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"'A Word other than *Crazy'*: Exploring the Stigma around Mental Health through Young Adult Literature"

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“Your now is not your forever.”

(John Green, *Turtles All the Way Down* 93)

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List of Abbreviations

TATWD: Turtles All the Way Down

IKOAFS: It's Kind of a Funny Story

BMASGK: Bundesministerium für Arbeit, Soziales, Gesundheit und Konsumentenschutz

BMBWF: Bundesministerium für Bildung, Wissenschaft und Forschung

CAMH: (Canadian) Centre for Addiction and Mental Health

DSM: Diagnostic and Statistical Manual of Mental Disorders

EFL: English as a Foreign Language

ESL: English as a Second Language

L1: First Language

L2: Second Language

NASP: (US) National Association of School Psychologists

WHO: World Health Organization

YA: Young Adult

YAL: Young Adult Literature

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1. INTRODUCTION

The inspiration for the topic of my diploma thesis hit me around two years ago while reading a newspaper article in the *Standard*. The (2017) headline read: „Fast ein Viertel aller Jugendlichen hat psychische Probleme“ [“Nearly a quarter of all adolescents have psychological problems”, my translation[1]]. As a future teacher this really shocked me and I truly had not expected the number to be so high. If this article was to be believed, on average, every fourth or fifth of my students would be struggling with serious mental health problems. Driven by my desire to find out more, I researched the study this article was based on.

In 2016 Wagner et al. conducted the “first broad nationwide and DSM-5 based” epidemiological study to assess the prevalence of young adults’ mental health problems in Austria (1497). This large-scale study featuring a sample of 3615 participants (10-18 years old) revealed that “the point prevalence and lifetime prevalence rates of young adults for at least one psychiatric disorder were 23.9% and 35.8%” respectively (Wagner et al. 1483). Comparing these findings, which expose that mental disorders are exceedingly prevalent among Austrian adolescents, to data provided by the World Health Organization, I quickly found out that mental health conditions are a global issue, in that 10-20% of children and adolescents around the world are battling mental disorders (WHO “Child and adolescent mental health”).

The study conducted in Austria further found out that of all adolescents with a “lifetime psychiatric disorder” less than half actually “had contacted mental health services” (Wagner et al. 1483), and the WHO similarly reports that even in high-income countries, up to 50% of people with mental disorders receive no treatment (WHO “Comprehensive mental health action plan” 5). Wagner et al. conclude that apart from access to and availability of mental health services, one of the leading causes for this low treatment rate in spite of great suffering is fear of stigmatization (1496). This is a severe problem, which is why the WHO’s “Comprehensive mental health action plan”, as well as the BMASGK’s “Austrian National Strategy for Mental Health” [Nationale Strategie zur psychischen Gesundheit] recognize the vital role of anti-stigma work to

[1] All translations used in this paper are my own.

promote mental health. As a future language teacher, this is where I saw my call to action and I began to think about ways in which I could contribute to the destigmatization of mental illness through my lessons.

I started to notice the rising number of mental health related YA novels on the bookshelves and articles which reported the "booming" of media targeted at adolescents that dealt with the subject of mental illness[2]. In 2009 Koss and Teale conducted a survey to analyze the trends of YA literature written in English and found that within their sample of 370 titles published between 1999–2005, 25 percent of the books reviewed were focused on illness or specifically mental issues (567), and if book lists and recommendations on internet platforms are any indication[3], the numbers have only risen since then. Koss and Teale frame these findings regarding the popularity of this subject matter within the idea that "[t]raditionally YA books have been identified as 'problem novels'", that is books which deal with social issues teenagers might be struggling with (467). Mental health related YA literature can then be understood as part of a tradition that established itself in the "revolutionary 1960s" (Hesse 34) of depicting teenagers in difficult situations, addressing topics that were previously considered taboo, and generally featuring higher degrees of "realism" (Hayn & Kaplan 21). It became clear to me that the rising popularity of mental health related YA literature is representative of a real demand for open dialogue about this topic, and I also realized that literature, more specifically these mental health related YA "problem" novels, could be the vehicle through which I could contribute to the destigmatization of mental illness.

The rough plan for my thesis was set. I would analyze a sample of mental health related YA novels, exploring the topic of stigma through them and evaluating their potential for destigmatization when used in a classroom. As a next step I needed to select primary literature for analysis. I chose Ned Vizzini's (2006) novel *It's Kind of a Funny Story*, which tells the story of fifteen year old Craig, who is battling depression and suicidality and later admits himself to a psychiatric hospital. The second book I selected was *Turtles All the Way Down* (2017) by John Green, in which readers follow 16-year old Aza Holmes and her struggle with OCD and anxiety. I chose these books not only for their recency and the balance of having one male and one female

[2] See for example Tonkinson, Carole. "The recent boom in mental health publishing—and why it is vitally important."
[3] See for example Jensen, Kelly. "50 Must-Read YA Books About Mental Illness (Plus a Few More)."

protagonist; my choice also relates back to Wagner et al.'s study, which revealed that the illnesses the two protagonists are battling, anxiety disorders and depressive disorders, are in fact among the most prevalent mental disorders in Austrian adolescents (1483).

Working with these two novels, as well as a range of secondary literature from various research fields including psychology, history, culture and media studies, linguistics, literature didactics and mental health awareness and education programs, I endeavor to fulfill three main research aims: First, I will explore, historically contextualize, and explain the meanings of and social mechanisms behind the stigma of mental illness, as well as give concrete examples of such stigma in today's media and show how this can impact the lifeworld of teenagers. Secondly, I aim to showcase all the ways in which the chosen YA novels, through the themes they address, as well as the stylistic devices and narrative techniques they employ, can act as counterforces to that stigma. Lastly, I will offer a rationale and some guidelines, as well as activities for making use of this literature's destigmatizing potential in a (foreign language) classroom.

2. DEFINITIONS AND LANGUAGE CHOICES

When I sat down to write this thesis, I knew that before discussing the language choices made by the characters in my primary literature, or reflecting on the stigma of our real-world society, I myself had to make some decisions on how I would write about the topic of mental health in a respectful manner throughout this paper. Getting the language right, so to speak, is of utmost importance. A thesis focusing on YAL's potential as a tool for the destigmatization of mental disorders, which uses inappropriate or insensitive, imprecise, or outdated language itself, would be defeating its own purpose and self-destructing its validity.

First and foremost I need to explore the questions "What is mental illness?" and "What is stigma?". Analyzing these two key concepts is crucial, because I will be using them and referring to them throughout my thesis.

2.1. What is mental illness?

As innocent as the question may sound, the answer is complex and multilayered. Any definition listed in the following will always reflect a certain paradigm, that is "an

ideology or frame of reference" which shapes "the way one perceives, understands, or interprets a topic or issue" (Baglieri and Shapiro 28) and embody the built-in power dynamics inherent to propagating that particular paradigm. These dynamics turn especially problematic when ideological concepts become "so ingrained in culture that they seem natural" and we no longer feel the need to continuously reflect on them (Baglieri & Shapiro 28).

Michel Foucault has contributed much to the exploration of the intricate relationships between language, power, knowledge, societal institutions and social control. His conception of discourse has informed a "structuralist" and later "post-structuralist" view which rejects the idea that language is "simply expressive", functioning merely as a "transparent [...] vehicle of communication", or "form of representation", and instead understands it as "a system with its own rules and constraints, and with its own determining effect on the way that individuals think and express themselves" (Mills 7). According to this definition, individual discourses then refer to "groupings of statements produced within power relations" (Mills 8). A critical analysis of these individual discourses will thus concern itself with the following key questions: "[W]ho has the right to use a particular discourse, what benefits accrue to them for using it, how is its usage policed, and where does it derive its authority from?" ("Discourse." *O Dict. of Critical Theory*).

Applying this focus to the field of disability studies, it becomes clear that language is not only crucial to the "self-concept" or identity of a person with an impairment, and the way they see themselves, it is also highly "political" in the sense that the "terms, classifications, categories, and labels" used by societal institutions "to talk about disability" directly influence the "policies that define disabilities and impairments" and "the social practices in which they become meaningful", thus profoundly shaping the way people with a disability or an illness are treated by others (Baglieri & Shapiro 45).

Foucault himself utilized his focus on the reciprocal link between power relations and language to investigate European society's cultural conception of "madness" in his work *History of Madness*[4] (1961), in which he historically traces the social construction of "madness" from the Middle Ages to the 18th century. According to him the "Classical Age" (around 17th to 18th century) brought a shift in the meaning and perception of

[4] Original title: *Folie et Déraison: Histoire de la Folie à l'âge Classique [Madness and Civilization: A History of Insanity in the Age of Reason]*, first published in 1961, later published as *History of Madness* (2006).

"madness", which presented a radical distinction between the rational and "the mad", the latter of which being constructed as the "other" and consequently confined to institutions, with the unequal, oppressive relationship between doctor and patient becoming manifest in "the language of psychiatry" (Foucault *History of Madness* xxviii), used to define and justify this relationship[5].

An examination of Foucault's key thoughts and concepts on this matter brings with it the central question that makes finding a conclusive definition of what mental illness *is* so difficult: Who gets to define its meaning?, or as Awais Aftab summarizes one of the most important questions in the "philosophy of psychiatry", boiling down to "whether the diagnosis of mental disorder is a matter of natural facts or social norms" (10).This question is precisely why the Oxford *Dictionary of Sociology* defines "mental illness" in itself as a "disputed concept", introduces the perception of mental illness as a "social construct" which "sets the boundaries of normal, acceptable mental functioning in different cultures and societies", thereby serving the "regulation of human conduct", and assesses that even today "medical conceptions of mental illness are still intimately linked to lay judgements of what is rational, reasonable, and appropriate".

The problematics lie predominantly in the blurry boundaries between mental illness and behavioral deviance or "madness and badness" and the difficulty of attesting the difference, as the Oxford *Dictionary of Sociology* outlines: "[M]ental illness is a judgement of mind, deviance one of behaviour." But since we can only make inferences about the condition of somebody else's mind from the outside, *through* the observation of behavior, "in practice confusions [...] arise" ("mental illness." *O Dict. of Sociology*). Additionally, we need to acknowledge that these distinctions between what we consider "normal" and "abnormal" behavior depend on conventions, which are subject to change according to different cultures, societies and time.

With all of these valid criticisms in mind, I want to caution against them leading us up the path of a rigorous anti-psychiatry movement that in its most radical forms sees psychiatry as an inherently malevolent instrument of coercion and oppression, thus calling for the abolition of all psychiatric or psychotherapeutic diagnoses and treatments[6]. Even if the actual disorder is a construct, and we cannot conclusively and

[5]This paragraph is based on Jean Khalfa's Introduction to Foucault's *History of Madness* (xiii-xxvi).
[6] See Desai, Nimesh. "Antipsychiatry: Meeting the challenge", for a critical examination of the anti-psychiatry movement.

universally answer what mental illness is or whether mental disorders “naturally” exist, the symptoms of mental illness definitely exist. The pain and suffering of millions of people experiencing feelings of helplessness, panic attacks, suicidal thoughts, and many other problems, are very real. And the people responsible and trained to help these individuals need definitions, benchmarks and guidelines to operate and communicate with and base their practical decisions on. Does the person seeking treatment need medication? Does a particular patient need to be admitted? Is a person’s condition stable enough to release them from hospital care? How much time can go by in between therapy sessions without putting an individual at risk? These are decisions readers see Craig’s and Aza’s doctors make constantly in the chosen primary literature, as mental health professionals do in real life, and it goes without saying that there has to be a theoretical framework encoded in language behind these judgements.

The current version of the DSM-5 (published in 2013) defines a mental disorder as

> a syndrome characterized by clinically significant disturbance in an individual's cognition, emotion regulation, or behavior that reflects a dysfunction in the psychological, biological, or developmental processes underlying mental functioning. Mental disorders are usually associated with significant distress in social, occupational, or other important activities.

Furthermore the definition explicitly tells readers what a mental disorder is *not*:

> An expectable or culturally approved response to a common stressor or loss, such as the death of a loved one, is not a mental disorder. Socially deviant behavior (e.g., political, religious, or sexual) and conflicts that are primarily between the individual and society are not mental disorders unless the deviance or conflict results from a dysfunction in the individual, as described above. (American Psychiatric Association 20)

Much like the concept of “significant distress” in the previous description, the Oxford *Concise Medical Dictionary* foregrounds the role of “suffering” in its definition of “mental illness”, and introduces the idea of symptoms of mental illness existing on a “spectrum” rather than requiring to be thought of in absolutes. Similarly, I would say, one can notice an appearing sense of openness or a broadening of definitions when comparing the WHO’s concept of “health” from their (1946) “Constitution”: “A state of complete physical, mental and social well-being and not merely the absence of disease or infirmity” to their revised definition from the (1984) “Health promotion discussion document” which added:

> The extent to which an individual or a group is able to realize aspirations and satisfy needs, and to change or cope with the environment; health is a resource for everyday life, not the objective of living; it is a positive concept, emphasizing social and personal resources as well as physical capabilities.

I would argue that this alteration relativizes and individualizes the concept according to a person's particular needs and also factors in social, physical, environmental and personal differences. While Eric Maisel in his article about "Rethinking Mental Health" is criticizing "[t]he very idea that you can radically change the definition of something without anything in the real world changing [...] to suit your current purposes", I nevertheless consider these changes a large advancement in overall mental health destigmatization efforts. If we for instance look at the changes in the definitions of a mental disorder between the DSM-4 (1994) and the current DSM-5 (the latter augmenting the former by now explicitly stating that social deviance does not equal mental illness)[7], I think we can observe how evolving concepts, reflection of social norms and a critical analysis of the terminology used in the field have made a change in the phrasing for the better. This ultimately leads me to believe in the progress made regarding the use of respectful language within the domain of psychiatry, which hopefully brings us, as a society in general, further and further away from using the power that lies in our language choices for stigmatizing and discriminatory purposes. But what does stigma actually mean, specifically in the context of mental illness?

2.2. What is stigma?

Derived from Latin and Greek, the word "stigma" in its original sense referred to a "mark made by a pointed instrument" or a "brand", "made upon the skin [...] as a token of infamy or subjection" (*OED*), signaling to the rest of society that those bearing such a mark were "to be avoided, especially in public places" ("stigma." *Dict. of Psychology*). The term was made popular among the social sciences by sociologist Erving Goffman, according to whom "stigmas are visible or invisible social distinctions that disqualify individuals or social groups from full social acceptance". ("stigma." *Dict. of the Social Sciences*). Referring to a particular social practice or act, "stigma" has also gained meaning as a verb: "to stigmatize" means to "devalue or discredit a person or category of people [...] whose social identity deviates from society's normative expectations, or

[7] See DSM-5 definition on previous page.

to exclude a person or group with a particular attribute from certain forms of social interaction" (*Dictionary of Psychology*).

