences and lodging itself into the readers heart, which I interpret as empathy for Connell and Marianne and a sense that the characters are easy to relate to. Both Cooke and Muller are great sources in this case because they are the audience I want to affect through *Normal People*. The adolescents in the classroom aren't experts in literature or scholars, but they are the general audience, just like Muller and Cooke.

However, Cooke argues that Rooney doesn't glamorize mental illness and that claim is up for debate. The relationship between Connell and Marianne can be interpreted in two ways; to romanticize the battle against mental illness in regard to how Connell can be viewed as Marianne's savior and vice versa. Marianne and Connell's struggle are viewed as some sort of love because they are in it together. The other way to interpret the relationship is as a helping hand on the way to find one's individualism, belonging and identity. To romanticize the battle against mental illness and mental health problems can be dangerous for various reasons. If a person with mental illness or mental health problems romanticize their own battle then they can refuse or avoid treatment, hope that someone will come along the way and be their savior, or they can end in a downward spiral with their other half (self-destructive behavior in the name of love). Connell and Marianne share their thoughts, traumas and insecurities with each other, which is basically healthy, but it can also be interpreted as romanticizing two people suffering together:

> When he talks to Marianne he has a sense of total privacy between them. He could tell her anything about himself, even weird things, and she would never repeat them, he knows that. Being alone with her is like opening a door away from normal life and then closing it behind him. He is not frightened of her, actually she's a pretty relaxed person, but he fears being

> around her, because of the confusing way he finds himself behaving, the things he says that he would never ordinarily say (Rooney, 7)

Their relationship is a safe haven and an escape from the real world in a sense, partly because there is no judgement and no stigma towards each other, which is why Connell is not frighten and describes her as a relaxed person. Connell also describes the relationship as confusing based on how he acts around Marianne, but isn't every relationship a little confusing in the start? Is it Marianne's social position and her own inner demons that make her so understanding of Connell and is that why Connell knows that she will never repeat his words and behavior outside there in the ''normal world''? The relationship between Marianne and Connell can be argued to be both great support through the safe haven or a downward spiral that affects them both negatively. I would argue that an on and off relationship isn't healthy for any of the parts involved and especially when both parts are struggling with inner demons that affect their behavior towards one another. However, I can also argue that Marianne and Connell would have ended up in a much darker place without each other and knowing that they always had each other gave them the peace, belief and drive to always keep going forward. I can even say that Rooney challenges the romanticizing of mental illness and mental health problems when she displays how Connell and Marianne are struggling with their own problems although they have each other in their lives and that the solution to their problems are not through another person. Why is it so difficult to give a clear-cut answer to the nature of the relationship between Connell and Marianne? Well, because Rooney is portraying how it is to be an adolescent in the real world we live in today and then she adds two of life's biggest mysteries in the pot; mental health and love. The complex world that makes half the student population of Norway in the need for help because of their mental health and the complex world filled with new diagnoses ''in perfect order'', to borrow the words of Foucault (1965, p.36), to pinpoint how you as an individual differ from the normality.

2 *Reasons to Stay Alive*

Matt Haig's *Reason to Stay Alive* captures the reader inside Haig's ill mind and the overwhelming sensations he experiences while battling the cocktail of depression, anxiety and panic attacks. Haig is very much aware that these sensations are not normal: ''And then I started to go. I sank, fast, falling into a new claustrophobic and suffocating reality. And it would be way over a year before I would feel anything like even half-normal again'' (Haig, 2015, p.14). This is Haig's own words and thoughts about when he first felt his mind going

dark and the feeling of normal left him in the back-rear mirror. His reality changed with the snap of a finger and the seriousness of ‘‘sinking and falling fast’’ because of mental illness is something Haig tries to get across through the whole memoir. He challenges the public explanation of depression and the stigma connected to mental illness right from the start:

> It is not ‘feeling a bit sad’. It is the wrong word. The word depression makes me think of a flat tyre, something punctured and unmoving. Maybe depression minus anxiety feels like that, but depression laced with terror is not something flat or still. (The poet Melissa Broder once tweeted: ‘what idiot called it “depression” and not “there are bats living in my chest and they take up a lot of room, ps. I see a shadow”?’) At its worst you find yourself wishing, desperately, for any other affliction, any physical pain, because the mind is infinite, and its torments – when they happen – can be equally infinite (2015, p.17)

‘‘Feeling a bit sad’’ is used in our everyday-speech and is a normal feeling that everybody will feel from time to time. Haig is using this specific expression to show how lack of knowledge of mental illness is affecting how the public talk about mental illness and how the public misjudge mental illness as less serious by describing depression as ‘‘feeling a bit sad’’. The lack of knowledge influences the lack of empathy for people suffering from mental illness or mental health problems because you can’t have empathy for something you don’t understand: ‘‘Some things are known, but more isn’t. Maybe this lack of true understanding explains why there is still stigma about mental health. Where there is mystery, there will be fear’’ (2015, p. 124). Haig even indicates that experts should come up with a more serious word than ‘‘depression’’ to make the term more aligned with how the mental illness actually is experienced by the individual. ‘‘feeling a bit sad’’ isn’t the only phrase or comparison to depression that Haig wants to take a swing at: ‘‘We use ‘depressed’ as a synonym for ‘sad’, which is fine, as we use ‘starving’ as a synonym for ‘hungry’, though the difference between depression and sadness is the difference between genuine starvation and feeling a bit peckish. Depression is an illness’’ (2015, p.61). There are two things I want to point out with this quotation. First of all, Haig use comparison to get his point across in regard to the difference of the sensations felt when you are sad and the sensations felt when you have a depression. Using sad as a synonym for depression works in the same manner as using the phrase ‘‘feeling a bit sad’’ to describe the feeling of depression; meaning the comparison between sad and depression undermines the seriousness of how severely depression impacts the individual. Secondly, Haig writes that ‘‘depression is an illness’’ which supports the idea of a diagnostic and pre-diagnostic phase, as well as the debate about why mental disorder and

mental health condition are vague and problematic terms. In other words, sad is an emotion experienced when you are in the pre-diagnostic phase, which this thesis has defined as mental health problems. If you are hungry and go hungry for a long time your problem will eventually reach the diagnostic phase, called starvation, but if you eat and function normally you can no longer compare the feeling of hungry to starvation. I think Haig's comparison between starvation and depression is genius because the comparison gives the reader a picture of someone starving with physical traits (skinny, tired and in need of help) and everybody knows that it is wrong to compare that picture and a picture of puckish or hungry. The comparison gives room to discuss how a picture of starvation may evoke feelings of empathy because the sensation of being hungry is universal and well-known, and the sensation of starvation feels a thousand times more brutal. Starvation has physical traits that ''proves'' the pain of the individual and the pain of starvation is relatable through the universal feeling of being hungry; in comparison to the invisible mental illness named depression where there could be zero physical signs. The ability to relate to depression is harder because the lack of knowledge about the pain experienced and that the pain is happening on the inside, or is it? Haig isn't just debating the term depression and the way the public talk about depression, but he also questions the usage of the term mental illness, the same term that this thesis use in relation to the diagnostic phase: ''I BELIEVE THAT the term 'mental illness' is misleading, as it implies all the problems that happen, happen above the neck. With depression, and with anxiety in particular, a lot of the problems may be generated by the mind, and aggravate the mind, but have physical effects'' (2015, p. 102). Haig refers to the NHS and that their list of physical symptoms is longer than that of psychological symptoms in relation to generalized anxiety disorder. Some of the physical symptoms he mentions are dizziness, dry mouth, muscle ace and tension, excessive thirst, excessive sweating and painful or missed periods (2015, p.102). Based on these symptoms I can agree that mental illness definitely affects the physical body of the individual, but are any of these symptoms easy to see for others, and do these symptoms convey the visualization of someone in severe pain? These symptoms aren't a broken leg or someone walking with a hunched back because of backpain. It isn't necessarily easy to connect the symptom of drinking a lot of water repeatedly to general anxiety disorder, or someone sweating more than usual, but that is exactly why Haig feels the need to address that physical symptoms are present for someone with mental illness. What all of these physical symptoms have in common is that they affect the individual in a negative way, in addition to the battle happening inside the mind. We all can relate to the feeling of being sick and that the nose is stuffy, resulting in a hopeless struggle to achieve sleep and

making the promise of never again take a free and functional nose for granted. The physical symptom of a stuffy nose affects our sleep which affects how we think, our energy the next day and so on, but in contrast to someone with a mental illness, we know that eventually we will breathe through our nose again and get that much needed rest. Someone with generalized anxiety disorder will according to Haig have the psychological symptoms of ‘‘restlessness, a sense of dread, feeling constantly ‘on edge’, difficulty concentrating, irritability, impatience, being easily distracted’’ (2015, p.102). Now, imagine sweating and aching in every muscle you move, but on top of that you are restless and feeling that something catastrophic is most likely to happen at any given time. This is the complex package of living with mental illness that Haig wants his readers to understand. By focusing on the physical aspect of mental illness and how the public talk about physical illness versus mental illness, the reader or an adolescent in a classroom can easier relate to Haig, and others with mental illness, and foster empathy like Richmond’s ‘‘Using Literature to Confront the Stigma of Mental Illness, Teach Empathy, and break Stereotypes’’ (2014) argues is possible through literature.

Haig’s comparison between depression and starvation in relation to sadness and hunger is a perfect example of stigma education to show a classroom full of upper-secondary school adolescents how easily they grade the seriousness of a physical illness and a mental illness differently just by the way they distinguish how they talk about physical illness and mental illness. The adolescent’s lack of knowledge about the stigmatization of individuals with mental illness and mental health problems most likely affects a substantial number of the adolescents to suffer in silence, because they know that their peers talk and view mental illness as less serious than physical pain and physical illness. Andersen (2011, p.6) showed us that in the last 12 months 80-85% of young people in Norway with significant mental health problems haven’t reached out to mental health services for help. Andersen argued that the school may play a role in shrinking that number and I argue that stigma education in the upper-secondary classroom with the help of Haig’s comparison between mental- and physical illness is a good place to start. Haig includes a list to illustrate how the public talk about mental illness and show the reader that the public voice would never talk in the same manner about physical illness:

> ‘COME ON, I know you’ve got tuberculosis, but it could be worse. At least no one’s died.’
>
> ‘Why do you think you got cancer of the stomach?’

> ‘Yes, I know, colon cancer is hard, but you want to try living with someone who has got it. Sheesh. Nightmare.’
>
> ‘Oh, Alzheimer’s you say? Oh, tell me about it, I get that all the time.’
>
> ‘Ah, meningitis. Come on, mind over matter.’
>
> ‘Yes, yes, your leg is on fire, but talking about it all the time isn’t going to help things, is it?’
>
> ‘Okay. Yes. Yes. Maybe your parachute has failed. But chin up’ (2015, p. 24).