Focusing particularly on the stigma around mental illness, Corrigan, Roe and Tsang set out to distinguish between "public stigma" occurring when a community collectively supports prejudiced views and discriminates against those with a mental disorder, "self-stigma" meaning the process of an individual internalizing said stigma and using it to put themselves down, and "structural stigma" referring to "the social forces" which arise "after many years of public stigma" (xiii).

When it comes to types of stigma commonly associated with mental illness, Corrigan, Roe and Tsang have grouped negative stereotypes into "three sets of stigmatizing attitudes": Firstly, the attitude of "[f]ear and exclusion", meaning the belief that people with a mental disorder are dangerous, fear-inducing, and, therefore must be avoided. Secondly, "[a]uthoritarianism", summarizing the belief that since a person with a mental illness is inherently "irresponsible", they cannot make their own decisions and must leave that responsibility up to other people. This is closely linked to the third set of stereotypes that fall under the umbrella term "[b]enevolence", in this case meaning the concept of infantilizing somebody with a mental health condition because of the assumption that such individuals "are childlike and need to be cared for" (27).

Above this trio of attitudes is an overarching, commonly adopted belief regarding the origins or root causes of mental illness. Namely, the judgment that a mental illness is an individual's own fault and responsibility. As Corrigan, Roe and Tsang explain:

> People believe […] that mental illness is moral weakness. Persons with mental illness, so the theory goes, failed to choose a healthy lifestyle: With a little effort, they could overcome their trials. Social psychologists refer to this kind of logic as an example of the "just world" hypothesis. Persons who experience significant life problems like mental illness must have a character flaw. A just world would never deal people such an unfair hand. Hence, persons with mental illness have earned the disrespect of their community. (57)

Moving away from what stigma *is* to what stigma *does*, it is time to examine the effect these negative stereotypes or forms of prejudice have on a society's behavior. "Discrimination" is the term most commonly used to refer to the actions that result from prejudice (Corrigan, Roe and Tsang 26). Discrimination can manifest itself more overtly through the use of hurtful language or even physical violence, but inspecting the often more covert practices of social exclusion, it becomes clear that the stigma

around mental illness hurts people in more ways than one. It “robs people of their rightful opportunities in work, relationships, housing, health care; all arenas in which a full life is achieved” (Corrigan, Roe and Tsang: xiii), and most importantly, stigma does not cause pain to a select few, an abstract minority; stigma affects everybody. Entire “[c]ommunities lose out from discrimination” because when we try to separate those with a mental illness out and thus deprive these individuals of ways to make a living, we also prevent them from actively contributing to our society and we make them unnecessarily dependent on social welfare, thus feeding a self-fulfilling prophecy of the stereotypes mentioned above and hurting the general public as a whole (Corrigan, Roe and Tsang 57).

Fighting stigma is no easy feat. Many of our prejudices have become so ingrained in our culture and everyday language use, that they feel natural and frequently go unquestioned. During my research I was shocked by how many sources I came across, that, while professing an intention to help, ended up hurting the cause through their own, in my opinion, stigmatizing language choices. In order to prevent myself from making the same mistake, I have devoted the following subsection to reflecting on and giving reasons for my own decisions with regard to terminology and expressions used in this paper.

2.3. How to talk and write about mental illness appropriately and respectfully

To inform my decisions I consulted Corrigan, Roe and Tsang’s *Challenging the Stigma of Mental Illness*, Baglieri & Shapiro’s *Disability Studies and the Inclusive Classroom*, and Susman’s “Ten Commandments for How to Talk About Mental Health”. I have learned that the current ongoing discourse on how to talk about mental illness offers fewer straightforward answers than I had initially anticipated, indeed Baglieri and Shapiro observe that there is great “variety in the words and terms, grammar and letter case used and preferred” (45).

Not using derogatory language, such as “lunatic” or “psychopath” should be obvious. Baglieri and Shapiro (40-41) inform readers that it is equally recommended to stay away from “disability euphemisms”, such as references to being physically or mentally “challenged” or “special”. These are widely viewed as patronizing and contributing to the false impression that discussing a disability candidly would be “shameful or impolite” (40). An additional problematic aspect of veiling a condition behind

euphemisms “is that using ‘nicer’ language obscures the significance that impairment and disability play in a person’s experiences”. Baglieri and Shapiro criticize the underlying romanticization of this view stating the majority of people with a disability do not see “barriers as ‘challenges’ that will make them stronger, more courageous, or better citizens by overcoming them and pulling themselves up by their own bootstraps” (41).

So far, all the advice I have included has been relatively undisputed and easy to adopt without extensive reflection about there possibly being another side to the argument. The one substantial decision I had to make was whether to use “person-first” or “identity-first” language, or whether it was acceptable to use a mixture of both for the sake of variety. The two different approaches, “person-first” and “identity-first”, can be explained as follows:

Person-first language refers to a “language movement” whose advocates aim to oppose labels and stigma by foregrounding the person rather than the impairment. Applied to a concrete example, person-first or people-first language would describe somebody as “a person with a mental illness”, rather than a “mentally ill person”. The aim of this approach is to “express the wholeness of persons with disabilities, rather than emphasize one aspect of him or her” (Baglieri and Shapiro 42).

On the flipside, proponents of the identity-first language movement choose to “claim a disability identity and experience” (42) by describing an individual as, for example, “a disabled person” (as opposed to a “person with a disability”). Through this phrasing, a certain group identity is highlighted. However that is not the only reason “identity-first” advocates give for their choice. According to Baglieri and Shapiro, identity-first wording might be favored due to its “grammatical construction, which emphasizes a sociopolitical perspective on disability” because referring to someone as a “person with a disability” establishes the disability “as an attribute belonging to an individual”, whereas “placing ‘disabled’ before ‘person’ is read, grammatically, to indicate a position of being dis-abled, or *made* not-able (emphasis added)” (43). People promoting “identity-first” language believe that through this phrasing “being disabled refers to an imposed social position or set of experiences, rather than a fact of an individual” (43). The third argument some people give for preferring an “identity-first”

approach is that they believe “person-first” language actually diminishes the significance an impairment has on an affected person’s life and identity (43).

While both sides offer valid arguments, in the end the choice I made was a commitment to using “person-first” language as opposed to “identity-first” language throughout the paper[8]. This corresponds to Susman’s first commandment: “When using diagnostic terms, put the person first, not the illness”, as well as Corrigan, Roe and Tsang’s recommendation for which they provide the following rationale: “Person first language reminds members of the public about personhood, namely, that the individual is first known as a person and all its intricacies with illness taking a distant backseat” (xiii).

Ultimately my decision came down to all of my sources, including Baglieri and Shapiro, who have compared both approaches in depth, stating that “person-first” language was largely preferred by the media as well as “recommended for professional writing” and can generally be found more commonly in literature (42). However, I will also admit factoring in my personal feelings of agreement with the underlying and most important principle of this approach, which is to make clear that a person is never (and should never be) first and foremost defined by their illness.

Having come to this decision, I do want to add two disclaimers before closing this section. First, I would like to draw attention to Susman’s tenth and final commandment, which is perhaps the most crucial one: “Despite these guidelines, still respect each individual’s preference for how they wish to refer to their own mental health status.” This relates to my previous discussion of discourse and power. Letting a person choose how they wish to be described and how they wish to talk about their experience with mental illness gives agency and interpretational sovereignty to the individual in contrast to oppressively labeling them with one’s own choices, and thus exerting power over them. Secondly, I must acknowledge the simple fact that “terminology and its usage continues to evolve”, meaning “today’s ‘politically correct’ language may not be okay at some point in the future” (Susman). So while the language used throughout this paper has been chosen to the best of my knowledge and belief and the rationale for it has been researched with the utmost care and consideration, it is not beyond reproach or questioning.

[8] However, I will utilize quotations from secondary literature that uses “identity-first” language.

The following sections will reflect exactly how much not only the language used to frame mental illness but also its underlying ideological paradigms and society's resulting practices have changed and continue to change over the course of history.

3. SOCIETY'S PERCEPTION OF MENTAL ILLNESS

Although capturing all attitudes of humankind towards mental illness would be an impossible endeavor, I do want to outline some of the most common stigmatizing beliefs and practices; those of today, via the discussion of popular culture and social media phenomena, as well as those of the past, in order to contextualize the current state of affairs within the historical conception of mental illness.

3.1. A summary of the history of psychological treatment & paradigm shifts

Over the course of history, there has been an ever-changing paradigm shift, influenced by different religious, philosophical, pedagogical, and political currents, trying to explain the causes of mental illness and determine the ensuing treatment of people with a mental disorder (Nissen 13). Ingrid Farreras, who specializes in the history of psychology, establishes that "[t]he evolution of mental illness […] has not been linear or progressive but rather cyclical", meaning different etiological theories "coexist as well as recycle over time". She classifies these etiological theories into three broad categories: supernatural, somatogenic, and psychogenic.

> Supernatural theories attribute mental illness to possession by evil or demonic spirits, displeasure of gods, eclipses[9], planetary gravitation, curses, and sin. Somatogenic theories identify disturbances in physical functioning resulting from either illness, genetic inheritance, or brain damage or imbalance. Psychogenic theories focus on traumatic or stressful experiences, maladaptive learned associations and cognitions, or distorted perceptions. Etiological theories of mental illness determine the care and treatment mentally ill individuals receive. (Farreras)

Unfortunately in many cases, said treatment has been inhumane, brutal, and largely inspired by prejudice. According to Corrigan, Roe, and Tsang "[m]uch of written history has examples of the broad-based prejudice and discrimination with which the public has branded people labeled with mental illness" (5).

[9] Hence the term "lunatic", derived from the Latin word "*lūnāticus",* meaning *"*affected with the kind of insanity that was supposed to depend on changes of the moon [lūna]". ("lunatic." *Concise O. Dict. of English Etymology*)

In this section, I want to provide a short overview of the differing viewpoints and developments in the psychological and societal treatment of those labelled "mentally ill", not only to show the progress mankind has made, but also to point out that many of the stigmatizing beliefs and attitudes formed across history still have an impact on how we as a society deal with the topic of mental illness in the present. The characters in *IKOAFS* and *TATWD* refer to "loony bins", asylum imagery, they talk about demons and being "locked up". I want to investigate the origin of a few of those elements, because, as Farreras points out, "our thinking today continues to reflect the same underlying somatogenic and psychogenic theories of mental illness discussed throughout this cursory 9,000-year history", and even the supernatural theories still find their way into our vernacular, for instance through metaphor or pejorative language[10]. Throughout history, stigma has often appeared as a direct consequence of the popular belief that mental illness was the result of demonic possession, a punishment of God, a sign of witchcraft, sin, or (in a less superstitious but no more truthful interpretation) an individual's overall "moral shortcomings[11]" (Nissen 13, Corrigan, Roe, and Tsang 6).

This understanding of mental illness as a sign of disapproval of a deity was mainstream in the times of Homer. It also manifested itself in the works of the Greek theatre, which often depicted an angry god or goddess punishing a human with psychotic illnesses (Corrigan, Roe and Tsang 5). In an article on "Empowerment and Serious Mental Illness", Corrigan also mentions that a description of stigma was first provided by the ancient Greeks, who already observed that those who were labelled "mentally ill" were frequently "shunned, locked up, or, on rare occasions, put to death" (218), as well as generally deprived of all opportunities in life.

However, it was also Greece, where during the so-called "Golden Age" "Hippocrates described psychiatric behaviors as an imbalance in the humors" (Corrigan, Roe, and Tsang 7), stated that "psychological symptoms have natural causes, just like physical disease states" (Hinshaw 57), and proved to be startlingly ahead of his time at around 400 B.C., by already recognizing "that the brain was the locus of thought, feeling, and action" (Hinshaw 57).

[10] See sections 4.4.3 and 4.1.2, respectively.
[11] See also the previously discussed "just world" hypothesis in section 2.2.

The rise of Christianity lamentably brought with it the “turning away from naturalism to a range of philosophical, religious, and occult beliefs” (Hinshaw 60). The prevailing creed concerning the etiology of mental illness once again was to regard “behavioral deviance” as the result of evil forces taking over somebody and overpowering their inner good. Under this influence, scientific medical progress in the research of mental illness was halted. Practices and methods that would have helped shed light on the role of the “psychological or physiological factors” in explaining mental illness, such as autopsies, were forbidden when “religion and morality, rather than humanism and science” became the domineering paradigms of the time (Hinshaw 60).

Arguably the most atrocious consequences of this “theological” paradigm manifested themselves in the Middle Ages. People with mental disorders were treated as the offspring of Satan, their symptoms understood as obvious signs of their inner evil. Consequently, mental illness was regarded as contagious and endangering the social community; people believed it had to be exterminated to avoid it being spread. This was either carried out through exorcism, where priests violently tried to draw out a demon from the patient or by forcing them to perform elaborate prayers or other rituals. On other occasions, a community would resort to even more drastic means, such as executions by burning a person at the stake (Corrigan, Roe and Tsang 5-6).

It is important to mention that these beliefs and the brutal acts that were carried out as a response to them were not limited to the Western world. All around the globe historical evidence has been found of stigmatization, discrimination and use of violence against people considered mentally ill. Examples include relics from Egypt around 5000 B.C. depicting “an attempt to cure a young princess” of what was thought of as “demonic possession” but today would likely be interpreted as mental illness, as well as proof of Mayan and Aztec groups seeking to remove demons from an individual and their entire community through “human sacrifice” (Corrigan, Roe, and Tsang 6).

A shift in the right direction came with the adoption of the “biological perspective”, which meant viewing “mental illness as ‘illness’” (Corrigan, Roe, and Tsang 6), also referred to as the somatogenic perspective, which was already represented by Hippocrates, but gained mass appeal with the beginning of the Industrial Age. According to this view, “[t]he mechanical mind is a collection of processes and actions; events that interfere with these actions lead to mental illness. This paradigm calls for

treatments and applications meant to halt diseased activity" (Corrigan, Roe and Tsang 6).

While this paradigm shift meant progress, Corrigan, Roe, and Tsang remind readers that "unfortunately, many practices in the industrial age reflected the injustices and harms of earlier times rather than some enlightened and efficient process of the era" and they mention "restraints, extreme hunger, living in total darkness, and intentional fright" as part of what was deemed appropriate treatment for people with mental disorders at the time (6). The way this abuse was justified to the public, according to Farreras, was by comparing the patients to animals lacking the ability to reason, unable to control their actions, liable to be violent for no apparent cause, possessing a weaker or different sense of pain and able to vegetate in misery without protest, and in a second step convincing the community that "instilling fear" was the "best way to restore a disordered mind to reason".

More and more asylums designed to treat those deemed "mentally ill" began to appear, for instance in Metz, Germany, around 1100 or "London's Bethlehem, [which] was opened in 1247" and "[b]y the early 1400s, reports began to emanate about the decaying, horrendous conditions there" (Hinshaw 61). And those conditions would regrettably continue to be commonplace throughout the next four centuries.

In the 1800s, conditions in asylums were just as bad as in prisons. Individuals perceived to have a mental illness were locked up in small cells, even chained to walls, and given only very poor food or clothing. Tourists would visit such institutions for the "fun" of staring at these people. Although some physicians tried to provide various kinds of treatment, these had hardly any effect and often were even more damaging. Some examples are bloodletting, which was believed to enable the bad "humors" to leave the body to make room for "healthy fluids", twirling patients tied to a chair or immersing them in water. Insulin shock and electroconvulsive strategies were applied, as it was believed that such seizure-provoking methods had the ability of "resetting" the brain, thus leading to "normal" functioning again (Corrigan, Roe and Tsang 6-7).

The end of the 18th century and the context of Enlightenment brought with it the development of so called "moral therapy", a term coined by French physician Philippe Pinel. At the core of this new concept lay the belief that the practices of imprisonment, neglect and violence so commonly found in asylums at the time were "fundamentally

immoral" and had to be "replaced by more humane approaches". Principles of this treatment method were the knowledge that people could only get better in "settings of kindness and respect", where they were provided with "visions of hope and opportunity" (Corrigan, Roe, and Tsang 7).

Whereas Corrigan, Roe and Tsang maintain that "[m]oral treatment led to the establishments of true asylums; pastoral locales removed from the stress of daily living where people could gently return to the noise of the contemporary world" (7) , Foucault referred to this form of treatment as a "gigantic moral imprisonment" (*History of Madness* 511) and Pinel's conception of an asylum as "a judicial space where people are accused, judged, and sentenced" as well as punished and taught to repent (*History of Madness* 503), showing once again the difficulty of assessing "real" progress in the history of the treatment of mental illness.

In the late 19th and early 20th centuries two theories emerged that would go on to shape society's perception of mental illness: Sigmund Freud's "psychodynamic theory" focused on the idea that mental disorders were the result of "the interplay of unresolved unconscious motives" and suggested "various methods of open dialogue with the patient" as treatment, while the theory of "behaviorism", promoted by John B. Watson, linked mental illness to "the effects of behavioral conditioning", and proposed "methods of adaptive reconditioning" as therapy (Jutras).

Even though Jutras asserts that these two "theoretical frameworks" provided a foundation from which "modern approaches to the diagnosis and treatment of psychopathology began to emerge", anyone thinking that these more modern approaches meant the end of stigmatizing beliefs in the field of psychology, will be disappointed by Hinshaw's account of how and why this was still not the case (75). One problem was that these newer paradigms still contained a lot of "folk wisdom" and with it many "ethical and moral judgments". Additionally, with the introduction of these novel psychological models came the frequent practice of "plac[ing] responsibility" or blame on the family for the root cause of mental illness. "[I]nsensitive or inadequate parenting (usually assumed to be mothering) were viewed as the primary causal variable for nearly all forms of mental illness" and because of this "stigmatization of family members increased". And lastly,

> psychological models presented a stark contrast to the biological and hereditary conceptions of the most severe forms of mental disorder, relegating these latter types

> of disturbance to a frightening and even subhuman level. In short, psychological and secular views of mental disturbance did not automatically reduce stigma. (Hinshaw 75)

One of many examples to showcase how the emerging secular models were not reducing stigma, was the frequent diagnosis of “hysteria” around the same time. It was perceived to be an “exclusively ‘female malady’” until well into the 19th century, due to an idea originating in ancient Egypt, Greece and Rome that “the female reproductive organ is able to move throughout the body and that this movement is triggered by an unsatisfied longing for a child” (“hysteria.” *Dict. of Critical Theory*). The scientific community of Victorian times then linked this conception of women’s reproductive organs “to a propensity for insanity” (“hysteria.” Bauer). The “psychologization” of hysteria, which came with the end of the 19th century, is mostly associated with the work of Sigmund Freud; in fact, “psychoanalysis began as a theory and therapy of hysteria” (“hysteria.” Micale).

Criticized today for the fact that the symptoms or “clinical descriptions lumped under” the diagnosis of hysteria were extremely divergent, the theories trying to explain them varying significantly, even contradicting each other (“hysteria.” Micale), the historical conception of hysteria can also be seen as a vehicle for patriarchal power. In *The History of Sexuality* Michel Foucault defines the "hysterization of women's bodies" as an exertion of power that functioned through processes of sexualizing the “feminine body” and inscribing it with “intrinsic” pathology (104). The oppressiveness of that practice becomes apparent when analyzing the concrete medical texts on the subject and realizing that “[t]o a very great extent, ‘the history of hysteria’ consists of a body of writing by men about women”, and that “this literature often depicts, in the descriptive language of the clinic, features of the opposite sex that male élites in past patriarchal societies found irritating, incomprehensible, or unmanageable” (“hysteria.” Micale). Recipients of the diagnosis or label “hysteric” were exposed to “misogyny, sensationalism” and resulting abuse, since they were often “forced into lurid roles and vaudevillian performances” as part of their “treatment” (“hysteria.” Micale).

Moving on to another particularly dark spot in the history of psychiatry, it was around the first half of the twentieth century that the eugenics movement, which originally had already appeared in the late 1800s, began to gain frightening popularity.

Staunchly connected to beliefs of racial superiority and backed by the theory of Social Darwinism, this movement purported pseudo-scientifically approved claims of "the dangers of unlimited reproduction among persons viewed as potentially tainting a society's gene pool" (Hinshaw 75-76). One of the most extreme and gruesome examples of this perverted ideology rising to power took place in Nazi Germany[12]. After Hitler gained absolute political control in Germany in 1933, the "Eugenic Sterilization Law" was passed, which forced people with "physical, mental, and [or] intellectual disabilities" to undergo sterilization (Hinshaw 76-77) and in 1939 the "T-4 'euthanasia' programme *Aktion T-4*" was created "to ensure the 'genetic purity of the German population'" by not only sterilizing Germans and Austrians who were deemed to have a disability or mental illness, but also systematically executing them (Luty 53). It is now estimated that between the years of 1939 and 1941 around 100.000 people with a mental illness, among them 5000 children, were murdered in Nazi Germany (Luty 52).

After WWII "a need for a formal classification system was recognized in order to provide more efficient and targeted mental health services for veterans" in the United States (Jutras). This led to the development of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) in 1952 (Jutras). Its current edition, the DSM-5, is still among the most popular diagnostic systems used today. It was also around the early 1950s that the first psychotropic medications were introduced, contributing to massive improvements in the field of treatment: "[P]sychiatrists for the first time had a tool to help people with serious mental illness managing their symptoms. Length of hospital stay decreased significantly, returning people to the community" (Corrigan, Roe, and Tsang 7-8).

While it is true that "[r]estraints, electro-convulsive shock therapy, and lobotomies continued to be employed in American state institutions until the 1970s, […] they quickly made way for a burgeoning pharmaceutical industry that has viewed and treated mental illness as a chemical imbalance in the brain" (Farreras). Not only could the length of individual patients' hospital stay be reduced, "the availability of medications to help alleviate the acute symptoms of severe psychoses and

[12] However, "[y]ears before Hitler attained power, […] scientists and mental health professionals throughout Europe and the United States were promoting legislation mandating sterilization of those with mental illness, under the banner of the eugenics movement. These restrictions provided a model for the Nazis" (Hinshaw xii).

depressions provided real enthusiasm regarding the potential for noninstitutional treatment" (Hinshaw 78), thus inspiring "a serious effort toward deinstitutionalization and community-based care" (Hinshaw 79), which still forms the basis of many treatments today.

As far as paradigms are concerned, a widely accepted etiological model mental health experts acknowledge today is a synthesis of the somatogenic and the psychogenic theory, forming "what the psychological discipline holds as the biopsychosocial model[13] of explaining human behavior", which can be explained as follows:

> While individuals may be born with a genetic predisposition for a certain psychological disorder, certain psychological stressors need to be present for them to develop the disorder. Sociocultural factors such as sociopolitical or economic unrest, poor living conditions, or problematic interpersonal relationships are also viewed as contributing factors. (Farreras)

In accordance with this model, modern treatments can factor in and address all of these different components, for example by combining the prescription of psychotropic medication with (cognitive behavioral) therapy, which is the exact treatment plan readers can observe in *TATWD* and *IKOAFS*.

After reviewing some of the most important cornerstones in the "messy" and "circular" (Hinshaw 54) history of mental illness and its stigma, I now want to show that despite all the advances discussed above, the problem of prejudice towards those with mental disorders is far from solved.

3.2. Mental health stigma today

Although great progress has been made in the treatment of mental disorders, stigma still very much exists. In fact, Corrigan, Roe, and Tsang observe that over the course of the last fifty years stigma has actually increased rather than decreased. They point out that "[p]eople in 1996 were about two and a half times more likely to view individuals with serious mental illness as dangerous compared to 1950" and they correlate this unfortunate trend to the development of our media landscape, claiming that "[o]ne reason [for this increase] is the change of the face of media around the world during these 40 to 50 years" (Corrigan, Roe, and Tsang 2-3).

[13] Originally promoted by George L. Engel in 1977 ("Biopsychosocial Model." Miles).

The media's great influence on our perception of people with mental disorders can be explained as follows: According to Corrigan, Roe, and Tsang, stigma can be learned in two ways. It is either "constructed by experience" (based on the sum of our interactions with a group) or "socially-given" (33). If we have limited actual experiences of a group, we will only develop "limited attitudes", shaped by the representations in "our lore" and "myths". If our myths and our lore are full of stereotypes regarding mental illness, this is what we absorb and pass on to others as a society. Today's myths and lore are largely propagated by modern media, such as films and television, music, or social media (Corrigan, Roe and Tsang 33).

An article in the newspaper *Der Standard* from 2013 titled "Stigmatisierung psychisch Kranker hält an" ["The Stigmatization of People with a Mental Illness Continues"], based on research conducted in Germany by Schomerus and Angermeyer (2011), discusses how this holds true not only for the United States but Europe as well. But what do experts mean when they claim that the media stigmatize people with mental health issues? How does this phenomenon manifest itself? The rest of this section will feature examples to showcase what the stigmatization of mental illness looks like today.

According to Corrigan, Roe and Tsang, "[m]edia in its various forms have suppressed stigmatized groups since humans first began recording their thoughts and behaviors" (11). They highlight that a popular way of depicting people with mental illnesses today is to portray them "as dangerous or inept" and, to provide one example for this trend, they ask readers to "listen to talk radio on the way home from work and count the number of times the host says 'crazies,' 'daft,' 'wacko,' or 'nutters'" (11).

> Many more examples follow from television, but also from movies, newspapers, advertising, and magazines. Headlines in the *London Evening Standard* read "Maniac killed twin sisters" in April 2005. At the same time, the *Daily Mail* posted "Knife maniac freed to kill. Mental patient ran amok in the park" in February 2005, "Violent, mad. So Docs set him free" (*The Sun*, February 2005), and "Royal stalkers are 'dangerous psychotics who need help'" (*Telegraph*, October 2008)." (Corrigan, Roe and Tsang 12)

The persistent associations of violence and danger with mental illness lend themselves to being utilized by the horror genre. Corrigan, Roe and Tsang present the following observations about the exploitation of these tropes through horror theme park attractions, for example at "Fright Night Scream Park in Clovis, California":

> In 2009, the park included two attractions:

> *The Asylum,* a psych ward gone very wrong. Recently the patients have taken over. Nurses and doctors are being twisted into the very patients they meant to help. Enter the Asylum and test the limits of your sanity!
>
> *Psychosis,* where the clowns are out to play! This world of sensory alteration and fantastic perceptions is not "clowning around." Dazzle your senses in a world of three dimensional doom as the freaky circus psychos roam. (12)

Reading about these examples, I wanted to know if I could supplement and validate Corrigan, Roe and Tsang's findings by researching my own cases in 2019 Austria. Finding examples was all too easy. There is a "Madness" themed horror escape room right here in Vienna. The description on the website reads like a jumble of different stereotypes surrounding the idea of a 'lunatic asylum':

> *In this escape room you accidentally ended up in the lunatic asylum that's run by a mean and mad professor who doesn't plan anything good. […] The goal of the professor is to drive you crazy so you won't be able to stop him from executing his evil plans. 60 minutes are not much time to try and stop the professor, otherwise you'll end up staying here permanently. Can you save your freedom and soul?*
>
> (Exit the Room GmbH. "Madness")

Apart from the fact that the term 'lunatic' is viewed today as discriminatory in itself, the company essentially capitalizes on a very outdated view of psychiatric treatment filled with images of confinement, evil caretakers, and brutality. And it is not just theme parks or attractions. Anyone can join in on displaying these types of prejudice by wearing a costume. In his *PsychologyToday* blogpost "Why is Mental Illness Scary?" clinical and forensic psychiatrist Praveen Kambam observes that

> mental illness has become such a common horror trope that it's even reflected in popular Halloween costumes. You can complete the serial killer look with a straitjacket, an orange jumpsuit, and a "biter mask." If that's not your style, you can always go as a "mad" scientist or a "deranged" ax murderer.

One quick internet search on my part revealed that, indeed, such costumes can be purchased at many costume stores and large online portals with just one click.

Unfortunately these discriminatory practices are not confined to Halloween. There is a plethora of movies, especially within the horror or thriller genre, exploiting the tropes of criminally insane people, chainsaw wielding homicidal maniacs or mad doctors. Again Corrigan, Roe and Tsang give us some examples:

> In *Batman: The dark knight*, Batman describes one of the Joker's henchmen as a paranoid schizophrenic, "the type of mind attracted to the villain." Three years earlier was *Batman begins*. Here a corrupt psychiatrist had planned to put a drug in the water supply which would cause people to have psychotic episodes. (13)

One really need not think long and hard to come up with some more. In their article "Horror films and psychiatry" Hatters Friedman, Espi Forcen, and Preston Shand provide the following overall assessment of the relationship between horror movies and the topic of mental illness:

> Arguably, horror films exploit society's misunderstandings about mental illness and profit from fear-mongering. Gruesome imagery of psychiatric patients committing random violent and illogical acts forms the basis for many horror films. […] Horror films reflect a sinister version of mental illness and psychiatry […], and psychiatrists [are] often portrayed as Dr Evil. […] We should keep in mind […] that horror films present viewers with misguided cinematic versions of mental illness (not limited by the DSM), which may impact stigma and public fears. (449)

They also give us more examples of such narratives. *Silence of the Lambs, Friday the 13th, Nightmare on Elm Street* are only a minute sample of all the films that feature portrayals of mental illness as something to be feared (448).