What do all of these have in common? They are part of the public stigmatization of people with mental illness or mental health problems, and they are excellent examples of how society undermines the seriousness of mental illness. Haig writes that ‘‘Depression is an illness’’ (2015, p. 61) and if depression is an illness, then society should reevaluate how they talk about depression and start to treat depression as an illness. Richmond (2014, p. 19) refers to the ‘‘Stop Bullying’’ (United States Department of Health and Human Services, 2014) campaign in the US and states that the ‘‘othering’’ of people with psychological difficulties happens on the basis of:

> A lack of understanding of depression, anxiety, schizophrenia, bipolar disorder, and obsessive-compulsive disorder (OCD)—as well as frequent disparaging references to mentally ill individuals in film, television and newspapers—encourage young adults to ‘‘other’’ those with psychological difficulties. In fact, one of the main risk factories of being a victim of a bully is being identified as having depression, anxiety, or low self-esteem.

Richmond and ‘‘Stop Bullying’’ argues that the lack of knowledge about mental illness and mental health problems, alongside public stigma, results in young adults to ‘‘other’’ the individuals that have mental illness or mental health problems. The idea of the connection between lack of knowledge on mental health and mental health stigma is a reoccurring in this thesis and is established as two major factors that influence how the public talk about, think about and treat individuals with mental illness or mental health problems. One of Richmond’s main claims is that teachers should: ‘‘They should also discuss methods to encourage empathy for those characters and for those in our communities’’ (2014, p.20). One of the ways to achieve empathy, increase knowledge and at the same time educate adolescents about stigma is through comparing physical illness and mental illness. Earlier I argued for the usage of the term mental illness, instead of mental disorder and mental health conditions, because of how the word illness is naturally connected to seriousness/severity, need for treatment and

that the definition of the term illness confirms that mental illness is the live-experience of a diseased condition and the presentation of a medical condition on the same basis as a physical illness (Amzat & Razum, 2014, p. 28-29). Haig's list or demonstration on society's distinction between physical illness and mental illness is an example of why juxtaposition of mental illness and physical illness can make a big difference in respect to public stigma and increase empathy for individuals with mental illness or mental health problems. A list like the one above also illustrates Stuart's point on how the negative response towards individuals with mental illness is experienced as more devastating, disabling and life-limiting than the illness itself (2012, p.455). Imagine that: ''There was no way I could express fully this experience in words, because it was beyond words. Literally, I couldn't speak about it properly. Words seemed trivial next to this pain'' (Haig, 2015, p.15). Haig was (and still is) suffering from mental illness and can't put his pain into words, but he doesn't have to worry because others know how to articulate his pain: ''Come on, mind over matter, chin up''. ''Even more staggeringly, depression is a disease so bad that people are killing themselves because of it in a way they do not kill themselves with any other illness. Yet people still don't think depression really is that bad. If they did, they wouldn't say the things they say'' (2015, p.23). Isn't it interesting? We as a society knows that depression is an illness so terrible and tormenting that people choose to leave everything behind just to get rid of the pain, and still, the public attaches stigma to mental illness that undermines the individual's pain and the seriousness of the illness. If a family member gets diagnosed with cancer and you know that the chance of them dying is present, you would feel empathy and sadness, but the same sadness and empathy wouldn't be present if a family member was diagnosed with depression.

The self-stigma that individuals with mental illness experience and attribute to themselves is influenced by the public stigma I have debated in this thesis. On top of the pyramid is institutional stigma, which deserves credit for being part of the problem of creating a distinction in terms of physical illness and mental illness on the basis of how the health care industry has more experience and is seemingly more concerned with physical illness than mental illness. At the same time, I have to acknowledge that the history of physical illness has a longer relation to hospitals and institutional treatment. As Foucault explains: the madmen roamed the countryside, then society decided to put them om ''Madships'', and a century after the ''Madships'' the ''Hospital of Madmen'' and the ''Mad house'' hospitalized the mentally ill (1965, p.35). However, the institutional stigma affects the public stigma, which is illustrated by the way people view mental illness as less serious than physical illness and how

we as a society choose to talk about mental illness versus physical illness. At the bottom of this pyramid is self-stigma and how people with mental illness and mental health problems stigmatize themselves. Haig rightly argues that ‘‘The more you research the science of depression, the more you realise it is still more characterised by what we don’t know than what we do. It is 90 per cent mystery’’ (2015, p. 52) and that ‘‘Some things are known, but more isn’t’’ (2015, p.124). Maybe this lack of true understanding explains why there is still stigma about mental health. ‘‘Where there is mystery, there will be fear’’ (2015, p.124). Does this fear only contribute to the institutional and public stigmatization of individuals with mental illness and mental health problems? This thesis argues that the fear related to lack of knowledge also influences self-stigma in various ways. First of all, this thesis has already mentioned how Haig feels misunderstood and desires to convey how severely he is affected by depression, anxiety and panic attacks. Secondly, Haig feels the need to address different terms, such as depression and mental illness, as well as how society talks about the sensations and feelings connected to the different diagnostic terms of mental illness. All of these can be traced back to the lack of knowledge about mental health and one of the main reasons why I am writing this thesis. Thirdly, one of the self-stigmas that Haig encounters is the guilt of depression and mental illness. The guilt of depression or the guilt of being an individual with a mental illness is connected to lack of knowledge, institutional stigma and public stigma. ‘‘‘I’m sorry,’ I said, weakly, wishing for a more visible illness. Guilt smashed me like a hammer’’ (2015, p.28), Haig thought when he had to tell his landlords in Ibiza that he was ill and needed to head back home. He felt guilty because the landlords second-guessed his use of illness. They saw Haig as a physical fine young man that was described as ill by his girlfriend, but they could see no evidence of illness: ‘‘[…] Matt would be okay. He looks fine’’ (2015, p.28) was the landlords response. Haig feeling the guilt like a hammer is supported by what this thesis has already established in terms of the negative response from society (institutional stigma and public stigma) targeting individuals with mental illness being more devastating, disabling and life-limiting for the individuals than the mental illness itself (Stuart,2012, p. 455). Haig’s self-stigma makes him think lesser of himself and he feels guilty because the landlords lack of knowledge undermines his pain caused by the mental illness and confirms to him that he looks fine and therefore the expectation is that he should feel fine:

> Also, one of the things depression often does is make you feel guilt. […] Actually, depression can be exacerbated by things being all right externally, because the gulf between what you are feeling and what you are expected to feel becomes larger. If you feel the same amount of

> depression as someone would naturally feel in a prisoner of war camp, but you are not in a prisoner of war camp, and are instead in a nice semi-detached house in the free world, then you think ‘Crap, this is everything I ever wanted, why aren’t I happy? (Haig, 2015, p. 106).

Haig explains that individuals with depression feels guilty because there isn’t a coherence between the external factors in their life and how they feel on the inside. Feeling miserable and depressed while you sleep in a nice house, have a good job and a nice girlfriend creates the question: ‘‘Why am I not happy? There are many people out there with a lousier life than me, but they seem happy’’. Society has a set-standard for when you should feel pain, sadness, stress and other negative emotions, and people with depression feel like they don’t have earned the right to feel like their world is collapsing. In comparison, would society question someone who broke their back and because of this had feelings of anger, despair, sadness and frustration? Most likely not, because social norms tell us that the individual has ‘‘earned’’ the right to feel less than fine and we can witness with our own eyes that the individual is in pain. Physical pain is a normal sensation and often a sensation that the individual can connect to something tangible and reasonable: ‘‘If you have a bad back you can say ‘my back is killing me’ and there will be a kind of separation between the pain and the self. The pain is something other’’ (2015, p.37). I interpret this quotation in relation to guilt and in relation to Haig’s desire to explain mental illness through physical illness. If you have a bad back the pain is associated with your back and not your sense of self, even though your own actions may have caused the pain. With mental illness Haig writes that there isn’t a separation between the pain and the self, the two sensations are associated as one and the question arises: ‘‘is there something wrong with ME?’’. This is closely related to the public stigma that the individual itself are responsible for getting a mental illness and that the individual therefore is the only one responsible for their pain and healing. It’s easy to see how a desire: ‘‘To escape a mind on fire, where thoughts blaze and smoke like old possessions lost to arson’’ (2015, p.19) results in guilt when you don’t understand your own pain, those around you doesn’t understand your pain, and the pain you feel is connected to your sense of self. Haig’s guilt and self-stigma is also affected by Haig’s own thoughts on his role as a son to his parents: ‘‘The weight of Mum. The weight of being a son that had gone wrong. The weight of being loved. The weight of being a disappointment. The weight of being a hope that hadn’t happened the way it should have (Haig, 2015, p.33). ‘‘The weight of being a son that had gone wrong’’ refers to his mental illness and the usage of ‘‘gone wrong’’ is interesting. Wrong in terms of what? In terms of what the world and his own parents expected from him?

Getting a mental illness isn't like ‘‘oh, I fucked up’’; getting a mental illness isn't the individual's fault (stigma may say otherwise), but it seems like Haig blames himself for getting a mental illness, because by getting a mental illness and become abnormal, he no longer can achieve the general expectations parents and society has to a normal son. ‘‘The guilt was – for me – not the spiritual guilt of Catholicism but the psychological guilt that depression brings. And it helped relieve the isolation that the illness brings’’ (2015, p.91) is Haig's thoughts after reading *The Power and the Glory* by Graham Greene. Haig is referring to the phycological guilt as something common or universal for individuals living with depression. If the psychological guilt is common for individuals with depression and partly created by public stigma, which in turn plays out as self-stigma, it becomes clear how widespread stigma targeting people with mental illness and mental health problems is. But an important point to mention is that the ‘‘discovery’’ about psychological guilt in *The Power and the Glory* is from Haig's own perspective and his perspective is influenced by a mental illness that he doesn't understand nor know how to express with words; Haig is looking for answers to his pain and most of all he (understandably) searches for some kind of comfort and hope. He is looking for someone or something that can relate to how he feels, and Haig confirms that he finds comfort in knowing another soul felt the same guilt has him ‘‘And it helped relieve the isolation that the illness brings’’ (2015, p.91). Consequently, Greene's novel *The Power and the Glory* offers an escape from social stigmatization and social structures of normativity, and a helpful alternative of prophylactic identification – a sense of the power of literature and arts that Foucault often promotes as subversive to the normativity structures in society.