Leaving the world of horror does not mean leaving the world of stigma in popular culture. Corrigan, Roe and Tsang cite the following instance to showcase that fetishizing mental illness has impacted the fashion world as well: "In October 2007, contestants on *America's Next Top Models* [sic] perfected their runway walk while wearing straitjackets on a set laid out as a psychiatric ward and coaches decked out as nurses." (14)

Finally, to feature a very recent example from the world of music: A song that has been played up and down on radio stations worldwide, managed to stay number one in the Austrian charts for four weeks, and has been in the overall charts now for a total of forty weeks between November 2018 and August 2019 (austriancharts.at) is "Sweet but Psycho" sung by artist Ava Max. Some of the more controversial parts of the song's lyrics can be seen below.

> *Oh, she's sweet but a psycho*
> *A little bit psycho*
> *At night she's screamin'*
> *"I'm-ma-ma-ma out my mind"*
> *Oh, she's hot but a psycho*
> *So left but she's right though*
> *At night she's screamin'*
> *"I'm-ma-ma-ma out my mind"*
> *[…]*
> *Grab a cop gun kinda crazy*
> *She's poison but tasty*
> *Yeah, people say, "Run, don't walk away"*
> *'Cause she's sweet but a psycho […]*

You're just like me, you're out your mind
I know it's strange, we're both the crazy kind
You're tellin' me that I'm insane
Boy, don't pretend that you don't love the pain

Music & Lyrics by Henry Walter, William Lobban Bean, Madison Love, Amanda Ava Koci, and Andreas Andersen Haukeland (austriancharts.at).

Although widely popular, the song unsurprisingly has its critics and there exists even a petition against it being played on radio stations. “It feeds right into a misogynistic ‘crazy girlfriend’ narrative, as well as stigmatising those who suffer from psychosis, psychopathy or other mental illnesses,” writes Clodagh Ní Maonaigh in her 2018 *Mental Movement* article “‘Sweet But Psycho’ Is a Problematic Song and Here’s Why”. She goes on to analyze the song’s music video: “The song has taken psychopathy and tried to make it edgy. The music video depicts a woman, poisoning a man, and following him with an axe while wearing a wedding dress.”

Mental health activist Courtney Smith is especially concerned with the frequent occurrence of the words “psycho” and “crazy” in the lyrics. “Using it in a song normalises it, it puts it into people’s vernacular, it encourages the use of the words, it does harm” (qt. in Ní Maonaigh). Ní Maonaigh, the starter of the petition “Remove 'Sweet but Psycho' from your station's playlist”, highlights the danger of trivialization and references one of her fellow petitioners as saying: “Absolutely awful song that rolls the mental health narrative back about 20 years. Being ‘psycho’ isn’t a cute personality trait, it’s a mental disorder and people with psychopathic tendencies need help, not to have their difficulties trivialised in a catchy pop song.” While my personal beliefs about the ethics and efficacy of censorship[14] prevent me from agreeing with the petition’s overall enterprise of trying to remove the song from stations, I do acknowledge that the petitioners’ comments reflect the genuine hurt and harm such a trivialization or romanticization of mental illness can cause.

3.3. Glamorization and trivialization of mental illness

This last and most recent example could be indicative of a phenomenon author John Green has previously called “the other side of […] [the] coin” when it comes to the stigmatization of mental illness (Green qt. on *Goodreads* 2017). In a 2017 *Goodreads*

[14] which I will elaborate on in the next subsection

Q&A the author discussed the difficult balance between talking about mental illness freely, openly, in widely accessible spaces and yet making sure that mental health is not talked about in a trivializing or romanticizing way. He first points out the perhaps more commonly discussed negative effects of the stigma around mental illness, such as making it difficult or impossible for people affected to find work, to build relationships, or to be generally treated as an equal human being. Then he describes romanticization as "the other side of that coin", as it also sets people with a mental disorder apart from society, once again representing them as something other than "richly and fully human".

> For instance, I started writing Turtles All the Way Down in part because I was so tired of the popular narrative of the brilliant detective with OCD. That may be true to some people's experience, but it isn't true to mine. In my experience, obsessive thinking makes me a TERRIBLE detective because I can't pay any attention to anything happening outside the torrent of my so-called self. And I do think there are real risks with romanticizing mental illness. (John Green, *Goodreads*)

Recently a worrisome trend can be observed, especially on social media platforms such as Tumblr or Instagram, which consists of postings featuring sinister images or melancholy quotes which romanticize mental problems such as OCD, depression, self-harm and even suicidal ideation. Posts often depict what has been deemed as "beautiful suffering" (Bine). I will refrain from showing examples in my thesis, but during my research I have come across pictures of cutting scars dripping with blood as an aesthetic, and "insta-stories" propagating mental illness and suicidal thoughts as a desirable personality trait. Serious health conditions are being trivialized; dangerous and debilitating practices, such as self-harm or self-starvation, are being promoted and glorified.

The controversial TV show *13 Reasons Why*, an adaptation of the 2007 novel by Jay Asher, has also been linked to the overall phenomenon of glamorization because of its portrayal of suicide. Experts warn about the risk of so-called "suicide contagion" or "copycat" suicides (Howard) as a result of teenagers being affected by some of the imagery in the TV series. The official statement of the US National Association of School Psychologists regarding the show cautions: "Research shows that exposure to another person's suicide, or to graphic or sensationalized accounts of death, can be one of the many risk factors that youth struggling with mental health conditions cite as a reason they contemplate or attempt suicide" (NASP). A study conducted by Jeffrey

Bridge et al. concludes that “[t]he release of *13 Reasons Why* was associated with a significant increase in monthly suicide rates among US youth aged 10 to 17 years” (Bridge et al. 236).

More and more correlations are drawn between mental health problems and dangerously false representations of them in the media. R. Jadayel, Medlej, and J. Jadayel examined the interrelationship between social media practices and the glamorization of mental illness via case studies and focus groups, as well as by utilizing data from the charity organization *selfharm.co.uk*. Through their research they found out that cases of eating disorders, cutting and similar self-harm practices, as well as depression have strongly increased, especially among young teenagers, as a consequence of social media channels spreading glamorizing accounts of such problems over the last ten years (R. Jadayel, Medlej, and J. Jadayel 468, 470).

The sheer popularity and quantity of such glamorizing accounts is overwhelming. In an article in the *Atlantic,* titled “Social Media is Redefining Depression”, Anne-Sophie Bine examined tumblr for content which romanticized mental illness and found plenty during her research:

> Black and white photographs of mystical emaciated women who stare off into the distance put psychological torment and beauty on the same page, and quotes like “So it’s okay for you to hurt me, but I can’t hurt myself?” and "I want to die a lovely death," try to justify self-harm. All this is at the tip of anyone’s fingertips: anyone can search tags like “self-harm,” “depression,” or “sadness,” and find thousands of blogs with a similarly distorted vision of what it means to be depressed. And this online cultivation of beautiful sadness is easy to join.

According to R. Jadayel, Medlej, and J. Jadayel these easily accessible posts lead to both a trivialization and a glamorization of mental health issues because through them “[m]any teenagers and young adults now see mental disorders as relatable, normal and desirable, while people actually diagnosed with any mental health disorder might get a false impression that what they are experiencing is normal and common” (474).

The purpose of sharing all these examples in my thesis is not to point fingers or to shame anyone’s film or music preferences, behavior, social media or language use. It is equally not my intention to advocate for censorship. I very much believe in free speech and also doubt the feasibility of making all the problematic narratives of mental illness in the media simply disappear. As Corrigan, Roe and Tsang (17) point out: “Disrespectful images hurt the person, but changing the media will not wipe away

stigma's harmful impact." They go on to say: "If anything, the media reflect society. Media depictions will decrease when cultures are able to corral their disrespectful images" (17), which I agree with only to a point, because I think the connex between media and society is a two-way street.

Media depictions *reflect* society as much as they can and do *influence* it. Because of this, I feel content creators and the platforms through which they publish their work are not free of responsibility. The ways in which this sense of accountability should manifest itself with regard to a specific media phenomenon, i.e. what "the media taking responsibility" should look like, is a contested area of current popular discourse. As mentioned above in the example of a petition against the song "Sweet but Psycho" being played, there are those who support the idea of platforms banning certain content, or editing portions out[15]. Content creators such as the team behind *13 Reasons Why* and the streaming service Netflix try to showcase their sense of responsibility by, for example, launching a support website featuring links to suicide helplines (Howard) and displaying so-called "trigger warnings"[16] before episodes, a practice which becomes increasingly popular among social media as well, but these measures are seen by some as lacking efficacy or simply not being enough (Howard). I cannot pretend to have a simple, all-encompassing answer to the complex question of *how* media should take responsibility for the power they have in shaping our society. However, this was also not the reason I brought forth all the previous examples of trivialization or glamorization of mental illness in popular culture[17].

My goal in mentioning these instances, as a first step, is to show the kind of imagery of mental disorders that is painted across our media landscape. This imagery greatly impacts the lifeworld of teenagers. It is the narrative and information about mental illness young impressionable minds are exposed to every day and everywhere they look; and there is scientific evidence to prove that it affects the way young people view and talk about mental illness.

For their research article titled "250 Labels Used to Stigmatise People with Mental Illness" Rose et al. set out to "investigate the extent of stigma in relation to treatment

[15] Netflix has, in fact, edited the graphic suicide scene from *13 Reasons Why* as a response to complaints (Bennett).
[16] trigger warning: "statement at the beginning of a piece of writing, before the start of a video, etc., warning people that they may find the content very upsetting, especially if they have experienced something similar" (*Camb. Adv. Learner's Dict. & Thes.*).
[17] Though the role and responsibility of the media is certainly a topic to discuss with students, see section 5.2.3.

avoidance in 14 year-old school students in England". They conducted a cross-sectional qualitative study among five participating schools. The research process can be summarized as follows: At the beginning, the participants in the study had to come up with words or phrases they commonly used to talk about mental illness. These were listed, and in a second step, they were grouped according to their denotative and connotative meanings. Then the "key themes" attributed to the concept of mental illness by the students were identified. The researchers also enumerated how often each word had been mentioned.

An overwhelming three quarters of the most frequently occurring words were "strongly negative in referring to people with mental health problems" (Rose et al.). The top 6 most frequently occurring words were "Disturbed", "Nuts", "Confused", "Psycho", "Spastic" and "Crazy". Rose et al.'s study further revealed that only 16% or seven items could be considered "broadly neutral, including the use of medical diagnostic terms", and an even smaller amount, merely 4 words "(9%) could be described as at all empathic or eliciting compassion". The researchers also grouped their data into five themes and found that "[t]he first theme called 'popular derogatory terms' (116 items) accounted for nearly half of the words examined". Rose et al. relate their findings to a body of previous research from around the world, published between 2000 and 2006, on common attitudes towards schizophrenic patients, relationships between stigma concerning depression and other mental disorders, suicidality, and the readiness of patients to seek help, as well as the impact seeking help for mental health problems might have on people's careers and social life, and come to the conclusion that

> [c]ompared with adults, young people have less favourable attitudes towards people with mental illness. Conversely, young people with mental illness may be exposed to higher levels of stigma than adults. Commonly young people feel that mental illness is embarrassing, should be handled privately, and people with these views tend to seek help less often.

They warn that stigma, manifesting itself as "strong negative emotional reactions" or as "overwhelmingly negative connotations used by young people to describe people with mental health problems" is a "major barrier to help-seeking" (Rose et al.).

For me personally, this link between stigmatizing, discriminatory language use and real-life tangible negative consequences, such as the discouragement of help-seeking, is where I see my call to action as a language teacher. As previously mentioned, I do not see censoring the media as a valid answer to the problem. The

solution I propose instead lies in offering students a different, alternative perspective of mental illness; a so-called “counter-discourse” or “counternarrative”.

4. COUNTERNARRATIVES

I have already discussed the concepts of “discourse” and “discourses” as they relate to Foucault and the societal mechanisms or power relationships expressed and maintained through language in section 2.1. Acting as a counterweight to “naturalized” prejudice is the creation of counter-discourses or counternarratives, which, according to Kagendo Mutua[18] can be described as stories which aim at shattering those “widely accepted truths” (132) about individuals or groups, cultures and institutions, and also question the validity of such institutions (e.g. the media or educational establishments), and the theories created by them. The notion of counternarrative as such already expresses distrust in the “authority of knowledge of human experience or narratives that make grand claims about what is to be taken as truth”. Moreover, counternarratives serve to showcase the mechanisms used to legitimize and justify the “marginalization”, “exclusion” and “oppression” of groups or individuals as well as their “erasure” from society’s radar. Consequently, counternarratives challenge and dissect the “official apparatus (e.g., systems of education, justice, and religion) used to create and sustain ‘otherness’ and maintain marginality”. Counternarratives can help break down a classroom’s (and by extension, a whole society’s) set of stereotypes because they

> hold emancipatory possibilities for groups that are marginalized […]. They dismantle the grand/official narratives that sustain hegemony, raise questions about the presumed superiority of one group over another, and take away the power of those entities that characterize, define, and/or claim to speak for all. (Mutua 132)

We as teachers have the responsibility, as well as the privilege, to walk into a classroom and bring in a medium that offers such a counternarrative to teenagers. I propose that *It’s Kind of a Funny Story* and *Turtles All the Way Down* serve as valuable models of counternarratives to incorporate into an English lesson. The next sections of this paper will be devoted to showing all the reasons why I think this is the case.

[18] The following definition of counternarratives is based on and contains quotations from Mutua 132.

4.1. Counternarratives show that words matter and stigma hurts

The following subsections each uncover a different aspect of the ways in which stigmatizing language greatly affects the lives of both the protagonists in the chosen primary literature, as well as real-life individuals with mental health problems.

4.1.1. The alienating and shame-inducing concept of "normal"

There are many instances of both protagonists 'othering' themselves by identifying as not "normal" and constantly comparing themselves and their lives to the unreachable goal of thinking, feeling, behaving and living like "normal people" do. Because they inevitably fall short of this social construct, both narrators suffer from low self-esteem issues.

In social situations Aza often tries to adapt her behavior to what she thinks 'a normal person would do', as for instance in this interaction with her romantic interest Davis: "I was trying to think of what a normal person would say, like maybe if I could just say and do whatever normal people say and do, then he would believe me to be one, or maybe that I could even become one" (*TATWD* 179). She frames her struggle with intimacy within the confines of not being able to give him what a "normal" person could:

> "I just wanted to be with him like a normal person would." (*TATWD* 179)
>
> "I told myself to be in this moment […]. […] It's fine you're fine just kiss him *you need to check something* it's fine just be fucking normal […]." (*TATWD* 152)

Aza also has a mean and destructive inner voice[19] that, among many other strategies, tries to put her down by using the term "normal". For example in the following passage the voice is repeating the word over and over, seemingly taunting Aza by pointing out all the things "normal" people are able to do, that she is not.