Being vulnerable and in search for answers, such as Haig arguably was when he read *The Power and the Glory*, make it easier to fall into the pit of confirmation-bias and misjudgment because our brain craves to comprehend the world and give meaning to our questions. When we comprehend and can explain our actions, explain our way of thinking and explain the choices we make based on meaningful information our brain feel comfort, and we have something outside of ourselves to blame if we feel guilty or ashamed. In the same manner as ICD contains diagnostic lists with symptoms and signs of mental illness, *Reasons to Stay Alive* contains several lists that are a good source for knowledge, but can create confirmation-bias, misjudgment and increase as well as strengthen already established stigma targeting those with mental illness and mental health problems. Foucault gave us an explanation of the labels used on ‘‘madmen’’ when institutions started to confine the abnormal individuals of

society: ‘‘mad drunkards, madmen deprived of memory and understanding, madmen benumbed and half-dead, the madmen of giddy and empty heads’’ (Foucault,1965, p. 36). As the world has become more complex the explanation of ‘‘madmen’’ has become more detailed and categorized. Haig’s list of some of his symptoms is more detailed than Foucault’s ‘‘madmen deprived of memory and understanding’’ (1965, p.36), but at the same time Haig’s symptoms are disturbingly general and vague in respect to confirmation-bias:

> THESE WERE SOME of the other things I also felt:
>
> Like my reflection showed another person.
>
> A kind of near-aching tingling sensation in my arms, hands, chest, throat and at the back of my head.
>
> An inability to even contemplate the future. (The future was not going to happen, for me anyway.)
>
> Scared of going mad, of being sectioned, of being put in a padded cell in a straitjacket. Hypochondria.
>
> Separation anxiety.
>
> Agoraphobia.
>
> A continual sense of heavy dread.
>
> Mental exhaustion.
>
> Physical exhaustion.
>
> Like I was useless.
>
> Chest tightness and occasional pain.
>
> Like I was falling even while I was standing still.
>
> Aching limbs.
>
> The occasional inability to speak.
>
> Lost.
>
> Clammy.
>
> An infinite sadness.
>
> An increased sexual imagination. (Fear of death often seems to counterbalance itself with thoughts of sex.)
>
> A sense of being disconnected, of being a cut-out from another reality.
>
> An urge to be someone else/anyone else.

> Loss of appetite (I lost two stone in six months).
>
> An inner trembling (I called it a soul-quiver).
>
> As though I was on the verge of a panic attack.
>
> Like I was breathing too-thin air (Haig, 2015, p. 36).

Haig's list contains many different sensations and mental states. Anyone who reads the list can relate to some of the symptoms, just like someone can relate to some of the symptoms ICD and WHO have listed for depression. WHO have included ‘‘poor concentration, feelings of excessive guilt or low self-worth, hopelessness about the future, thoughts about dying or suicide, disrupted sleep, changes in appetite or weight and feeling very tired or low in energy’’ as well as ‘‘During a depressive episode, a person experiences a depressed mood (feeling sad, irritable, empty). They may feel a loss of pleasure or interest in activities. A depressive episode is different from regular mood fluctuations. They last most of the day, nearly every day, for at least two weeks (World Health Organization, 2023). For a young adult or adolescent looking for answers and are in the search for something or someone telling them why they feel the way they feel; for this individual the language used by both Haig and WHO are objectionable. ‘‘As though I was on the verge of a panic attack’’ is vague and can easily be misunderstood because not many adolescent's knows what it feels like when the body and mind is on the verge of a panic attack, and therefore it is a good example on how confirmation-bias can take place. Adolescent's meets challenges in life and some of them feel overwhelming and can be interpreted as ‘‘on the verge of a panic attack’’ if they don't have the information and knowledge to differ between a stress- or fear response and a panic attack. As a teacher-student I know that many adolescents feel an overwhelming sensation when they know they need to present something for the class. Many of them will say that they struggle breathing, they may also feel like they are about to fall over when they stand in front of the class, inability to speak and a trembling inside are also common physical responses to stress. Some of them will note that they felt ‘‘anxiety’’ the moment they learned that they had to present something for the class. The days before the presentation many will have poor concentration, disrupted sleep, changes in appetite and feel very tired or low in energy because they use all their energy and mental capacity on worrying about the presentation. Haig had a similar experience when he was an English-History student and was told he needed to have a presentation:

> For about five weeks I couldn't really enjoy anything because this was coming up, and I couldn't do a no-show because it was assessed, as part of course work. The thing that I was particularly worried about was the fact that I had to coordinate reading my words with the presenting of slides. What if I put the slides in upside down? What if I spoke about Juan Gris' Portrait of Picasso while actually showing a Picasso? There were a seemingly infinite number of nightmare possibilities (2015, p. 120)

Haig went five weeks worrying and right before the presentation ''I went to the union bar and had a pint of lager and two vodka and limes. I had a cigarette'' (2015, p.120) to calm his nerves. Haig got a physical reaction to the stress in from of a rash. Under the presentation ''I *derealised*. The string that holds on to that feeling of selfhood, the feeling of being me, was cut, and it floated away like a helium balloon'' (2015, p.121) and had what he describes as an out-of-body experience. Looking back Haig realizes that ''It was, I suppose, a panic attack'' (2015, p.121). The sensations Haig is describing are both physical and psychological, and his thought pattern is interesting unrealistic. A student may be afraid of a presentation and describe a stress- or fear sensation, but I argue that if you spend five weeks thinking about every possible wrong outcome you are moving away from the rational stress- or fear response felt before and in the start of public speaking. I would have loved to have a description from an adolescent and the adolescent's negative thoughts before a presentation to compare and use as an example of how the severity differs between the adolescent and Haig. In the absent of better options, I will instead use what Haig describes as ''This is the craziest thing I have ever done'' (2015, p. 72). Haig fights his demons and chooses to go all alone to the shop, the same shop he has been to 1000 times before:

> There is no way I can do this. There is no way I can walk to the shop. On my own. And find milk. And Marmite. If you go back home you will be weaker still. What are you going to do? Go back and be lost and go mad? If you go back the chances of living for ever in a padded cell with white walls is higher than it is already. Do it. Just walk to the shop. It's a shop. […] Get a grip. Get a grip. But on what? There is nothing to grip onto. Everything is slippy. Life is so infinitely hard. It involves a thousand tasks all at once. And I am a thousand different people, all fleeing away from the centre. […] Maybe the fall that happened in Ibiza had only landed me halfway. Maybe the actual Underworld was much further down in the basement and I was heading there, and I'd end up like a shell-shocked soldier from a poem, dribbling and howling and lost, unable even to kill myself. And maybe being in this shop was going to send me there (2015, p. 71-73)

Haig's stream of consciousness acts as portal to Haig's inner monologue and is a tool for the reader to understand and comprehend Haig's struggle in addition to how Haig's actions are influenced by the illness. The stream of consciousness can also be a tool for us to use to convey the thoughts of an individual with mental illness and offer adolescent's the opportunity to compare how they think a panic attack affects the individual compared to how the panic attack affects Haig's physical body, as well as his thoughts and mental state. Haig suffers a panic attack in the shop, and he admits that a pounding heart alongside worst case scenario thoughts incoming non-stop is not the normal response for someone in a store. His mind takes him on a trip where he mentions that he feels fragmented and he is terrified of fueling the already tormenting disease. As I follow his inner monologue, I witness how he falls deeper and deeper into his own mind and loses touch, not only with reality, but his thoughts are far from rational, in comparison to his claimed panic attack during the presentation in school, where his stressors and triggers are connected to the presentation, PowerPoint and people watching him. Haig's earlier presentation in school affects his body and mind in a lesser degree than the episode in the store, but for him personally, both episodes are panic attacks related to anxiety, he just didn't know the first one was a panic attack while it took place. Does this place him in the pre-diagnostic phase? It seems to me that his own reflection in retrospect implies that he had a mental health problem at the time, and this thesis knows from The World Health Organization (2022) that untreated mental health problems can evolve into a mental illness. Haig describes two examples of a panic attack in his memoir: I interpret the first one as a panic attack rooted from a mental health problem and the second one rooted in a mental illness, resulting in a difference in the severity of the physical- and psychological symptoms. Haig's description of the two panic attacks offers a good opportunity to complement his list of sensations and feelings in relation to mental illness and mental health problems, and in this particular case the feeling of ''As though I was on the verge of a panic attack'' (Haig, 2015, p.36). In other words, the list of Haig's feelings in relation to his battle with mental illness increases the risk for confirmation-bias because the feelings, mental states and sensations are not described in context and he only scratches the surface, leaving plenty of room for interpretation and misunderstandings. In the same manner as Haig's lists, ICD's and WHO's diagnostic system offers lists of symptoms, how to diagnose different mental illnesses, what treatments are available for those mental illnesses and how-to self-care if you think you have the mental illness or mental health problem in question. ICD and WHO's lists of symptoms and description of depression is vague, easy to misunderstand and like Haig's list it contains too little detail in respect of the knowledge gap

that is present in the young adult and adolescent generation (Watson et al., 2004), increasing the risk for confirmation-bias among the adolescent's and other individuals that are interested in answers. *Reasons to Stay Alive* can complement the knowledge-gap, the awareness of how different sensations and feelings actually affect an individual with mental illness and contextualize the sensations and feelings. I argue that an increase in knowledge and awareness in relation to mental health will decrease the risk for confirmation-bias, but also increase the empathy for individuals with mental illness and mental health problems. Learning more about the symptoms and how the symptoms affect the body and mind, and then contextualize in what situations the individuals are affected by the symptoms is a form of stigma education, which is the best stigma reduction technique for adolescents (Corrigan et al.,2012). Haig touches upon established public stigmatization, such as: you can just stop thinking about it, time will heal (not when you are having a panic attack), mental illness does not create physical pain, mental illness is less serious than physical illness and so on. The new knowledge and the new information affect and creates reduced stigmatization of individuals and impacts the adolescent's empathy for individuals with mental illness and mental health problems. Increased knowledge, increased awareness, increased empathy and decreased stigmatization facilitates new perspectives that can be transferred to other school activities where perspective-taking is essential (Richmond, 2014, p.20).

One of the main questions in relation to mental health, mental illness, mental health problems and the diagnosis-system is: where do they draw the line between normal versus abnormal? Who will define the blurred line in-between normal and abnormal, and how? Are there diagnoses inside the blurred sphere or is the blurred sphere reserved for all the attributes that make every human being different and special? The SHoT survey presents high numbers in relation to mental illness, adolescent's and the diagnostic criteria's: ''57.3% of the female and 42.5% of the male students fulfilled the criteria for a mental disorder during the last year (Rådet for Psykisk Helse, 2023, par. 3) and Andersen follows up with: ''''Between 15 and 20% of all young people in Norway have psychological problems that go beyond their own functional ability. Between 4 and 7% have such serious problems that they need treatment'' (Andersen, 2011, p.6). The numbers from ShoT and Andersen are far apart, and especially in respect of individuals in the need of treatment. My interpretation is that 57,3% of female students and 42,5% of male students fulfilled the criteria for a mental illness, meaning that a percentage close to 50% of students are in the need for some kind of treatment or help. Andersen identifies 4-7% of young people in Norway needs treatment, while 15-20% are

affected by either mental illness or mental health problems to the degree that their functional ability is influenced. The data is difficult to interpret since I don't know what kind of mental illnesses they are referring to, to what degree the individuals are influenced, but mainly because there is no clear distinction to when they are referring to mental health problems (pre-diagnostic phase) and when they are referring to mental illness (diagnostic phase), but this thesis will primarily focus on the 4-7% group of young people in need of treatment and the close to 50% group of students that fulfilled the criteria for a mental illness during the last year. There's a big difference between the numbers provided by SHoT and Andersen, and as I state in the introduction: the numbers provided by SHoT is staggering high, but at the same time they are referring to international criteria being used in the survey. In other words, there is a chance that the diagnostic criteria being used is fallible in terms of drawing the line between normal and abnormal to close to each other and therefore suffocating the blurred sphere in-between. Foucault is a critique of the diagnostic system and how stigmatization affects the worldview of madness. He is a protector of the blurred sphere in-between normal and abnormal, because within the blurred sphere are the differences that make every human special, in the blurred sphere are the minds that change how the public view art, change how the public use technology, creates the things nobody thought was possible and think differently than the ''normal'' minds. The blurred minds are brilliant because, not despite, a little pinch of madness:

> We owe the intervention of the arts to deranged imaginations; the Caprice of Painters, Poets, and Musicians is only a name moderated in civility to express their Madness. Madness, in which the values of another age, another art, another morality are called into question, but which also reflects-blurred and disturbed, strangely compromised by another in a common chimera-all the forms, even the most remote, of the human imagination (Foucault, 1965, p. 28).

In Norway (and maybe rest of the world) a normal saying is: ''if everybody was the same the world would be a boring place to live''. It praises the differences between us as humans and indicates that everybody, even how special you are, contributes positively to the world in their own way. In the same way, Foucault focuses on the contributions from madness and the blurred-sphere, and the negative consequences of labelling, as well as confine those who move to the ''forbidden'' part of the human imagination. Haig challenges the idea of normal versus abnormal: ''There is no standard normal. Normal is subjective. There are seven billion versions of normal on this planet'' (2015, p.82) when he lists ''How to be there for someone

with depression and anxiety''. But if there are seven billion (as of right now there are 8,1 billion) versions of normal out there, why do the health care sector and the organizations in power keep increasing the numbers of disorder groupings and diagnoses (Gaebel, Stricker & Kerst, 2019)? The increase of disorder groupings and diagnoses are in reality creating new ways to distinguish normal from abnormal and healthy from unhealthy human beings. The situation regarding the increase with individuals with mental illness and mental health problems, alongside the increase in disorder categories and diagnoses is complex. Are there more people with diagnosis because of the increased number of potential diagnoses or are there more diagnoses because in reality there are more people struggling with their mental health and there is a need to create new diagnoses to give them the correct treatment and help them? I interpret that Foucault argues against the increase in disorder categories and diagnoses, because the increase in disorder groupings and diagnoses confines more ''madness'', creates more stigmatization and have a positive effect on the numbers of individuals with a diagnosis. Haig also asks the interesting question: ''Also, over time, facts have changed. Indeed, whole concepts and words change. Depression didn't used to be depression. It used to be melancholia, and far fewer people suffered from that than they do from current depression. But did they really? Or are people more open about such things?'' (Haig, 2015, p.41). If I break done Haig's statement: Haig, in the same manner as Foucault, use the historical background of madness and mental illness to convey and portray how the theme mental illness has changed throughout history and is heavily influenced by the development of society. Haig mentions that more people suffer from depression in today's society in comparison to the ''old'' depression (melancholia). The most interesting part in relation to normality and diagnosis, is Haig's statement that fewer people were diagnosed with depression in the past, when it was called melancholia, but he questions if this really is the case and have the number of individuals with depression risen because of the focus on mental health and openness about mental health? It's a difficult question to answer and Haig doesn't try to answer it, but he implies that the openness at least plays a part in the rising numbers of individuals with depression. I argue that the openness Haig is referring to is critical in order to save those who suffer in silence, but openness is also critical to fight stigmatization of mental illness and mental health problems, as well as normalize mental illness and mental health problems. Our common goal is to decrease stigmatization of mental illness and mental health problems, but that is difficult without openness, and to facilitate openness we need to normalize the talks, debates, discussions and reflections related to mental illness and mental health problems. *Reasons to Stay Alive* does all of these things, but

what I find most interesting about the whole memoir is Haig's usage of the term ''normal'' in relation to his own mental illness (his own perspective) and his own pain:

> A little over a year before I had read a lot of Michel Foucault for my MA. Much of *Madness and Civilization*. The idea that madness should be allowed to be madness. That a fearful, repressive society brands anyone different as ill. But this was illness. This wasn't having a crazy thought. This wasn't being a bit wacky. This wasn't reading Borges or listening to Captain Beefheart or smoking a pipe or hallucinating a giant Mars bar. This was pain. I had been okay and now, suddenly, I wasn't. I wasn't well. So I was ill. It didn't matter if it was society or science's fault (2015, p. 18).

Haig challenges Foucault's idea of letting madness be madness and that society is in the wrong for branding those who are different as ill, because some are actually ill, and Haig argues that whatever brand society intends to stick to his name, is the brand of illness. At the same time, I interpret ''the wacky individuals'' as Haig's acknowledgment of Foucault's argumentation of madness being allowed to be madness; that there are individuals that society brands as different, but these individuals are playing in a lower league than Haig in terms of illness. In other words, I interpret that Haig challenges Foucault on the question of illness versus madness and that there is a difference between the two terms, but Haig defends and agrees with Foucault's idea that there are more than the two labels of normal and abnormal. This quotation and discussion between Foucault and Haig facilitate reflection on normality, diagnosis, madness versus illness and stigmatization. Haig mentions ''normal'' multiple times in the beginning of the memoir: ''I had insisted Andrea sleep on the bed, not out of straightforward chivalry but because that is what I would have done if I was normal'' (2015, p.35) and ''But I never really felt very normal. (Does anyone?) I usually felt anxious'' (2015, p.45). In both of these examples Haig use society's version of normal as a starting point to explain why his mental illness is abnormal. At the same time, Haig confirms that he knows how he differs from society's definition of normal in behavior, thoughts, and feelings, which can amplify and help explain the guilt Haig feels in relation to depression. Take it a step further, stigmatization and labelling make the distinction between normal and abnormal, which in turn affects how Haig views himself and results in amplifying the already established guilt he feels. In Haig's memoir there is a permanent change in his interpretation between mental illness and normality:

> If you are a man or a woman with mental health problems, you are part of a very large and growing group. Many of the greatest and, well, toughest people of all time have suffered from

> depression. Politicians, astronauts, poets, painters, philosophers, scientists, mathematicians (a hell of a lot of mathematicians), actors, boxers, peace activists, war leaders, and a billion other people fighting their own battles. You are no less or more of a man or a woman or a human for having depression than you would be for having cancer or cardiovascular disease or a car accident (2015, p.49).

It is my interpretation that Haig's focus is on the illness itself and how depression, anxiety and panic attacks affect his physical body, as well as his mind, in the start of the memoir because he wants to capture the reader and early on fight the stigmatization of mental illness and mental health problems. His audience in this part of the memoir is the ''normal'' individuals that lack knowledge on mental health, the individuals who never suffered from mental illness or mental health problems and the general public that controls and contributes to the public stigmatization of individuals with mental illness or mental health problems. As you read the memoir there is a change of focus and another audience is included; the individuals that knows how mental illness or mental health problems feels, the individuals that have or has had a mental illness or mental health problem and all the people that live with or knows someone struggling with their mental health. The focus alters from ''I am not a normal human being because of my mental illness'' too ''us with mental illness or mental health problems, are normal human beings just like the rest, not despite, but because of our mental illness''. Like this thesis has mentioned before, Haig compares mental illness to physical illness to help explain why the stigmatization of mental illness and mental health problems is fundamentally wrong: ''You are no less or more of a man or a woman or a human for having depression than you would be for having cancer or cardiovascular disease or a car accident'' (2015, p.49). Haig also attacks the guilt of mental illness because he juxtaposes physical illness and mental illness, and by doing so he validates that you are allowed to feel like shit when you have depression because you would feel like shit if you were in a car accident or got cancer. ''It is not you. It is simply something that happens to you'' (2015, p.49) is a therapeutic sentence Haig tells himself and offers to others in the same situation. Foucault praises madness for the fine arts, the beautiful music and the sweet poems (1965, p.28), and Haig ''honors'' individuals with depression: ''Many of the greatest and, well, toughest people of all time have suffered from depression'' (Haig, 2015, p.49). Foucault and Haig may never agree that madness should be allowed to be madness in relation to who needs treatment and who can live in the blurred sphere (illness versus madness), but they both seem to advocate the normalizing of mental illness and mental health problems, and have a desire to

end the stigmatization of those who are different and suffer from mental illness or mental health problems.