> *He's trying to treat you like you're normal and you're trying to respond like you're normal but everyone involved knows you are definitely not normal. Normal people can kiss if they want to kiss. Normal people don't sweat like you. Normal people choose their thoughts like they choose what to watch on TV. Everyone in this conversation knows you're a freak.* (*TATWD* 157)

Aza frequently worries about her future and her perceived inability to have a "normal life": "I can't have a normal life if I can't kiss someone without freaking out" (*TATWD* 155). Any deviation from what is considered "normal" is regarded as a personal failure.

[19] which will be further discussed in section 4.4.4

Craig equally uses “normal” as a yardstick for his behavior. On the very first page of *It’s Kind of a Funny Story* he compares his way of speaking to that of a “normal person”: “They [words] don’t come out smooth and in conjunction with your brain the way normal people’s words do” (*IKOAFS* 3). Craig berates himself for not being able to eat full portions, or doing other activities, like ‘a normal person’ should: “I should be frickin’ eating and sleeping and drinking and studying and watching TV and being *normal*” (*IKOAFS* 44). He also describes the effect of his medication Zoloft by using the concept of “normal”: “I took my Zoloft every day. Some days I woke up and got out of bed and brushed my teeth like any normal human being” (*IKOAFS* 114), as if he needed medication to “normalize” him.

When Craig’s therapist Dr. Minerva wants to hear about his progress after admitting himself to the hospital, Craig is reluctant to see his successes, such as better eating or sleeping, as a real improvement, because of the fact that he is in hospital, which according to him is not a “normal” environment:

> “What’s it like compared to Friday, Craig?”
>
> “Better. Much, much better. But the question is, am I really better, or am I just lulled into a false sense of security by this fake environment? I mean, it’s *not* normal here.” (*IKOAFS* 305)

Dr. Minerva swiftly and skillfully breaks down the illusion of “normal” by saying: “Nowhere is normal, Craig” (*IKOAFS* 305), thereby highlighting the abstract nature and artificiality of the term, and refocusing on the value of Craig feeling better rather than worrying about adhering to societal norms.

By the end of the novel, Craig realizes that what he considered the “normal” path he needed to follow in order to become a successful, functional adult, put pressure on him and made him feel inadequate and anxious in the first place. He then decides to deviate from that ‘normal’ path and go to art school. Aza too, accepts that mental illness, while it does not define her, is a part of her story, and reevaluates what “getting better” means to her, thereby also defining *her* normal.[20] The next segment is concerned with one common reaction to identifying something or someone as deviating from the norm; the use of derogatory language.

[20] More on that in section 4.3, which deals with the realistic narrative of mental illness.

4.1.2. Derogatory language

In both books there are various instances in which the narrators (and other characters) use derogatory terms to refer to people with mental conditions, such as “freak”, “crazy”, “messed-up”, “shizo”, or “loony”, to name only a few. Craig and Aza experience stigmatization by friends or family members in many different scenes.

During her visit to the hospital Craig’s sister Sarah remarks: “It’s like *One Flew Over the Cuckoo’s Nest!”* […] “I mean, all these people look like ... serious crazies!” (*IKOAFS* 219). Not only is she referencing yet another infamous pop-culture moment in the history of mental illness representation, but she is also using very insensitive language. She further tells Craig that he “used to look freaky", after which her mother corrects her with more appropriate and compassionate language: “She doesn’t mean freaky” […] “She just means that when you were down, you looked a little under the weather. Isn’t that right, Sarah?” (*IKOAFS* 412-413).

It is important to point out here that Craig’s sister is still very young and (like all family members in both books) generally has the protagonist’s best interests at heart. This language might be a reflection of her struggling to come to terms with the overall situation of visiting her brother in the psychiatric unit of a hospital. Later in the book Craig asks her “Are you embarrassed by this place?” and she replies “Yeah, but whatever” (*IKOAFS* 417), which goes to show that “[s]tigma’s impact is not limited to people with mental illness. Relatives are also plagued by the effects of stigma […]” (Corrigan, Roe and Tsang 53).[21]

Aza’s best friend, Daisy, equally sometimes struggles to find the right words or tone to deal with Aza’s anxiety. One time she tells Aza “‘You’re so stuck in your head,’ […] ‘It’s like you genuinely can’t think about anyone else.’” The effect on Aza is immediate, as she thinks: “I felt like I was getting smaller” (*TATWD* 140). While generally supportive, Daisy deeply hurts Aza at one point of the story. As a way to release some of her pent-up frustration with Aza, she creates a character in her fanfiction stories called Ayala. This character shares many similarities with Aza, especially her anxiety, and is portrayed in a most horrific light. Ayala is described as the main character’s “best friend and greatest burden” (*TATWD* 194). Readers are also told that “Ayala couldn’t get

[21] How the books could help friends and family cope with and react appropriately to a loved one’s mental illness will be explored in section 4.5.

anything right. And the more she worried, the worse she made everything" (*TATWD* 194). Possibly the worst quote is this one: "Ayala wasn't a bad person, just a useless one" (*TATWD* 195). When Aza stumbles upon this fanfiction, she is crushed: "I now saw myself as Daisy saw me – clueless, helpless, useless. Less" (*TATWD* 196). The repetition of the word "less" serves to illustrate the direct loss of self-esteem Aza experiences after reading the texts.

One of the most malicious examples of derogatory language use comes from Craig's friend Aaron. Aaron makes a very unkind phone call from a party (surrounded by his friends and their roaring laughter) in which he uses a lot of problematic language. He starts the phone call with "Hey, is this the loony bin?" (*IKOAFS* 254) and reacts to Craig's diagnosis of clinical depression with a sarcastic joke and some more pejorative terminology:

> "No way! You're like the happiest guy I know!"
>
> "What are you *talking* about?"
>
> "That's a joke, Craig. You're like the craziest person I know." (*IKOAFS* 255)

He further refers to the hospital as a "mental ward" and when informed by Craig that his own girlfriend Nia has been taking medication for depression for a while without him knowing, he angrily lashes out at Craig with even more abuse:

> "What, like I don't know what this is really about? […] You want my girl, dude. […] You're mad that you didn't get her, and now you've decided to turn being mad into being depressed, and now you're off somewhere, probably getting turned into somebody's bitch, trying to play the pity card to get her to end up with you… […]." (*IKOAFS* 257)

Deconstructing this scene, I first want to draw attention to the obvious misuse of the word "decide" which shows Aaron is buying into one of the frequent stereotypes discussed in section 2.2, namely that of a mental health condition arising through one's own fault or choice. Not only is this belief that an individual is responsible for their mental illness due to their own "bad life choices" proven to lead to a "loss of sympathy" and "an unwillingness to help", rather like a chain reaction, it also leads to "blame for problems", then to "anger in response to blame" and ultimately to "a call for punishment to meet one's anger" (Corrigan, Roe and Tsang 95-96). I would argue that Aaron's use of cruel and derogatory terms throughout his phone call represents the infliction of such a punishment, a verbal one in this case, and one which Aaron at the time seems to think is justified.

Going further in the analysis, the phrase “being turned into somebody’s bitch”, or “turned out” is a reference to prison slang, meaning “the process by which a male inmate through violent coercion is transformed into a […] passive sexual role”, thereafter “belonging to another inmate” and “perform[ing] the functions of a girlfriend or wife” (“turned out.” and “prison bitch.” Urban Dictionary). This kind of language shows that Aaron (like so many others) still links mental illness to violence and crime and the idea of being ‘locked up’ – all imagery, as previously discussed, widely popularized in mainstream media. His use of “playing the pity card” is a demonstration of yet another stereotype, namely, that mental illness is a ploy to get people’s attention and sympathy.

Readers later learn that Aaron has been struggling with mental problems himself, when he apologizes to Craig for his insensitivity towards the end of the book. More than anything, I think his storyline shows us how quickly the stigmatization of others can turn into self-stigmatization and thus result in long periods of denial of one’s own problems. This kind of thinking “distances the general public from its own brushes with anxiety and depression”, because “persons steeped in stigmatizing beliefs” would rather “deny their own woes” than be “associated with ‘these weak mentally ill’” (Corrigan, Roe and Tsang 57).

Our narrators, too, use derogatory language to refer to themselves, thus verbalizing their own self-stigma in the most vicious ways. Self-stigma as a concept

> refers to the state in which a person with mental illness has come to internalize the negative attitudes about mental illness and turns them against him- or herself. During this process, a person often “loses” previously held identities (e.g., as student, worker, parent, etc.), while the stigmatized “illness identity” becomes the dominant one. […] Self-stigma often takes the form of “I am” statements such as […] I really am unable to care for myself. […] I’m weird (Corrigan, Roe, and Tsang 115).

Aza often makes such self-statements. She calls herself a “freak” (*TATWD* 157), “pathetic” (*TATWD* 154), a “disgusting narcissist” (*TATWD* 226) and even more frequently uses the word “crazy” to describe herself. She utilizes these cruel terms to admonish herself for her behavior, for example when she fights with her inner voice about not drinking hand sanitizer: “Drinking hand sanitizer is not going to make you healthier, you crazy fuck” (*TATWD* 210). This language clearly represents the “loss in

self-esteem and self-efficacy" that Corrigan, Roe, and Tsang describe as a consequence of self-stigma (40). During one session, Aza's therapist actually brings this up and points out the underlying cruelty of Aza's words:

> "I mean, I'm still crazy, if that's what you're asking. There has been no change on the being crazy front."
>
> "I've noticed you use that word a lot, *crazy*. And you sound angry when you say it, almost like you're calling yourself a name."
>
> "Well, everyone's crazy these days, Dr. Singh. Adolescent sanity is so twentieth century."
>
> "It sounds to me like you're being cruel to yourself." (*TATWD* 86-87)

During the same therapy session Dr. Singh establishes a correlation between the difficulty of verbalizing one's inner pain (to someone else) and the resulting societal use of simplistic, insensitive terminology like "crazy".

> One of the challenges with pain [...] is that we can really only approach it through metaphor. It can't be represented the way a table or a body can. In some ways, pain is the opposite of language. […] And we're such language-based creatures that to some extent we cannot know what we cannot name. And so we assume it isn't real. We refer to it with catch-all terms, like *crazy* [...], terms that both ostracize and minimize. [...] [T]he term *crazy* arrives at us with none of the terror and worry you live with. Nor do [...] those terms connote the courage people in such pains exemplify, which is why I'd ask you to frame your mental health around a word other than *crazy*. […] Can you say that? Can you say that you're courageous? (*TATWD* 89)

In this scene many different aspects I discuss in my paper are succinctly addressed. The powerful role of metaphor in framing and describing the protagonists' battle with mental illness will be given its own subsection in 4.4.3, but this moment is also a prime example for the definition of a counternarrative. Dr. Singh wants Aza to look at and talk about herself and her mental disorder in a different way. Societal mainstream stigma has shaped the way she describes, or narrates, herself, and her therapist is now offering an alternative perspective – courageous, instead of crazy. It is noteworthy here that Dr. Singh is not censoring Aza's use of the word "crazy", by telling her she should not say it anymore; she is merely offering another choice. This corresponds neatly to my preference of counternarratives over censorship. Unfortunately at this point of the story Aza cannot accept this counternarrative (and its inherently more positive language use), and will continue to refer to herself with derogatory terms for the majority of the book.

Craig calls himself crazy too, and like Aza, also belittles or trivializes his disorder, thinking: “Depression isn’t a disease. It’s a pretext for being a prima donna” (*IKOAFS* 302). He refers to the psychiatric floor as the “loony bin” (*IKOAFS* 391), shames his use of medication at one point, judging that “pills were for wimps” (*IKOAFS* 122) and refers to his psychiatrists as “shrinks”. While this last word seems more harmless and conventionalized than the previous examples, and therefore at first glance not really derogatory, it is worth exploring the roots of this term.

Originally the word “headshrinker” was used to refer to the “Javaro Indians of South America, who shrunk the heads of their enemies killed in battle” (Gadon and Johnson 634). There are several theories as to how and why this term became a slang word for psychiatrist or psychotherapist. Optimistic interpretations suggest that the term is used to denote the idea that a shrink is able to “shrink the patient's problems and anxieties” (Gadon and Johnson 635). On the other hand, the word may reflect and tap into “[f]ears that the psychotherapist will somehow shrink, deflate, or deplete” the patient, or, that the psychiatrist, “like a witch doctor”, uses dark magic for their practice (Gadon and Johnson 635).

Gadon and Johnson conducted a study among 129 participants to explore the “consequences of hearing a mental health professional referred to as a ‘shrink’” (634). They found that individuals who had heard a psychologist referred to as a “shrink”, as opposed to those that had been exposed to a professional label, evaluated the professional in question as having less expertise and being less considerate (646). Participants exposed to the term “shrink” also “expressed less interest in seeking therapy” from that psychologist, than the control groups (634). Gadon and Johnson’s findings suggest that using derogatory labels to refer to people working in the mental health sector, may encourage bias towards those professionals, thereby possibly impairing their capacity to help.

Craig even reflects on his choice of words implying a certain lack of respect for the profession: “I used to not want to call them shrinks, but now that I’ve been through so many, I feel entitled to it. It’s an adult term, and it’s disrespectful, and I’m more than two thirds adult and I’m pretty disrespectful, so what the hell” (*IKOAFS* 9). Aza similarly at one point describes her sessions with Dr. Singh as “therapy bullshit” (*IKOAFS* 164). What is so problematic in these last two examples is that the narrators are stigmatizing

their own sources of help, feeding a self-fulfilling prophecy of mistrusting their therapists, medication, hospitalization and treatment plans, as well as increasing their feelings of embarrassment for using these services.

There is a very interesting passage in *IKOAFS* in which Noelle questions the meaning of Humble's frequent use of the term "wack" or the phrase "whacked out of your mind":

> "Where'd you hear the term 'wack'?" Noelle asks.
>
> '"Whacked?"' Humble picks a piece of salad out of his teeth with his thumb.
>
> "No, she thinks you're saying 'wack,' like 'that's wack,'" I explain.
>
> "Wack, wacky, whacked, it's all the same word. This is an old word. I used to have an uncle named Wacky—what are you laughing at?" (*IKOAFS* 372)

I believe this short conversation is in the book specifically to make the reader consider how often people use derogatory language without thinking or indeed even knowing what it means or where the terminology originally came from.