3 *Normal People*

Normal People (Rooney, 2018) is a coming-of-age novel that questions normality, variation, and mental health. The modern world is a complex playground for an adolescent, and like Foucault, Rooney expresses how society's definition of normal must be reevaluated on the basis of how the world has changed (historical, social and cultural factors). Rooney doesn't just get the reader to question and reflect upon normality but shows the reader how the normal versus abnormal social construct directly influences the mental health of our younger generations through public stigmatization, self-stigma and general negative response in relation to mental illness, mental health problems and being viewed as different. Marianne and Connell are both struggling with belonging, affiliation, identity and their mental health. These variables or factors interfere with how they see themselves in relation to others (self-image and self-stigma) and the world in general. They have a sense of not being normal and not being like the rest of the herd. *Normal People* challenges the idea of normality and how complex the life of an adolescent can be in the modern world but still be labelled as a normal human being. Marianne is viewed as the abnormal individual at school and sticks out in relation to the others, but nobody has access to the information that tells them why this is the case. She is the one that doesn't seem to care about the set rules of desiring popularity, she doesn't care about having many friends and she absolutely doesn't care about being accepted by the majority. Marianne describes herself as: ''Marianne sometimes sees herself at the very bottom of the ladder, but at other times she pictures herself off the ladder completely, not affected by its mechanics, since she does not actually desire popularity or do anything to make it belong to her'' (2018, p. 29). I interpret the ladder as a ladder of social achievement and social acceptance in the eyes of other important persons at the school and the social arena for the adolescents. The popular people are on top of the ladder and as popularity drops you take a step down the ladder. Marianne sees herself at the bottom of the ladder, but she doesn't play by society's rules nor is affected by its mechanics, which she interprets as being off the ladder. Marianne is off the ladder because she is different and doesn't feel belonging among the others climbing the ladder. In other words, she feels out of place. Does this make Marianne abnormal? Is she abnormal or is the ladder and its mechanics abnormal? Firstly, Marianne views the ladder and herself through the eyes and experiences of trauma. Marianne

was beaten by her now diseased father, but her brother, Alan, and her mother, Denise, continuous the physical and psychological domestic violence:

> Denise decided a long time ago that it is acceptable for men to use aggression towards Marianne as a way of expressing themselves. As a child Marianne resisted, but now she simply detaches, as if it isn't of any interest to her, which in a way it isn't. Denise considers this a symptom of her daughters frigid and unlovable personality (2018, p.65).

Marianne detaches herself from the abuse and lets it happen, rather than put up a fight. To detach one's emotions and responses to domestic violence is a defense-mechanism to protect herself from further abuse. She is trying to make herself invisible. Marianne's mother convinces Marianne that she is unlovable and cold, which leaves Marianne with the idea that she can't be loved. In other words, Marianne has no reason to chase popularity and climb the ladder because she believes that she is unlovable and life is easier if you are invisible to the people around you: ''She had tried to be different in the past, as a kind of experiment, but it had never worked'' (2018, p. 14). I interpret this quote from Marianne as a statement about an attempt to be a different person in terms of socializing and trying to fit in, but that her attempt was deemed unsuccessful. We are left with an adolescent traumatized by physical and phycological domestic violence, who believes she is unlovable and her attempts to disapprove her unlovability has only reinforced her own belief of being unlovable. Other people may view Marianne as abnormal, but in reality, her response to life is totally understandable and totally normal in relation to her trauma. Her savior is the child of the family's cleaner: ''If she was different with Connell, the difference was not happening inside herself, in her personhood, but in between them, in the dynamic'' (2018, p.14). Marianne implies that her dynamic with Connell makes her a different person and I believe she refers to becoming a lovable person without committing to any personal changes, she is being accepted for who she is. Connell opens a new world for her, but not without the normal complicating troubles associated with romance. Connell is the football star of the school and is in the upper tier of the ladder, but he also fights his own silent inner battles. Connell is a nervous human being, more worried about other people's opinion of him than what he thinks of himself: ''If anything, his personality seemed like something external to himself, managed by the opinions of others, rather than anything he individually did or produced'' (2018, p. 70), which makes him tell Marianne: ''Don't go telling people in school about this, okay? He said'' (2018, p. 16) after their first intimate moment. Connell's request can easily be labelled as rude and abnormal, but with all the information of his character at our disposal I know that he is a

fragile individual trying his best to achieve a sense of belonging and acceptance by the people important to him, and he knows that being associated romantically with Marianne would drag him down the ladder. In opposition to Marianne, Connell wants to be popular and have many friends, but at the same time he is a people pleaser that avoids confrontation and is afraid what other people may say behind his back. Yang describes Connell's masculinity as: ''In the context of post-feminist masculinity, Connell's reserved and conformist traits place him in this exact category of masculinity'' and that Connell has a ''Non-heroic masculinity in emotional and social crisis'' (2023, p.9). The potential social crisis in relation to people learning about Connell and Marianne is too much for Connell to handle because of how Marianne is labelled and judged by the rest of the school. The starting point of the relationship isn't the best, but it's important because Rooney tells us about two different individuals feeling lost in the world in two different ways, and I argue that Rooney wants to show how both of their reactions can be labelled as abnormal, but the actions are done by normal people. Marianne is from a rich family, she is traumatized, lost, detached from life itself, and wants to achieve a more normal life. In other words, she wants to step into her form of normal life and away from whatever life is now. Connell is from a middle-class family, he is a football star, he has more than enough friends, girls show interest in him, he is the typical nice guy, but he wants to step outside of normal life. Their interpretation of ''normal life'' is different and therefore I can argue that normality is questioned and introduced as a subjective idea influenced by culture, history and society: ''All this world of disorder, in perfect order, pronounces, each in his turn, the Praise of reason. Already, in this ''Hospital'' confinement has succeeded embarkation'' (Foucault,1965, p.36). Foucault critiques the power structures that decides who are normal and who are abnormal, and it is my interpretation that Rooney does the same through Connell and Marianne. Connell and Marianne take the power themselves and decides for themselves what a normal life looks like. In terms of *Normal People*, this means that Connell and Marianne have the ability to alter what they deem as normal and abnormal, which in a sense they do, and I argue everybody does when there is love between two human beings. On top of that, Marianne wants to step into Normal life through Connell, but Connell wants to step out of normal life through Marianne: ''Being alone with her is like opening a door away from normal life and then closing it behind him'' (Rooney, 2018, p.7) Connell thinks, and Marianne equates normality with being lovable, in other words she believes that she will have a normal life if Connell loves her: ''I don't know why I can't be like Normal people. […] I don't know why I can't make people love me'' (2018, p. 181). This difference lays the foundation for their relationship and the different

choices they make in relation one another and themselves. I interpret that Rooney wants to challenge the normality term as a social construct and include normality as a subjectively feeling, but Rooney also wants to show how much impact factors as background, social environment influence what individuals judge as normal and abnormal. The reason for my comparison with Foucault is foremost because of the questions I was left with after reading the introduction to Foucault's *Madness and Civilization* (1965). Social factors, historical factors and cultural factors are the factors that influence why Marianne is judged as abnormal at school and the same factors are the reason why Connell is judged as normal. Connell fits into the idea of normal in terms of social, historical and cultural factors in the modern world, while Marianne challenges these factors in relation to her behavior, and therefore she is deemed abnormal, when in reality both Connell and Marianne do different things that would fall under the umbrella of normal and abnormal, because they are human beings. The roles of abnormal and normal changes when the social, historical and cultural factors change in the novel. When they go to university in Dublin: ''That makes her laugh and it's like everything is fine between them, like they live in a slightly different universe where nothing bad has happened, but Marianne suddenly has a cool boyfriend and Connell is the lonely, unpopular one'' (2018, p.73). Marianne is off the ladder when she attends high-school and Connell is off the ladder when he attends university in Dublin: ''They just move through the world in a different way, and he'll probably never really understand them, and he knows they will never understand him, or even try'' (2018, p.68). This illustrates how the social, historical and cultural factors influence what society view as normal, but also how these factors influence how individuals subjectively judge people as normal and abnormal. This is also an example of how stereotypes and stigma in general are imbedded in our societies. If the baseline between normal and abnormal changes from place to place, even from school to school, how can anybody establish a general baseline for normal versus abnormal? It becomes a complex self-fulfilling prophecy; society lays the foundation for what is normal and abnormal, and the individuals within that society subjectively deems normal and abnormal on the basis of the set rules by society. This affects how individuals threat the one's that differ from the baseline, public stigmatization, which in turn results in self-stigma within the individuals differing from the baseline. This is an extreme example, but in reality, the ''abnormal'' individuals never stand a chance of getting accepted because the rules are against them, and more importantly society has created a model where every individual can justify the way they treat the ''abnormal'', and if every individual can justify a certain behavior there is no limit to how far a human being can be influenced to go. In *Normal People* this type of model plays out in the

sense of the majority distancing themselves from Marianne in high school and Collin at university. After a while, both Marianne and Connell chose to distance themselves because they don't feel belonging and have started to question themselves, like the majority questioned them in the beginning.

Marianne struggles with trauma from her family, which affects her behavior, her thoughts and how she deals with the world, which in turn affects how individuals judge her and treats her. Self-stigma and public stigma are present in *Normal People* in relation to both characters. Rooney establishes early on that Marianne is the odd one in school and at some point, Eric and Rachel discuss Marianne right in front of Connell: ''I wouldn't hold it against you, Eric said, she's not a bad looking girl when she makes an effort. Yeah, she's just mentally deranged, said Rachel'' (2018, p. 53). In contrast to *Reasons to Stay Alive*, this thesis has to take into consideration that Rachel is an adolescent with limited information about mental health awareness (Watson et al., 2004) and that this limits her information about mental health stigma (Simmons, Jones & Bradley, 2017, p. 30), as well as the romantic twist of Rachel wanting Connell for herself. ''Mentally deranged'' is a label that Rachel uses for the purpose of portraying Marianne as crazy and Marianne is an easy target based on her social status. Another point to make is that Connell doesn't defend Marianne, but instead avoids the conversation with Eric and Rachel. I argue that Connell is afraid of the association with Marianne, which shows us that public stigma contributes to people purposely distancing themselves from the individuals that are being stigmatized, instead of defending them. This is another reason why: ''[…] people who have a mental illness still experience society's negative response to them as more devastating, disabling, and life-limiting than the illness itself'' (Stuart, 2012, p. 455). Marianne's stream of consciousness and her conversations with Connell shows us how difficult it is for people who struggle with their mental health to open up to others, but also how public stigma affects Marianne: ''Marianne, he says. The whole time we were together, why didn't you tell me any of this? I don't know. I supposed I didn't want you to think I was damaged or something. I was probably afraid you wouldn't want me anymore'' (Rooney, 2018, p. 183). The public stigmatization of mental illness and mental health problems have silenced Marianne because she knows what people think of her and she is afraid that Connell will leave her if she tells him the truth: ''She wants to tell him things. But it's too late now, and anyway it has never done her any good to tell anyone'' (2018, p. 119). ''it has never done her any good to tell anyone'' indicates that Marianne's feedback from earlier attempts to tell her story and how she feels inside hasn't been successful, and at

some point, she gave up telling her story anymore. This is one of the most dangerous consequences of public stigmatization of mental illness and mental health problems. The silence it can create for a group that only wants to be heard, seen and understood. One of the most interesting facts about *Normal People* is that the traumatized, misused and self-destructive adolescent never reaches out for professional help, while the nervous, anxious and previous popular Connell does. I argue that the strongest reason for this fact is that Marianne experiences more public stigmatization targeting her as an individual from various different persons and that this results in strong and imbedded self-stigma, which makes her self-diagnose and as a consequence remove the subjectively feeling of need of help: ‘‘But it was hard to dismiss something she had admittedly been hearing all her life from various sources: that she was mentally unwell and needed help’’ (2018, p. 193). In other words, public stigma in relation to her mental health has followed her all her life and come to the conclusion: you need help. The public stigmatization along with domestic violence and unhealthy relationships affects Marianne’s self-image and contributes to self-stigma: ‘‘Maybe I want to be treated badly, she says. I don’t know. Sometimes I think I deserve bad things because I'm a bad person’’ (2018, p. 133), ‘‘Marianne pinches her lower lip and then says: Well, I don’t feel lovable. I think I have an unlovable sort of. . . I have a coldness about me I'm difficult to like’’ (2018, p. 101) and ‘‘I don’t know what’s wrong with me, says Marianne. I don’t know why I can’t be like Normal people. […] I don’t know why I can’t make people love me. I think there was something wrong with me when I was born’’ (2018, p. 181) are all examples of how external factors such as public stigma, trauma, her mother, her brother and personal experiences with Connell, Jamie and Lukas affects her self-image and results in self-stigma. Connell chooses to take another girl, Rachel, to the Debs, Jamie labels Marianne as: ‘‘You’re a fucking mental case, you are, says Jamie. You need help’’ (2018, p. 179) and Lukas tells her: ‘‘You’re worthless, Lukas likes to tell her. You’re nothing. And she feels like nothing, an absence to be forcibly filled in’’ (2018, p. 190). After all these experiences she starts to attach the public stigma and negative responses from others to her identity and self-image, resulting in self-stigma. Marianne knows where her problem is and is somehow convinced that her problem is internalized within her, she is born with it, and all the reinforcing and conforming factors removes the hope and desire of getting help. I argue that it is impossible to not sympathies and feel empathy for Marianne’s situation, especially since she gets told over and over again that she is unworthy of love, even from the Denise, who is the one person in the world that should love her unconditionally. Watson et al. (2004) describes how adolescents have limited information about mental health awareness and Simmons, Jones and Bradley

(2016, p.30) argues that this affects their knowledge about mental health in general, including mental health stigma. Marianne's character is a good example of how adolescents limited knowledge about mental health influences public stigma, which influences self-stigma, which in turn is devastating for young people's mental health. With a more enlightened group of adolescents in relation to mental health in our society and schools, the chance to create openness, empathy, understanding and destroy the stigmatization of mental health, mental illness and mental health problems, and ultimately save lives increases.

Connell, on the other hand, is the character that ''dives'' deeper into the system of public stigmatization and how it affects his life. Connell, in contrast to Marianne, actually gets a diagnosis and treatment in the form of psychotherapy and medicine. Connell thrives in high school, but at the same time he is a fragile soul that cares more about what other people think of him than what he thinks of himself. ''What kind of person would want to do this with her? And yet he was there, whatever kind of person he was, doing it'' (2018, p. 24). Connell indicates that he doesn't know what kind of person he is, as well as confirming a moral dilemma in relation to his relationship with Marianne. ''I like you so much, Marianne said. Connell felt pleasurable sorrow come over him. Which brought him close to tears. Moments of emotional pain arrived like this, meaningless or at least indecipherable'' (2018, p. 25) is in my interpretation the first sign of depression, and more specifically a sign of the ''depression guilt'' Haig mentioned in *Reasons to Stay Alive*: ''Also, one of the things depression often does is make you feel guilt. […] Actually, depression can be exacerbated by things being all right externally, because the gulf between what you are feeling and what you are expected to feel becomes larger'' (Haig, 2015, p. 106). Marianne declares her fondness of Connell, but he is left with incomprehensible emotional pain because he knows that he should feel happiness, but it never arrives. Another example is: ''Connell always gets what he wants, and then feels sorry for himself when what he wants doesn't make him happy'' (2018, p. 33) which indicates that Connell feels the ''depression guilt'' but at the same time he doesn't know why this is happening, he just knows that he should feel more happiness than he actually does. The difference between Connell and Marianne's story, in relation to others response to their mental health, is that Connell's story starts with concerns from others, while Marianne's story starts off with already established public stigmatization and negative response: ''Teachers spoke to him about it. The guidance counsellor told Lorraine she was 'concerned'. […] He couldn't summon up the energy to act normal. At lunch he sat in the same place as always eating sad mouthfuls of food, not listening to his friends when they spoke'' (2018, p. 73-74).

The teachers become concerned because of Connell's new behavior after Marianne quits school and instead of receiving public stigma or negative response, Connell receives empathy and an open door to discuss his problems. At this point Connell's behavior indicates the pre-diagnostic phase of a mental illness. He has a mental health problem, and he chooses to close the door of help and continuo his life, even though he doesn't feel ''normal''. Connell and Haig share the diagnoses: depression, anxiety and panic attacks and in *Normal People* we read about Connell's first panic attack:

> What's wrong? she says. He feels a kind of tingling in his fingers now and he can't breath right. Oh, I don't know, he says. I don't know, sorry. Did I do something? No, no. sorry. I had a weird. . . I feel weird. I don't know. She doesn't get up. But she would, wouldn't she, if he told her to get up. His heart is pounding now and he feels dizzy. […] He forces a laugh and takes his hand away. No, a weird feeling came over me, he says. I don't know what it was. I'm okay now (2018, p. 106).

The tingling, trouble breathing, heart pounding, dizziness and overall feeling resembles Haig's first panic attack toned down a little bit. Rooney captures multiple of the symptoms that the real Matt Haig describes when he has a panic attack and therefore Connell's experience is realistic and conveys the feeling of a panic attack in real life, which is important in terms of correctly increasing adolescents' knowledge about mental illness and mental health problems. Connell realizes that he needs professional help when he learns that his high-school friend Rob has committed suicide and for the first time the reader gets to witness Connell's pain: ''It's true, he feels his future is hopeless and will only get worse. The more he thinks about it the more it resonates'' (2018, p. 200-201), but Connell chooses to: ''Not wanting to alarm the woman who will receive the questionnaire, he circles statement 2 instead'' (2018, p.201). Connell agreed with statement three and that he feels his future is hopeless and will only get worse, but he chooses to circle the less serious statement because he doesn't want to alarm the professional clerk whose job is to help people struggling with their mental health. That's the power of stigmatization of mental illness and mental health problems. Connell knows he need help and he goes to the office and gets the questionnaire, but he realizes that he resonates with the most serious statement and the questionnaire's four different statements is also an acknowledgement of how far you are away from the state of normal. For every statement along the list Connell knows that statement zero is the ''fine, you are normal'' and as you move to statement one, statement two and statement three you are slowly moving towards abnormal and craziness, and both Connell and the lady knows this.

Connell cares more about what the lady may think of him than his hopeless future: ‘‘He glances back over at the woman again. He doesn’t want to confess to her, a total stranger, that he would like to kill himself’’ (2018, p. 203). It isn’t just the ‘‘killing himself’’ part he wants to avoid her knowing, but Connell knows that the most serious statement is also the most abnormal statement and therefore he would be labelled as the abnormal kid with suicide thoughts. While he is there, Connell questions why the lady is sitting behind glass and Connell acknowledge that he is aware of the public stigma attached to what he is feeling on the inside:

> Do they think that because Connell sometimes lies on his floor for hours, he might one day purchase a semi-automatic machine gun online and commit mass murder in a shopping center? […] Still, he can see the logic: mentally unhealthy people are contaminated in some way and possibly dangerous. If they don’t attack the woman behind the desk due to uncontrollable violent impulses, they might breathe some kind of microbe in her direction, causing her to dwell unhealthily on all the failed relationships in her past (2018, p.202).

Rooney uses a mix of seriousness and irony to convey public stigmatization of the mentally ill. Rooney ironically presents the idea that there must be something wrong with the mentally ill and then she presents the stigma and stereotypes attached to those who are have a mental illness or mental health problem: possible mass murderer, dangerous, uncontrollable violent impulses and Rooney remembers that it is better to be safe than sorry, so she adds (ironically) that there is a chance that mental illness is contagious. Connell goes on to explain how his anxiety has become more serious and again I see how his descriptions resonates with the descriptions of Matt Haig and at the same time it shows how aware Connell is of his own mental state:

> His anxiety, which was previously chronic and low-level, serving as a kind of all-purpose inhibiting impulse, has become severe. His hands start tingling when he has to perform minor interactions like ordering coffee or answering a question in class. Once or twice he’s had major panic attacks: hyperventilation, chest pain, pins and needles all over his body. A feeling of dissociation from his senses, an inability to think straight or interpret what he sees and hears. Things begin to look and sound different, slower, artificial, unreal (2018, p.206).

Connell is in the end diagnosed with a very serious depression based of how he answered the questionary and is offered medication, as well as therapy. Connell is a character that shows us that everybody can struggle with their mental health and he is a reminder that no matter who you are the dark clouds can come sneaking in. Because of this his character normalizes the struggle with mental illness and mental health problems, but at the same time the fictional character of Connell represents the very real battle against stigmatization of mental illness and mental health problems. Connell captures how damaging stigmatization can be in relation to seeking out help and treatment, openness around the theme of mental health, self-image and captures the effects Stuart (2012, p.455) refers to when he states that: ‘‘The Stigmatization of mental illness’’ that: ‘‘[…] people who have a mental illness still experience society’s negative response to them as more devastating, disabling, and life-limiting than the illness itself’’.

Does Rooney romanticize mental illness through the relationship of Connell and Marianne? This is a difficult question to answer, but it is very relevant for two reasons. Firstly, this thesis intends to show why you should incorporate *Normal People* in the upper secondary classroom for the intention of increasing adolescents’ knowledge about mental health, mental illness and mental health problems, as well as decrease stigmatization of individuals with mental illness and mental health problems. Secondly, if the relationship of Connell and Marianne could be interpreted as romanticizing mental illness, the teachers need to know how to address it. There is, in my opinion, two possible interpretations of the relationship: the first being that Connell and Marianne grow together and that the relationship is important for their development as individuals, as well as the relationship being crucial as a form of support every time life throws them a curveball:

> But for her the pain of loneliness will be nothing to the pain that she used to feel, of being unworthy. He brought her goodness like a gift and now it belongs to her. Meanwhile his life opens out before him in all directions at once. They’ve done a lot of good for each other. Really, she thinks, really. People can really change one another (2018, p.266).