4.1.3. Self-stigmatization vs. linguistic re-appropriation

One can definitely see instances in both novels where characters with a mental disorder use this kind of language to put themselves down, as a form of cruelty they think they deserve due to internalized prejudice, self-hatred and shame. However, there is also a second way in which people who have a mental disorder may use initially pejorative language. They sometimes seem to apply these terms in a positive way that marks group identity and pride. This reclaiming of oppressive language is widely known as "linguistic re-appropriation". Baglieri and Shapiro describe the phenomenon as "the ways that oppressed groups reappropriate hurtful language or negative characterizations of their features for their own use and meaning" (43). They further give some historical context from which to deduce linguistic appropriation for the field of disability studies and by extension the field of mental health. In analogy to the re-appropriation of the term "queer" for gays and lesbians from pejorative to positive, disabled persons have also started adopting terms such as "cripple" or "gimp" to identify themselves:

> Like the term, queer, terms that once referred to "despised distinctiveness," now refer to "celebrated distinctiveness" (Galinsky et al. qt. in Baglieri and Shapiro). […] In disability rights circles, identifying oneself as a "crip" is a testament to the struggle for rights and equity and a reminder of the damaging beliefs and attitudes still held by many. (Baglieri and Shapiro 43-44)

There are studies that show “taking possession of a slur previously used exclusively by dominant groups to reinforce another group’s lesser status” (Galinsky et al. 2020) could be beneficial for oppressed groups. Galinsky et al. investigated the effect of “self-labelling” and found out that this re-appropriation of derogatory terms by stigmatized groups helped individuals feel more confident, as others they interacted with perceived them to be “more powerful”. The results of the study further “suggest that self-labeling with a derogatory label can weaken the label’s stigmatizing force” within society (2020).

It’s Kind Of A Funny Story contains a scene in which Craig describes the relationship he has started with fellow patient Noelle to Aaron:

> “I met this girl in here—”
>
> “Oh yeah?”
>
> “Yeah, and she’s really screwed up, as screwed up as me, but I don’t look at that as an insult. I look at that as a chance to connect.” […]
>
> “People are screwed up in this world. I’d rather be with someone screwed up and open about it than somebody perfect and . . . you know . . . ready to explode.” (*IKOAFS* 397)

Craig refers to himself and Noelle as “screwed up”; but he tells Aaron that he does not see the term as demeaning in this context. In another scene Craig’s father uses the term “screwed up” to refer to people who go to the art school Craig wants to transfer to and Craig takes ownership of that label, even telling the reader he takes pride in it:

> “What art school are you going to go to?” Dad asks.
>
> “Manhattan Arts Academy? It’s easy to transfer to with my grades—”
>
> “Oh, but Craig, that’s the school for kids who are all screwed up,” Dad says.
>
> I look at him. “Yeah? Dad?” I raise my wrist, show him the bracelets. I have pride in them now. They’re true, and people can’t screw with them. And when you say the truth you get stronger. (*IKOAFS* 414-415)

Although Craig associates the use of the derogatory term with the values of truth and strength in this scene, thus implying empowerment through such re-appropriation, it is important to mention here that the lines between taking ownership of an oppressive label and demeaning oneself are blurry. Craig’s assessment of his own feelings is not always reliable or healthy, nowhere does this become more evident than when he tells the audience that his planned suicide “makes a lot of sense” (*IKOAFS* 134). He may

think the use of the words does not hurt him, but we cannot know if this is true in the long term, or even in this particular situation. In general, experts warn that "such self-labeling is controversial" as "many people fear that it reinforces existing stigma" (Galinsky et al. 2020). Linguist and slang expert Tony Thorne notes that "language reappropriation does carry a risk of misunderstanding and confusion — particularly in the case of loaded terms, or words still commonly used in a demeaning manner" (Thorne qt. in Gregoire).

The next section will focus on one of the most harmful, immediate, real-life consequences of such demeaning language use, namely "label-avoidance".

4.1.4. Lying, denying and covering-up or label avoidance

Because society's perception and treatment of those who have a mental illness is largely still so negative, and because the language used to refer to it is so deeply discriminatory, many people go to great lengths to hide their illness. They try "to avoid stigma altogether by keeping away from places where individuals are tagged mentally ill, perhaps most notably mental health clinics in their various guises" (Corrigan, Roe, and Tsang 1). This is called "label avoidance" and comes at a great cost for those affected. According to Corrigan, Roe and Tsang a majority of the individuals suffering mental disorders never even schedule a first appointment with a psychiatrist, for fear of the stigma, and what is more, over 60 % of the patients who have started treatment terminate it prematurely (1). "People distance themselves from mental health clinics, psychiatrists, and college counseling centers so they are not associated with the kinds of places that mean they are somehow mentally insufficient" (Corrigan, Roe, and Tsang 35).

Just as it does in the real world, the perceived stigma around mental health conditions drives our protagonists to stay silent about their problems over long periods of time. Often they do not communicate openly and honestly about what they think, how they feel, and which symptoms they are experiencing. Aza frequently lies to her mother in order to ease her worry. She, for example, lies to her after a substantial panic attack: "'How was your day?' 'Okay,' I said. […] 'Do you feel sick?' 'Just tired, I think'" (*TATWD* 134). The communication with her mother in times of great distress only gets worse as Aza becomes more and more evasive about her condition: "'You feeling anxious?' she said askingly. 'I'm fine,' I answered, and turned toward my room. […] When Mom

came in, a few minutes later, I pretended to be asleep so I wouldn't have to talk to her" (*TATWD* 160).

Aza keeps things from her friends as well, in order to seem more "normal" and to fit in. She pretends to be enjoying herself when she is in fact deeply anxious: "I tried to smile and shake my head at the right times […]. They laughed because something was funny; I laughed because they had" (*TATWD* 98). She also lies to Davis, and goes along with levels of intimacy she is not comfortable with, due to her anxiety disorder, thinking: "I didn't want his microbiota near me, but I let him keep his arm there, because I didn't want to seem like a freak" (*TATWD* 154). Essentially she finds herself constantly "forced to choose between lying and seeming weird" (*TATWD* 42).

Craig also tries to keep his condition a secret from his peers for as long as possible. He desperately does not want his friends and his teachers to find out about his stay on a psychiatric floor at a hospital, as he tells one of his doctors, during a discussion about the duration of his treatment:

> "*Thursday?* I can't wait until Thursday, Doctor. I have too much school. […] Plus, my friends…"
>
> "Yes?"
>
> "My friends will know where I am!"
>
> "Aha. Is this a problem?"
>
> "Yes!"
>
> "Why?"
>
> "Because I'm *here*!" (*IKOAFS* 240)

As a result of his shame, Craig keeps postponing important conversations with his teachers, the principal, and his friends, which in turn makes him feel even more anxious and ashamed. Perhaps even more problematically, Craig lies to his psychopharmacologist when asked about whether he hears voices.

> "Do you hear voices?" Uh-oh. Now we were getting into the real meat. Dr. Barney was cuddly enough, but I was sure that if you gave him a straitjacket he'd be able to handle it just fine, coaxing you into it and leading you to a *very comfortable* room with soft walls and a bench where you could sit looking at a one-way mirror and telling people you were Scrooge McDuck. […] I knew I had problems, but I also knew I wasn't crazy. I wasn't *shizo*. I didn't hear voices. Well, I heard that one voice, the army guy, but that was *my* voice, just me trying to motivate myself. I was not going to get thrown in the loony bin. "No voices," I said. Lied, technically. (*IKOAFS* 108)

Here readers get a glimpse of the special place within the prejudice against mental illness that is reserved for schizophrenia. According to Sartorius

> [s]chizophrenia as a syndrome is a paradigm of mental illnesses and the general public, when asked to describe a mentally ill person, invariably lists symptoms such as delusions and hallucinations – hallmarks of schizophrenia – as the defining features of a 'madman'. Stigma related to schizophrenia is more pronounced than the stigma attached to, say, anxiety states or dementia of old age. (39)

Hearing voices is immediately associated with the very stereotypical and highly outdated view, still perpetuated by horror movies, theme park attractions and TV shows, that psychological treatment means being confined to a cell and having to wear a straitjacket. This imagery induces fear and thereby forces Craig to keep one of his symptoms concealed.

Now that I have examined manifestations of stigma and their consequences in the books, it is time to explore what the chosen literature does to dismantle the flipside of this phenomenon, the trivialization, romanticization or glamorization of mental illness.

4.2. Counternarratives deconstruct romanticization and trivialization

Both John Green and Ned Vizzini put copious passages into their books which help dismantle harmful narratives of romantic suffering. At various points of each story, the narrators make sure readers understand that a mental condition is serious and not a quirky personality trait. Both books tackle the glamorization of mental illness or suicide by addressing common tropes and then cleverly subverting them, for example that of the "defective detective" (TV Tropes.com), meaning the idea that people with OCD would make particularly brilliant detectives, which John Green also criticized in his Q&A[22].

Because *Turtles All the Way Down* does contain a mystery element – a case which Aza needs to solve – she reflects on the faulty 'mental illness equals brilliant detective' narrative quite a lot:

> You hear a lot about the benefits of insanity or whatever – like, Dr. Karen Singh had once told me this Edgar Allan Poe quote: 'The question is not yet settled, whether madness is or is not the loftiest intelligence.' I guess she was trying to make me feel better, but I find mental disorders to be vastly overrated. Madness, in my admittedly limited experience, is accompanied by no superpowers; being mentally unwell doesn't make you loftily intelligent any more than having the flu does. So I know I should've been a brilliant detective or whatever, but in actuality I was one of the least observant

[22] See section 3.3.

> people I'd ever met. I was aware of absolutely nothing outside myself on the drive to Daisy's apartment building […]. (*TATWD* 132-133)

She sarcastically rattles off a plot that could have been inspired by formats such as *Sherlock Holmes* or *Monk* (both "defective detectives" according to TV Tropes.com):

> The arc of the story goes like this: Having descended into proper madness, I begin to make the connections that crack open the long-dormant case of Russell Pickett's disappearance. My dogged obsessiveness leads me to ignore all manner of threats […]. I focus only on the mystery […] and in finding the answer despite my madness, I simultaneously find a way to live with the madness. I become a great detective, not in spite of my brain circuitry, but because of it. I'm not sure who I walk into the sunset with […] but I walk into it. You see me backlit, […] holding hands with somebody. (*TATWD* 232)

Only to tell the reader straight afterwards "[Y]eah, no. That's not how it went down" (*TATWD* 233), shattering the romanticized imagery completely by contrasting it with her real experience: "What happened was relentlessly and excruciatingly dull: I lay in a hospital bed and *hurt*" (*TATWD* 233).

It's Kind of a Funny Story likewise offers many instances in which a glamorized or romantic notion of mental illness is debunked. Perhaps to combat the frequent glorification of cutting, Vizzini includes a passage in which Noelle shares her regrets about cutting her face and expresses her worry about never being employed because of the scars:

> I'll have scars for the rest of my life. I didn't know what I was doing. I just wanted to get off the world a little after this… this *thing*… and now I'm never going to be able to have a job or anything. What are they going to say when I go into a job interview looking like . . . (*IKOAFS* 366)

In addition to deconstructing glamorization, *IKOAFS* also explicitly addresses the problematics of trivializing attitudes towards mental illness. In another scene of the book Nia, who is depressed herself, reacts to the news of Craig's depression by shrugging off the seriousness of mental illness and stating how frequent the taking of psychotropic medication has become. Craig wants to make it clear that he is not a trend, and that his story is still personal.

> "Craig, like eighty percent of the people I *know* are on medication. For ADD or whatever."
>
> I knew too, but I didn't like to think about that. Maybe it was stupid and solipsistic, but I liked to think about *me*. I didn't want to be part of some trend. I wasn't doing this as a fashion statement. […] "Not that I'm the only one…just that it's a personal thing." (*IKOAFS* 119)

Yet, Craig himself also at times uses trivialization and idealization of his suicidal feelings – possibly as strategies of saving face and maintaining a distance to his problems – but maybe this is also indicative of how popular culture has framed his own view of depression. When questioned by his psychopharmacologist about suicidal thoughts, this is how Craig responds:

> "Well . . . I've had them for years. Just less intense. I thought they were, you know, just part of growing up." What was he so serious about? […] It's an option taken by a lot of successful people: Ernest Hemingway, Socrates, Jesus. Even before high school, I thought that it would be a cool thing to do if I ever got really famous. If I kept making my maps, for instance, and some art collector came across them and decided to make them worth hundreds of thousands of dollars, if I killed myself at the height of that, they'd be worth millions of dollars […]. [...] "I thought . . . you haven't really lived until you've contemplated suicide," I said. (*TATWD* 102-103)

Craig thinks suicidal feelings are simply part of adolescence and clearly associates coolness, fame and artistry with suicide, which is exactly the kind of trivialization and glamorization experts warned us about in section 3.3.

Ned Vizzini also dispels the notion that depression and suicide are romantic in the sense of making a good plot point in love stories. Nia's attraction to Craig grows when she finds out he is depressed. In her eyes, Craig's depression makes him more sophisticated and interesting. "'You're not like all these other people with their stupid little problems. You're like, really screwed up.' She giggles. 'In the good way. The way that gives experience'" (*IKOAFS* 345-346). In addition, Nia buys into the idea of a romantic savior narrative; the idea that we can be 'saved' from our problems by a love interest: "I thought that you got bad because of me. And I thought I could make you better" (*IKOAFS* 345). Most disturbingly, Nia seems to think Craig is a romantic hero for contemplating suicide and she deludes herself into believing Craig wanted to die because of his love for her. There is a powerful scene in which Craig corrects her, explaining that mental illness is infinitely more complex and multi-layered than the sting of an unrequited high-school crush.

> "You wanted to kill yourself over *me*?" […] "Craig, I'm so flattered."
>
> "No, you have the wrong idea. Don't be flattered."
>
> "How could I not be? I never had a boy want to kill himself for me before. It's like the most romantic thing."
>
> "Nia, *it wasn't about you.*"

"Are you sure?" […]

"*Yes. I have bigger problems than you.*" (*IKOAFS* 234-235)

What should be pointed out here, is that Craig himself at one point feels flattered when a girl calls him after she finds out he is depressed (*IKOAFS* 313) and also buys into the idea of love conquering all − even depression − believing that if Nia only were his girlfriend, he would no longer be depressed, thinking: "*This is a girl who can save me*" (*IKOAFS* 120-121).

Similarly, Aza questions why her romantic relationship with Davis does not miraculously solve her mental problems, apparently expecting that it would: "He's cute and smart and I like him, but I'm not getting any better, and I just feel like if this can't make me happy, then what can?" (*TATWD* 163). Fortunately, by the end of the novels, both narrators have arrived at much less glamorous, more realistic perspectives of mental illness; which leads me to the next section.

4.3. Counternarratives help overcome an idealized 'illness-to-cure' narrative

TATWD and *IKOAFS* address the faulty idealized pattern of narratives that represent mental illness as an obstacle or problem that can and will be overcome once and for all. This formula is certainly popular among many mainstream media, as it makes for the neatest way to a classic Hollywood-style "Happy Ending". Both novels' protagonists long and hope for this kind of resolution to their stories as well. Throughout the book Craig keeps waiting for the "big Shift" as he calls it (*IKOAFS* 239), essentially wishing for everything to simply go back to the way it was before his depression set in.

Readers are shown how Craig is always looking for "quick fixes" to his problems, such as asking his psychopharmacologist for a "fast-acting version" of Zoloft, because he refuses to accept that it will take the medication up to four weeks to get into his system (*IKOAFS* 111), or only wishing to stay on said drugs or in therapy for a minimal, insufficient amount of time. Audiences can also observe how Craig keeps expecting his therapist to act as some sort of "miracle worker" and trigger the Shift: "I'm waiting for her to say something profound. [...] I'm waiting for her to say 'Craig, what you need to do is X' and for the Shift to occur. [...] I'm waiting for the phrase that will invoke it" (*IKOAFS* 17).

I would argue that it is partially this thinking pattern that ultimately gets him into big trouble, when he simply stops taking his antidepressants because he feels a little better, thinking "the big Shift" has come and he no longer needs medication (*IKOAFS* 121-122). It is the realization that "the big Shift" might just be a fantasy, at least in the way he has originally envisioned it, that eventually helps him to get better. Instrumental in Craig's process of accepting that there is no magical cure for mental illness is hospital psychiatrist Dr. Mahmoud, who tells Craig that the goal of treatment for mental illnesses is not to find a cure at all: "Life is not cured, Mr. Gilner. […] Life is *managed.* […] We don't keep you here until you are cured of anything; we keep you here until you are stable – we call it 'establishing the baseline'" (*IKOAFS* 239).

At the end of Craig's hospital stay readers find out what this established baseline looks like. He makes it clear that just because he is discharged from institutional care does not mean he is suddenly free of depression. "I'm not better, you know. The weight hasn't left my head. I feel how easily I could fall back into it, lie down and not eat, waste my time […] go and get my bike and head to the Brooklyn Bridge. All of that is still there. The only thing is, it's not an option now. It's just … a possibility […]. It's not a very likely possibility" (*IKOAFS* 441).

Throughout his time in hospital, readers are shown smaller improvements to his condition, "partial shifts" as I would call them, realistic indicators of getting better, such as more honest communication, improved eating and sleeping, as well as finding an artistic outlet. Craig acknowledges these improvements as follows: "Something deep in my guts, below my heart, has made a shift to the left and settled in a more comfortable place. It's not *the* Shift, but it's *a* shift" (*IKOAFS* 236). I think the differentiation between definite and indefinite article, as well as upper- and lower case letters in Craig's reflection here can be interpreted as a certain willingness to accept a more un-idealistic mental health narrative, a readiness to think in small steps rather than pursuing the likely unreachable goal of "overcoming" depression.

Yet, on the very last pages, after Craig has left the hospital and the decision to transfer schools has been made, he describes himself feeling *the* Shift. "I haven't cured anything, but something seismic is happening in me. [...] I feel my brain on top of my spine and I feel it shift a little bit to the left. […] It's a huge thing, this Shift, just as big as I imagined. My brain doesn't want to *think* anymore; all of a sudden it wants to do"

(*IKOAFS* 441-443). While it is true that in this last part Craig sounds absolutely euphoric, his emotional state in the moment is tempered somewhat to a more realistic level by the immediately preceding statement which acknowledges that he has not cured his depression. Even at his most optimistic, Craig does not lose himself again in the trap of feeling he is somehow "finished" with the chemical imbalance in his brain. In my opinion this shows a considerable amount of personal growth and self-reflection on his own mental health narrative.

Aza equally contemplates her narrative of mental illness, frequently contrasting what she thinks society informed by popular culture would like to hear versus what she truly experiences. She, for instance, ponders what would be the socially desirable answer to her therapist's routine question of how she was doing: "The whole way up, I thought about what I'd say to Dr. Singh. […] I wanted to tell her that I was getting better, because that was supposed to be the narrative of illness: It was a hurdle you jumped over, or a battle you won. Illness is a story told in the past tense" (*TATWD* 85).

She once again highlights the impact narratives in popular culture have made on her story with mental illness and the pressure she feels to give answers that conform to these narratives in this scene: "'Do you feel like you're getting better?' Everyone wanted me to feed them that story – darkness to light, weakness to strength, broken to whole. I wanted it, too" (*TATWD* 253). Aza even explicitly reflects on the idea of a happy ending towards the end of the novel, saying: "The problem with happy endings [...] is that they're not really happy, or not really ending, you know? In real life some things get better and some things get worse. And then eventually you die" (*TATWD* 276). In this more realistic version of a narrative, progress is not always linear and neat; symptoms recur, for instance when Aza finds herself re-opening the cut on her finger, as part of her ritual, after the wound had already healed (*TATWD* 280).

Towards the end of *TATWD* Aza finally learns to accept that her illness is not an entity she can extract or remove to become her true "healthy" self: "I would always be like this, always have this within me. There was no beating it. I would never slay the dragon, because the dragon was also me. My self and the disease were knotted together for life" (*TATWD* 280). The expression of slaying the dragon serves both as

a metaphor[23] as well as an allusion to the common trope or story resolution used in fairy tales, movies, video games, etc. of a hero defeating the ultimate enemy and then living happily ever after. Aza does not live happily ever after but she does improve: "Over the next few months, I kept going. I got better without ever quite getting well. Daisy and I started a Mental Health Alliance […] even though we were the only two members […]" (*TATWD* 281). Apart from self-acceptance I think we can also observe here a real sense of agency over one's own fate or mental health journey. This can be compared to Craig's plan to volunteer at the psychiatric unit of the hospital once he leaves (*IKOAFS* 392), as well as both characters' willingness to stick to their treatment plans.

This sense of agency is especially important for Aza, who has previously likened her lack of control over her intrusive thoughts to being a character in a narrative she did not get to write: "I felt like […] my whole story was written by someone else" (*TATWD* 106), "I think I might be a fiction" (*TATWD* 165), "I am a story they're telling. I am circumstances" (*TATWD* 166). This mindset eventually changes to a more optimistic outlook on her future, but, like Craig, Aza tempers any overenthusiastic utterances regarding her mental state. She informs the reader that she feels "okay much of the time" and that there are now "[f]our weeks between visits to Dr. Singh" (*TATWD* 283). To her, this is what getting better means.

After analyzing Aza's and Craig's stories, I was interested in comparing them to the plot pattern Diane Scrofano regards as typical for mental health related YA novels. According to her, many of these stories share the same formula:

> First, there is the hiding of the mental illness, the denial that help is needed, the fear of what will happen if others find out. Then, there is a climax or crisis point where the illness can no longer be hidden or ignored. Finally, the story is resolved with a diagnosis or care prescribed; this might be seen as a sort of happily ever after. (Scrofano 18)

In my opinion, *IKOAFS* and *TATWD* both definitely fit elements of this pattern, such as the characters' denial of the severity of their symptoms or the act of hiding them in front of friends and family, the crisis-followed-by-hospitalization "arc", as well as the

[23] whose role will be discussed in depth in section 4.4.3

resolution that comes with self-acceptance of one's illness and improved treatment plans that give an optimistic outlook towards the ending of both stories.

However, there are also aspects in each story that deviate from the conventions Scrofano has observed. For example, both Craig and Aza are already in treatment and on medication as the story begins, thus enforcing the fact that generally people do not suddenly wake up with a mental illness that leads to a crisis and then quickly get over it, but rather that there is a disposition and a certain neurological likelihood of developing a mental condition and typically symptoms will manifest themselves gradually over time, making diagnosis and recovery a long and ongoing process. This depiction makes the books already fit in with Scrofano's recommendation that future literature needs to reflect the medical community's understanding of mental illness as a "chronic condition", and should thus focus on the concept of "recovery" instead of "cure" (19).

Another suggestion Scrofano gives is that books should not end with a prescribed treatment, but should rather "focus on […] life after diagnosis and treatment", exploring questions such as "How do the families and the patients adjust?" (18-19). While I would argue Craig's story somewhat ends with Scrofano's idea of a "happily ever after" because it finishes with the day of his hospital discharge, Aza's story gives us more of an explicit glimpse into her future. She tells readers that "she would grow up, have children and love them, be hospitalized, get better, and then get sick again" and "go to college, find a job, make a life, see it unbuilt and rebuilt" (*TATWD* 285). This prospect equally shows us her successes as well as the fact that she will get worse again, then better again, then worse again, as part of her story. And while the reader might have wished the protagonists a perfect "happily ever after", because he or she has been feeling for them and empathizing with their struggles every step of the way, ultimately I think audiences will come to realize that this type of closure is more truthful and therefore more satisfying. But what is it exactly that makes us sympathize with the mental health struggles of the narrators in the first place? The next sections will aim to answer this question.

4.4. Counternarratives help foster empathy

In section 4.1.2. I have already quoted a scene from *TATWD* in which Dr. Singh explains the correlation between the difficulty of truly demonstrating or articulating one's pain to another person and encountering stigma and a lack of compassion from others as a result. In Aza's own words: "Nobody gets anybody else, not really. We're all stuck inside ourselves" (*TATWD* 244). However, while it may not be possible to access someone else's pain first-hand, readers of *TATWD* and *IKOAFS* are given plenty of tools and opportunities to develop empathy for the protagonists. I want to analyze some of the literary strategies employed by the authors to trigger such understanding and sympathy in more detail in the following subsections. First, however, I need to briefly contextualize this analysis within the empirical field of empathy studies.

4.4.1. Empathy studies or how reading fiction can improve affective Theory of Mind

Empathy studies concern themselves with the link between texts and "readers' emotional responsiveness" to them (Keen 127). For this investigation the phenomena of "character identification", "role-taking or perspective-taking imagination" are examined, as well as the "textual cues" that would encourage such "experiences of emotional fusion with literary texts" (Keen 126). There is much debate within the field of empathy studies as to whether or not the empathy one feels for another living human being is the same as "literary empathy" (Keen 127), and whether reading literary fiction can actually foster altruistic behavior by helping readers develop "sympathetic imagination" (Keen 133), causing them to establish a link between the lives of fictional characters and the plights of actual people "that share their real world" (Keen 131).

To contribute to this discussion, Comer Kidd and Castano conducted five experiments to affirm their hypothesis that "reading literary fiction led to better performance on tests of affective ToM [Theory of Mind]", which refers to "the ability to detect and understand others' emotions" (377). They emphasize that their results of temporarily enhanced affective ToM in test subjects' scores were true for only those participants that had read literary fiction, as opposed to non-fiction, because according to their research, "literary fiction [...] uniquely engages the psychological processes needed to gain access to characters' subjective experiences" (378). Comer Kidd and Castano argue that since these experiences do not always resemble what an audience is used to from

their own lives and the regularly applied “social scripts” they encounter in them, “[r]eaders of literary fiction must draw on more flexible interpretive resources to infer the feelings and thoughts of characters. That is, they must engage ToM processes” (378).

One implication of Comer Kidd and Castano’s research is the question of whether the ongoing engagement with literary fiction helps us “promote and refine interpersonal sensitivity” and over the course of our lives turns us into more empathetic, kinder human beings (377). Like Keen, I find the idea that “fiction-reading alone” would “permanently [...] shift a reader’s disposition” improbable (133), however, Comer Kidd and Castano have provided evidence that leads me to believe that engaging with literary fiction can promote empathy, thus bearing the valuable potential of helping to reduce stigma and prejudice, transform attitudes towards marginalized groups, as well as affect the way we treat others as a result[24]. Comer Kidd and Castano go on to address how this perceived link between reading fiction and increased affective ToM is already being applied to various kinds of social welfare programs, for instance in the field of medicine or the penal system (380). I will explore another area of application in section 5, by discussing the incorporation of mental health related YA fiction in the English literature classroom.

Before that, we need to ask ourselves what it is about a text that invites emotional engagement with characters’ feelings in the first place. To answer this question we must look for the devices that “set literary fiction apart from non-fiction” (Comer Kidd and Castano 380). According to Keen (127), “[n]arrative empathy overarches narratological categories, involving actants, narrative situation, matters of pace and duration, and storyworld features such as settings”, meaning authors who seek to arouse empathy in their readers have a variety of techniques at their disposal to do so. Comer Kidd and Castano claim that it is through the skilled employment of those “phonological, grammatical, and semantic stylistic devices” that fiction has the potential to “unsettle readers’ expectations”, “challenge their thinking” and ultimately “change *how*, not just what, people think about others” (377; emphasis added).

[24] A belief that Keen also shares, see 133.

The following subsections will take a closer look at some of those devices employed in *TATWD* and *IKOAFS*, and discuss their potential effects on the reader, beginning with the stylistic choice of point-of-view switches in the narration.

4.4.2. Effect of stylistic choices: POV switches

For the larger part of both novels, the authors rely on first-person narration, allowing readers to experience the viewpoint of the protagonists along with their thoughts and feelings. However, observant readers will notice that the first-person pronoun "I" occasionally shifts to the second-person pronoun "you" in certain parts of the narrative. In fact, *IKOAFS* starts with this second-person narration in the opening sentence. "It's so hard to *talk* when you want to kill yourself. […] it's a physical thing, like it's physically hard to open your mouth and make the words come out. [...] So you just keep quiet" (*IKOAFS* 3). This introduction directly catapults the reader into Craig's mindset at the beginning of his story and I would argue the use of the pronoun "you", especially in the part of the sentence "you want to kill yourself" functions to shock readers by "inserting" their being into such a jarring thought and painful context right away.

TATWD equally describes some of the main character's most grueling thoughts and experiences using the pronoun "you". For instance, chapter twenty is told entirely in the second-person. In it, readers are shown the immediate aftermath of Aza's crisis point, i.e. drinking hand sanitizer despite knowing how harmful it would be after her liver had already been lacerated during the car crash preceding this event (*TATWD* 181). Readers are pulled into Aza's hospital experience via the use of the second-person pronoun: "The next morning, you wake up in a hospital bed, staring up at ceiling tiles. Gingerly, carefully, you assess your own consciousness for a moment, *You wonder, Is it over?* [...] Your body hurts." (*TATWD* 230-231)

I would say that through the use of the second-person, these passages can trigger a full-on immersion into the darkest parts of the characters' lifeworlds better than reading them from the character's first-person perspective ever could have. According to Monika Fludernik, "second-person fiction", meaning a "narrative which uses a pronoun […] of address in reference to the main protagonist of a story" ("Category of Person" 105), can have a "disorienting" effect on audiences because it blurs the boundaries of

"fact vs. fiction" (101), by pulling the real-world reader into a fictional realm, and thus potentially increasing identification and empathy, often through the function of the "generic you" (113), whereby the reader understands the pronoun "you" to stand in for "'one,' 'anyone,' therefore: 'possibly, me'" (106). Adding even more to the "unsettling" (Fludernik "Second Person Fiction" 232) quality of this use of the second-person in the novels, I think, is its combination and alternation with the use of the first person.