Pierini’s article ‘‘Sharing the Same Soil: Sally Rooney’s Normal People and the Coming-of-Age Romance describes the relationship as:’’ Connell rescues Marianne from her abusive brother, they both fully understand the importance of one another’s presence for their respective mental health and well-being’’ (2021, p.157). Because of their relationship and

maturing they understand how much influence they have over one another in terms of helping the other master life. In that sense Marianne and Connell and their relationship is a good role model for openness about one's mental health and how much impact human support and empathy can have. I also think that their relationship is a good example of how normal it is to have difficult times as individuals, but also in the relationship itself, and still, they get through it with patience, honesty and maturing. In other words, there are many aspects from their relationship that can normalize struggling together with mental illness and mental health problems, as well as how much positive impact one individual can have on another: ''Really, she thinks, really. People can really change one another'' (Rooney, 2018, p. 266). The other interpretation bases itself around Marianne's retrospective reflection on the relationship with Connell:

> She hates the person she has become, without feeling any power to change anything about herself. She is someone even Connell finds disgusting, she has gone past what he can tolerate. In school they were both in the same place, both confused and somehow suffering, and ever since then she has believed that if they could return to that place together it would be the same (2018, p. 238-239).

Marianne concludes that her relationship with Connell was built around their shared confusion and suffering, and she indicates that she wants to go back to that place at one point. She wants to go back to a place where they both suffer, but at least they suffer together. This is a normal human response because Marianne hates herself at this point in her life and she wants Connell by her side to remove her self-hatred and feel some sort of comfort. To put it in another way, this passage can be used to discuss romanticizing mental illness, but also include normality in terms of how human it is to desire someone to share one's pain with. Connell's retrospective analysis of the relationship also questions their relationship in terms of healthy versus unhealthy in relation to mental health:

> Whatever there is between him and Marianne, nothing good has ever come of it. It has only ever caused confusion and misery for everyone. He can't help Marianne, no matter what he does. There's something frightening about her, some huge emptiness in the pit of her being. It's like waiting for a lift to arrive and when the doors open nothing is there, just the terrible dark emptiness of the elevator shaft, on and on forever. […] You lean in expecting resistance, and ever, and everything just falls in front of you. Still, he would lie down and die for her at any minute, which is the only thing he knows about himself that makes him feel like a worthwhile person (2018, p. 247).

Connell admits to himself that whatever he and Marianne had, it never came anything good out of it and he portrays Marianne as a lost case. That their relationship can't survive, not because of all the bad things that happened because of the relationship, but because he can't help her. In other words, Marianne wants them to suffer together, while Connell wants them to achieve wellness together, which is understandable if I take into consideration their different approach to achieving wellness. Connell seeks out professional help and Marianne avoids professional help for reasons already discussed. Rooney leaves Marianne to be the one romanticizing their shared struggle and Connell makes the reflection that he won't be dragged back to the place of struggle again through his relationship with Marianne. From the point of view of normality, I can discuss empathy, openness and public stigma in relation to distancing oneself from individuals associated with mental illness and mental health problems, and the question about when do you give up on a person? Is it fair to yourself to stand by a person through their struggles if it only lands you right next to them? The romanticizing of mental illness isn't the main focus of this thesis, but I see how it can be included to reflect on what is a healthy relationship when mental illness and mental health problems are involved, and is it your responsibility to fix the problem or should you just be there along the way.

Normal People is an extremely fascinating novel, and you could write multiple thesis about mental health and the characters because Connell and Marianne are authentic adolescent characters. Every little happening influences how they view and judge their own life. Every comment analyzed and interpret in every possible way possible. This is the real life of an adolescent in the modern world and the input is endless with social media and 1000 friends they have ‘‘accepted’’ on various social platforms. Connell and Marianne are normal adolescents and can be put in the close to ‘‘57.3% of the female and 42.5% of the male students fulfilled the criteria for a mental disorder during the last year’’ (Rådet for Psykisk Helse, 2023, par. 3). Rooney's fictional story entertains and fascinates, but as the title indicates, Connell and Marianne are normal people, part of a growing group: ‘‘If you are a man or a woman with mental health problems, you are part of a very large and growing group’’ (Haig, 2015, p. 36).

4 Comparison: *Reasons to Stay Alive and Normal People*

Before I start on the comparison itself, it is important to acknowledge that *Normal People* is a fictional novel and *Reasons to Stay Alive* is a memoir. Matt Haig's memoir is from his

perspective and his truth about living with depression, anxiety and reoccurring panic attacks. *Reasons to Stay Alive* focuses only on that part of Haig's life and the reoccurring theme throughout the memoir is mental health. *Normal People* on the other hand has many other aspects that comes into consideration while reading the novel; there is a plot, romance, character development and two main characters, Connell and Marianne, who the reader gradually gets to know and understand. In other words, how you read these two literary works are very different and what you have to process while reading them is very different. Firstly, *Reasons to stay Alive* starts off with Haig considering suicide as an option, while *Normal People* later on in the story introduces us to mental illness and Connell's desire to kill himself. This affect both stories and how you read them; Haig is gradually getting better while he captures how tormenting mental illness is. Connell is slowly, and more hidden, becoming depressed, anxious and struggling with happiness. Another aspect is that the reader knows that Haig is suicidal and depressed from the very start and the only voice the reader has is Haig's own, meaning that the reader gets the raw truth, while in *Normal People,* Rooney leaves breadcrumbs and hints that the reader later on in the story understands to be symptoms of depression. In that sense, in an educational setting *Reasons to Stay Alive* is more straightforward in comparison to *Normal People* where you gradually put the puzzle together as you go. Regardless, this thesis will focus on how *Reasons to Stay Alive* and *Normal People* are similar, different and complement each other on the theme's mental health, normality, public stigmatization, self-stigmatization, stigma education and the diagnosis debate.

Connell and Haig are similar in the sense of their mental illnesses, but also as persons, even though Haig is a real persona and Connell is a fictional Character. Connell describes himself in relation to others: ''But I kind of suffer from anxiety with these things'' (Rooney, 2018, p. 92) and Haig said that he was: ''But I never really felt very normal. (Does anyone?) I usually felt anxious'' (Haig, 2015, p. 55) when he describes his childhood. Both of them seems to have personality trait that they deem as abnormal and as a contributing cause to their mental illness. On the other hand, because of the difference between the memoir and the novel, the reader doesn't get introduced to Connell's inner pain before he actually asks for help, while Haig more or less pours out his inner pain. Connell's journey happens while the reader reads and Haig's story is in retrospect; Connell's journey represents how it is to be an adolescent and discover your struggle as you go through life; Haig's story is in retrospect and because how his state he doesn't participate in everyday life, but he fights his way back to everyday life. Haig is openly sharing his inner struggle with his girlfriend Andrea and his parents,

resulting in the openness he needs, and that's why I argue that he isn't directly influenced by public stigmatization that silences him. Connell feels the direct influence of public stigmatization to the degree that he won't admit the seriousness of his inner struggle to the very people he asks to help him. One of the questions I asked myself when I thought about similarities on Connell and Haig was: Do Haig mention public stigmatization that he himself has experienced? Yes, in *Reasons to Stay Alive* there is a passage where his landlords question his invisible sickness and that makes him feel guilty: ‘‘‘I'm sorry,' I said, weakly, wishing for a more visible illness. Guilt smashed me like a hammer'' (Haig, 2015, p. 28), but other than that he is referring to what the group of people with mental illness or mental health problems may experience of public stigmatization. Haig takes upon himself the task to tell his audience and lecture them about what ‘‘his group'' experiences of institutional- and public stigmatization, while *Normal People* offers examples of how Connell keeps quiet of his mental illness and feelings because he is afraid of public stigmatization: ‘‘He glances back over at the woman again. He doesn't want to confess to her, a total stranger, that he would like to kill himself'' (Rooney, 2018, p. 203). This difference is influenced by Haig telling his story in retrospect and Connell is experiencing things as the reader reads the novel, but the difference is also an example of how the two literary works complement each other. Haig's examples can be made alive when I use Connell's experience in the waiting room as support to Haig's claims, and Connell's experience supports the idea of adolescents being aware that there is public stigmatization associated with having a mental illness, as well as the public stigmatization influences their openness in relation to mental illness and mental health problems.

Normal People is more relatable to adolescents than *Reasons to Stay Alive* because of the age group and that Connell and Marianne lives in the same ‘‘world'' as adolescents. That's why I argue that *Normal People* can be used to put a familiar face, a familiar setting, a relatable person and a familiar situation to the experienced pain Haig describes in his memoir. Both of the literary works explain panic attacks with similar physical symptoms (Rooney, 2018, p. 106) and Haig's first panic attack happened when he had a presentation (Haig, 2015, p.121), as a teacher-student who have worked at various schools lower- and upper secondary schools, I can confirm that presentations in front of class is one of the most dreadful things for an adolescent. The interesting question is: will sharing the experience of Haig getting a panic attack during a presentation and his sensations confirm to an adolescent how dreadful a presentation is, or would it put their own worrying into perspective? This issue can be seen in

relation to ICD, WHO and the possibility of self-diagnosis, which is more prominent in *Reasons to Stay Alive* than in *Normal People*, mainly because of Haig's various lists of symptoms and felt sensations in relation to his mental illnesses. The physical symptoms Connell felt in relation to his panic attack was tingling in fingers, shortness of breath, heart pounding and dizziness, while Haig got an out of body experience when he got a panic attack during a presentation at school. The physical symptoms experienced by Connell matches the physical symptoms Haig lists underneath the title ''THESE WERE SOME of the other things I also felt'' (Haig, 2015, p.36). I can use Haig's list to complement Connell's panic attack, and at the same time I can discuss how Haig's out of body experience is a different panic attack than Connell's. Putting Haig's and Connell's experience into perspective can help the adolescents understand how severe sensations are afoot when I am talking about a panic attack versus the normal nervousness everybody feels before a presentation. The important thing is that a teacher must know where the adolescent students are in terms of knowledge, and the teachers already know there is a knowledge gap in relation to awareness and stigma, but how much knowledge do they need before they can rationally differ and understand their own experience versus the sensations felt by Haig in real life and Connell in a fictional world. The knowledge and awareness of mental illness and mental health problems is instrumental for the students to be able to feel empathy for the individuals suffering. How can you have empathy for something you don't understand, and if there is no empathy the chance of decreasing stigma declines massively. Without knowledge, the chance of self-diagnosis and misinterpretation of their own feelings increases. In other words, knowledge about mental health cannot be talked about enough.

At first, I struggled to put Marianne into the same puzzle as *Reasons to Stay Alive*, but then it hit me: Marianne and Haig are both two individuals that know very well that they are different, and they label themselves as abnormal based on their behavior and how their minds work. They are different in terms of experienced trauma and reasons for their abnormality, but they both are aware and have accepted that the way they act, think and are perceived by others is different from what they believe to be the normal standard. ''I don't know why I can't be like Normal people'' (2018, p.181) Marianne states, and Haig writes that: ''I had insisted Andrea sleep on the bed, not out of straightforward chivalry but because that is what I would have done if I was normal (2015, p.35). The difference between Marianne and Haig is that Haig gradually makes the effort to get better, while Marianne has more self-destructive behavior and she doesn't seek out help (other than talking to Connell). Haig is a grown man,

with a girlfriend that sticks by his side no matter what and his parents cheers him on, while Marianne is a traumatized adolescent that has been told again and again that she is the problem: ‘‘But it was hard to dismiss something she had admittedly been hearing all her life from various sources: that she was mentally unwell and needed help’’ (Rooney, 2018, p. 193). I see this in relation to Stuart’s claim that: ‘‘[…] people who have a mental illness still experience society’s negative response to them as more devastating, disabling, and life-limiting than the illness itself’’ (2012, p. 455), because Haig doesn’t need to address public stigmatization to the same degree that Marianne needs, and therefore Marianne struggles more than Haig in terms of self-stigma and seem to avoid seeking out professional help. Haig views his mental illness as something he has to live with (after a while), but Marianne thinks that it is an incorporated part of her: ‘‘I think there was something wrong with me when I was born’’ (Rooney, 2018, p.181). I interpret this as Marianne attaching her mental problems to her being and her identity, proving that the self-stigma is more severe in her case, than in Haig’s case. The public- and self-stigma limits Marianne’s life more than the mental illness or mental health problem (since she doesn’t get a diagnosis), while Haig experiences the mental illness itself as more life limiting because his safety net (girlfriend and family) protects him from the public stigmatization which limits the self-stigmatization; showing how empathy and support can help tone down the influence of stigmatization and negative response.

Normality as a theme is present in both literary works, but in different ways. This thesis has already established that Haig talks more on behalf of everybody with mental illness or mental health problems when he discusses normality, while Rooney shows us examples of how normal it is to have a mental illness or mental health problems as a young individual in today’s world, as well as what kind of challenges adolescents normally meets and how they handle them. Haig is influenced by the fact that he is writing about his own experience and the sensations he felt is the strongest sensations he has felt in his whole life. Haig is really clear about the abnormality of the sensations related to his depression, anxiety and numerous panic attacks, but he is also clear on how normal it is to experience these abnormal sensations. What mental illness and mental health problems make you feel is abnormal, but you aren’t abnormal for feelings those things. Haig wants to normalize the diagnoses, the labels, the thoughts, the stereotypes and everything that makes the person having a mental illness the abnormal object in the calculation. *Normal People* portrays how a normal life of a normal adolescent in the modern world looks like, and how normal it is to feel down, different and have problems with identity, affiliation and belonging. The main message from both these

literary works is that we collectively have to acknowledge mental health, mental illness and mental health problems as a normal part of our society and juxtapose it with all the other illnesses out there, because reality is that if we affect normality in relation to mental illness and mental health problems, there will be a positive ripple effect on stigmatization, negative response, treatment and how the public generally addresses and talks about mental health, mental illness and mental health problems.

5 Conclusion

This thesis intends to show that by increasing the student's knowledge and awareness about mental health, through working with the fictional novel *Normal People* and the non-fictional memoir *Reasons to Stay Alive*, I hope to decrease the student's stigmatization of people with mental illness and mental health problems. I hope to replace the negative representations and misunderstandings connected to mental health in general and people with mental illness and mental health problems through empathy and a better understanding of how it is to live with mental illness and/or mental health problems. Replacing stigma with empathy, knowledge and humanity can also create introspective students who better understand their own feelings, how to express those feelings and more importantly how to deal with them; preparing the students for the small and bigger challenges that they will meet along their journey in life.

I have been critical towards the diagnostic-system and WHO in terms of being part of the institutional stigmatization of mental illness and mental health problems, and to some degree being dangerous in relation to self-diagnosis and the ripple effects connected to self-image and self-stigma. The terms used by WHO are at best problematic and contributes to affecting the negative stereotypes and public stigmatization of mental illness and mental health problems. At the same time, the definitions of the terms are in my opinion vague and can easily be misunderstood contributing to self-diagnosis and misunderstanding that can be damaging for struggling individuals looking for answers for the sensations and feelings they can't describe with their own words. Consequently, we are left with a staggering amount of adolescent's and younger people that self-report, based on international-diagnostic criteria, that they have problems with their mental health: ''57.3% of the female and 42.5% of the male students fulfilled the criteria for a mental disorder during the last year''(Rådet for Psykisk Helse, 2023, par. 3). I argue that the numbers are too high, but more importantly these numbers tell us that something is wrong with the diagnostic-system and what the public judges as abnormal and normal in today's society. The most important information is

regardless that a staggering high number of students needs help to manage their mental health, something they lack education and information about in school (Watson et.al, 2004) and Simmons, Jones and Bradley (2017, p. 30) confirms that this directly affects their overall knowledge about mental health. I argue that there are numerous reasons why we should implement education about mental health in the upper-secondary English classroom with the tool of English literature at our disposal. Adolescents naturally spends a lot of time in school, which is their main learning arena, which means that they arrive with the expectation to learn. Secondly, stigma education is the best stigma reduction technique for adolescents and the adolescent's beliefs about mental illness are still developing and may therefore be more malleable, according to Corrigan et al (2012) and Strassle (2018). Thirdly, the adolescents have the opportunity to influence the next generation in relation to stigmatization and overall views of individuals with mental illness and mental health problems, which Bailey (1999, p.109) argues is important because early education about mental health and mental illness is critical if we want to alter the attitudes present in today's society. Lastly, statistics from both the SHoT survey: ''57.3% of the female and 42.5% of the male students fulfilled the criteria for a mental disorder during the last year (Rådet for Psykisk Helse, 2023, par. 3) and Andersen: ''Between 15 and 20% of all young people in Norway have psychological problems that go beyond their own functional ability. Between 4 and 7% have such serious problems that they need treatment'' (2011, p.6) shows that the younger generation is struggling with their mental health and is in the need of guidance.

The theme mental health is integrated in the interdisciplinary topic of health and life skills. The governing document on the topic health and life skills in the English subject states that:

> In the English subject, the interdisciplinary topic of health and life skills refers to developing the ability of the pupils to express themselves in writing and orally in English. This forms the basis for being able to express their feelings, thoughts, experiences and opinions and can provide new perspectives on different ways of thinking and communication patterns, as well as on the pupils' own way of life and that of others. The ability to handle situations that require linguistic and cultural competence can give pupils a sense of achievement and help them develop a positive self-image and a secure identity (The Norwegian Ministry of Education, 2019, p.3).

In the analysis and comparison between *Normal People* and *Reasons to Stay Alive*, this thesis has shown that *Normal People* and *Reasons to Stay Alive* can be used as tools in stigma education (institutional-, public- and self-stigma), increase mental health awareness and increase general knowledge on mental health. In addition, the thesis shows how *Normal People* and *Reasons to Stay Alive* facilitates reflection on the theme of normality, and consequently decreasing stigmatization of mental illness and mental health problems by affecting and altering the perspective on mental illness and mental health problems. The negative perspective and stigma attached to mental illness and mental health problems are in this thesis proposed to change primarily through empathy, reflections about normality and increased knowledge about stigma, mental illness and mental health problems. Richmond (2014) argues that changing an individual's stereotypes, stigmatization and negative response in relation to mental illness and mental health problems are possible through the human ability to feel empathy for the individuals being attached to the stereotypes, stigmatization and negative response, and that the empathy is possible to foster through English literature. Another important thing that influences stereotypes, stigmatization and negative response is normality and the question of abnormal versus normal. Foucault questions the social construct of normality and the powers in charge, as well as conveying that normality should be viewed as a grey zone, not as black and white. Foucault's opinions and ideas: ''All this world of disorder, in perfect order, pronounces, each in his turn, the Praise of reason. Already, in this ''Hospital'' confinement has succeeded embarkation'' (1965, p.36) complements *Normal People* and *Reasons to Stay Alive* in terms of facilitating reflections about normal versus abnormal, madness versus illness, and why individuals that are different experiences a negative response. I argue that it is reasonable to think that the students will be positively influenced in relation to expressing their own feelings, thoughts, experiences and opinions, and create new perspectives on different ways of thinking and communication pattern, as well as on the pupils' own way of life and that of others, like The Norwegian Ministry of Education (2019, p.3) is asking from the interdisciplinary topic of health and life skills. In correlation to this Richmond argues that: ''The development of empathy can help high school and college students improve as peer responders in writing workshop and other cooperative learning activities in which perspective-taking is essential'' (2014, p. 20). In other words, the stigma education, the overall knowledge of mental health, mental illness and mental health problems, the empathy, as well as the new perspectives, will influence other topics at school and influence students to be better at cooperative learning activities where perspective-taking is essential. I also find it reasonable to think that this type of educational form can have a

massive impact on general openness about how the students feel and create a new arena where individuals are open to the idea of sharing their problems instead of keeping them locked inside, because the intention is to break down the stigmatization and negative response that silences individuals with mental illness and mental health problems.

For future research I think the researchers should, like this thesis has done, discuss normality but go more into detail and see how normality directly influences established stigmatization and stereotypes. One of my experiences with this thesis is that normality has a more central role than I first anticipated, and therefore should be examined in more detail. It would also be interesting to follow various classes and groups of adolescents and see how the type of education and teaching discussed in this thesis influences their knowledge, their attitudes, thought about stigmatization and general reflections about mental health, mental illness and mental health problems. How do they rate learning about mental health through literature in terms of interest? How do they rate literature as a learning tool in general, in relation to motivation, degree of difficulty, cognitive workload and so on? How do this type of teaching influence them as fellow human beings? Do they feel that the teaching can be transferred and help them in other subjects, as well as other aspects of their own life? Do we see a positive change in the generations to come because of the increased focus on mental health in an educational setting? These are big questions that can change, influence and ultimately save human lives. This thesis has tried to incorporate a consistent message in respect to why mental health is an important topic to include in the educational system and why mental health is an important topic to get the younger generation (and everyone else) to reflect upon, but I think Haig describes the importance best: ‘‘Even more staggeringly, depression is a disease so bad that people are killing themselves because of it in a way they do not kill themselves with any other illness. Yet people still don’t think depression really is that bad. If they did, they wouldn’t say the things they say’’ (Haig, 2015, p.10), but at the same time we have to remember that: ‘‘People can really change one another’’ (Rooney, 2018, p.266) and as a world community we have an obligation and a responsibility to change one another to the better, through awareness, knowledge and empathy: ‘‘If we want to achieve our goal, then let us empower ourselves with the weapon of knowledge and let us shield ourselves with unity and togetherness’’ (Yousafzai, 2013).

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