Because these pronoun shifts are dispersed through several parts of the books, especially in *TATWD*, they can serve to break up expected patterns[25], adding a sense of immediacy to a scene whenever the reader is at risk of becoming too comfortable watching events unfold from a more distanced point of view. I believe the use of the second person can be interpreted both as a direct address, as if in conversation with the main character[26], but also as an imperative, a prompt or call to action on the audience's part to put themselves into the narrators' shoes, to imagine what a particular situation, such as being hospitalized or rendered unable to speak by one's own anxiety or depression, must feel like to the characters, and in the larger context a real person with a mental health condition.

But even if readers feel this pull, this urge to adopt the protagonist's point-of-view, without a personal frame of reference for the symptoms of obsessive compulsive disorder or depression, it may still be difficult to respond on a deeper emotional level. The challenge both Vizzini and Green faced in the conception of their stories was to explain the impact of what Aza and Craig are going through to someone who has not felt the same symptoms. This is where the rhetorical figures of metaphor, simile and personification come in.

4.4.3. Effect of stylistic choices: Metaphor/Simile

TATWD and *IKOAFS* are rich with imagery that mental illness or a specific symptom of a mental disorder are being compared to in order to establish new ways of relating

[25] See also Fludernik ("Category of Person" 117), where readers' expectations of pronouns being "safely confined within the realms of fiction" are addressed.
[26] See also Fludernik's discussion of the second person in "conversational storytelling" ("Second Person Fiction" 231).

to and understanding those conditions. The most frequently used image in both books is that of a "spiral" or the sensation of spiralling. Aza sometimes calls it a "whirlpool" which "shrinks and shrinks and shrinks your world until you're just spinning without moving" (*TATWD* 150) and although Craig mentions the word "spiral" explicitly too (*IKOAFS* 14), he more commonly refers to the sensation of spiralling as "the Cycling" explaining to Dr. Barney what this means: "Going over the same thoughts over and over. When my thoughts race against each other in a circle. [...] [T]houghts of what I have to do. Homework. And it comes up to my brain and I look at it and think 'I'm not going to be able to do that' and then it cycles back down and the next one comes up" (*IKOAFS* 105). In each case the notion of thoughts "spiraling" out of control is highly prevalent in the stories when it comes to the characters trying to describe the effect of obsessive, anxious and intrusive thoughts.

Aza tells the reader that the spiral stands for more than just the idea of being engulfed or carried away by something external, it stands for something happening deep inside herself: "I knew what it was like to be *in* a feeling, to be not just surrounded by it but also permeated by it […]". When my thoughts spiraled, I was *in* the spiral, and of it" (*TATWD* 150). I would argue that this inseparability of the self from her obsessive thoughts is also reflected in the notion that a spiral is infinite, or as Aza says: "The thing about a spiral is, if you follow it inward, it never actually ends" (*TATWD* 7). For the majority of the book it feels to me as if Aza is trying to reach the end of the spiral, by looking to define her "real" self and find out who she is apart from her circumstances – what she would be like without her OCD, how to be "normal", who she is when she is taking her medications, who she is when she is not taking them. Finally Daisy tells her an anecdote about an argument between a scientist and an old lady who claims "the earth is a flat plane resting on the back of a giant turtle" (*TATWD* 245). When asked by the scientist what that turtle was standing on, the woman replies that it was standing on another turtle, that it was in fact "turtles all the way down"(*TATWD* 245). By saying "You're trying to find the turtle at the bottom of the pile, but that's not how it works" (*TATWD* 245), Daisy is trying to tell Aza that OCD is part of her, and that there is no extractable or improved essence of self without it that she needs to go look for.[27]

[27] This also connects to the ideas of realistic happy endings and there being no "cure" for mental illness discussed in section 4.3.

The spiral could also refer to the mental image of something “tightening” around and “pulling” at our protagonists against their will until they feel helpless and completely immersed in a thought to the point of being unable to think about or do anything else. Connected to this imagery of pulling and tightening, I would say, is Craig’s usage of the term “Tentacles”, which is his way to describe responsibilities that cause him tremendous anxiety, or as he calls them “the evil tasks that invade my life” (*IKOAFS* 14). Opposite to those “Tentacles” are Craig’s “Anchors”, which he identifies as anything that makes him “feel good temporarily” (*IKOAFS* 15). Throughout the book Craig is looking for suitable Anchors, and discusses his ideas of potential ones with Dr. Minerva. She cautions him against seeing his romantic relationship to Noelle as an Anchor (*IKOAFS* 309), and encourages him to start seeing arts as an Anchor instead (*IKOAFS* 391).

What is interesting to me here is that Dr. Minerva readily accepts and operates with the metaphors Craig likes to use, and upon comparing this aspect with *TATWD*, I found that Dr. Singh likes to do the same for Aza. This allows the narrators to discuss their experiences with mental illness on their own terms but it also helps them think about the possible deeper meanings and implications of the language they are using themselves. After Dr. Singh comments on Aza’s frequent use of metaphor and discusses the challenges of expressing pain through language (*TATWD* 89), Aza starts reflecting on the reasons behind the mental imagery she evokes in relation to her symptoms and overall mental state. “The words used to describe it—despair, fear, anxiety, obsession—do so little to communicate it. Maybe we invented metaphor as a response to pain. Maybe we needed to give shape to the opaque, deep-down pain that evades both sense and senses” (*TATWD* 231).

Another image Aza uses to express her pain is that of being stuck in a prison cell. Only she tells the reader that she is “not *in* a prison cell” but rather that she herself *is* the prison cell (*TATWD* 150). Once again this highlights the notion that she cannot simply extract herself from her mental illness, as a separate entity. Like the previous metaphors it also addresses the lack of control by referring to the idea of being held somewhere against one’s will. Additionally, it speaks to the notion of confinement and isolation, which I would argue is something both protagonists experience frequently, in that they feel their mental illness holds them back and keeps them from truly

connecting with their peers, doing their schoolwork successfully or tackling other everyday tasks and life experiences.

Aza and Craig often frame the struggle for control over their thoughts, the lack of which was articulated by the previous metaphors and similes, through another set of images which are all connected to the idea of a fight. Aza mentions the phrase “slaying the dragon” to express the idea of overcoming her OCD (*TATWD* 280), and Craig uses the terms “Battle” and “Slaughter” to explain his deteriorating and increasingly unstable relationship with food as a result of his depression (*IKOAFS* 33). He further explicitly labels his struggle with a mental disorder as a “war” he is fighting in his own head (*IKOAFS* 287). What these terms have in common is that they all refer to a fight with very high stakes, “kill or be killed situations” so to speak, and that they all imply the presence of an antagonist. Somebody our narrators are fighting *against*.

4.4.4. Effect of stylistic choices: Personification

The figure of speech that lends itself to representing this antagonistic force our heroes must battle is that of personification. Craig articulates his inability to eat or keep food down by introducing the visual of a man with a rope.

> My stomach shrank or something; [...] It’s like a gnawing, the tug of a rope wrapped around the end of my esophagus. There’s a man down there and he wants food, but the only way he knows to ask for it is to tug on the rope, and when he does, it closes up the entrance so I can’t put anything in. If he would just relax, let the rope go, I’d be able to give him all the food he wanted. But he’s down there making me dizzy and tired [...]. (*IKOAFS* 33)

It seems that reasoning with this figure, willing the man to relax, is impossible. In the same vein, Aza is struggling to reason with her inner voice. This voice is not assigned a persona as such, but it is given an easily recognizable stylization throughout the novel (italics and capital letters whenever it becomes increasingly loud and insistent), as well as typical characteristics a human adversary could have, like hostility, the use of demeaning language, and significant destructive power over the protagonist. Readers see Aza pleading back and forth with her inner voice to leave her be, but frequently the inner voice wins out and forces Aza to engage in obsessive checking and cleansing rituals, like in this scene, in which the inner voice is interspersed with

Aza's more rational pleads and counter-arguments for reasons not to drink hand sanitizer.

> *You know how to deal with this*. […] *you're just going to sanitize your hands and your mouth* please fucking think about something else [...] it'll just make me barf *you'll be clean* […] the doctor said stay in bed and the last thing I need is a surgery […] *wheel your IV cart to the front of the room* please *and you will pump the hand sanitizer foam* […] *and you will put that foam in your mouth* […]. But that stuff has alcohol in it that my damaged liver will have to process *DO YOU WANT TO DIE OF C.DIFF* no but this is not rational *THEN GET UP AND WHEEL YOUR IV CART TO THE CONTAINER OF HAND SANITIZER MOUNTED ON THE GODDAMNED WALL YOU IDIOT*. (*TATWD* 227-228)

This deeply spiteful voice may be a facet of a character Aza sometimes refers to as "the demon". Not only does she think of herself as having to "cohabitate" with this ultimate embodiment of evil (*TATWD* 128), at a later point she actually describes herself as being "possessed" by this demon (*TATWD* 227), and when she is at her most vulnerable and self-destructive, she adopts the mindset that she herself actually *is* the demon (*TATWD* 229). This use of personification is a great example for the way Aza vilifies her mental illness and by extension herself. It also connects to the crucial point I made in section 3.1, in which I highlighted that while the paradigms around the etiological theories of mental illness have shifted over the course of history, the dark supernatural forces once associated with mental disorders can still influence and find representation in our thoughts and language today.

The last persona I would like to inspect more closely is Craig's inner voice. Like Aza's voice, it is stylized in italics throughout the novel, but unlike Aza, Craig has explicitly named his voice: "the army guy". This character can be compared to a drill sergeant in that he calls Craig "soldier", makes frequent references to "war", or "the enemy", and berates Craig for his lack of discipline and laziness (*IKOAFS* 99). Similar to Aza's inner voice, the sergeant can be extremely volatile, but Craig reflects on this persona stating that it is really just his own voice, trying to motivate himself (*IKOAFS* 108). I find this persona the most compelling of all because of its total ambiguity. Unlike the previous personas or voices, it is hard to tell whether "the army guy" is fighting with our protagonist or against him. He threatens Craig "*How about I pump you full of lead, soldier"* (*IKOAFS* 29), puts him down *"Great, soldier, now you're depressed and in the hospital and a drug addict"* (*IKOAFS* 260), but also tells him that he is smart and needs to keep fighting the "enemy" (*IKOAFS* 29). The "army guy" encourages Craig to follow

through with his suicide plan after talking to his sister has raised doubts in him: "*Don't let that distract you, soldier. [...] You've made your decision and you're sticking to it [...]. [...] [Y]ou gotta do what you gotta do, and sometimes you gotta commit hara-kiri, ya know?"* (*IKOAFS* 129), only to tell Craig he is proud of him for not jumping just three chapters later: "*Good job out there. I'm glad you're still on board*" (*IKOAFS* 161). Further along into the story he praises Craig for "*making gains"* as an acknowledgment of his improving condition (*IKOAFS* 287). To me the army sergeant's ambivalence symbolizes first and foremost the emotional roller coaster Craig's depression and his symptoms put him through. The low points of self-hatred, shame and resignation are intertwined with the highpoints of small gradual successes and sometimes bigger motivational milestones that bring hope of getting better.

It is worth pointing out that towards the end of both *TATWD* and *IKOAFS*, the personas or voices appear less and less often, seemingly fading out over the last few chapters. Perhaps this is indicative of the characters' improved condition, at least for the moment, or perhaps their frequency of appearance decreases because the authors felt before the stories could reach their conclusion other elements such as changes in relationship dynamics and communication patterns with family and friends, as well as the establishment of realistic goals, needed to be given more space, while the rhetorical figures of personification had already served their purpose in the narratives, namely to make the agony of mental illness more tangible.

4.4.5. Effect of stylistic choices: References to the visual arts

After analyzing all the ways language can be used to evoke mental images and thus create opportunities for readers to relate to the main characters, I also want to address the importance both authors place on the visual arts within their stories, both receptively, as a way for characters to identify and work through pain that cannot be verbalized, as well as actively, as a creative outlet for a person struggling with mental illness themselves.

When visiting Davis' house, Aza notices a painting by Raymond Pettibon.

> I found myself pulled toward the painting [...]. It was a colorful spiral, or maybe a multicolored rose, or a whirlpool. By some trick of the curved lines, my eyes got lost in the painting so that I kept having to refocus on tiny individual pieces of it. It didn't feel

> like something I was looking at so much as something I was part of. I felt, and then dismissed, an urge to grab the painting off the wall and run away with it. (*TATWD* 100)

From the moment she sees it, Aza deeply connects with this painting, and she keeps thinking about it, as well as trying to use it to calm her thoughts during her crisis point by refocusing on it: “Can’t stop thinking. Trying to find something solid to hold onto in this rolling sea of thought. The spiral painting” (*TATWD* 225). On the penultimate page of the book readers learn that Davis has gifted the painting to Aza, and that it would “follow [...] [her] from one apartment to another and then eventually to a house” (*TATWD* 285).

I think the incorporation of the painting into the storyline serves two purposes. Firstly, I want to address the symbolism behind Davis’ act of gifting the painting to Aza. Davis may not always be able to relate to what Aza is going through or understand, for example, why she feels she cannot kiss him or be his girlfriend, but he cares for her deeply, and in giving her the painting, he acknowledges that her feelings and her experience are as valid and real as the piece of art she associates with them.

Secondly, the introduction of the painting and Aza’s reaction to it re-address the idea that language is what Dr. Singh has called the opposite of pain (*TATWD* 89) because it cannot accurately describe and speak to everything Aza is going through. It is imprecise and imperfect, and Aza often experiences moments where she is unable to speak, and becomes frustrated and desperate with the use of metaphors to articulate her inner turmoil as for example in this scene shortly before her crisis point:

> Nothing worked. [...] I returned to a question Dr. Singh had first asked me years ago, the first time it got this bad: *Do you feel like you’re a threat to yourself?* But which is the threat and which is the self? I wasn’t *not* a threat, but couldn’t say to whom or what, the pronouns and objects of the sentence muddied by the abstraction of it all, the words sucked into the non-lingual way down. […] Felt myself slipping, but even that’s a metaphor. Descending, but that is, too. Can’t describe the feeling itself except to say that I’m not me. (*TATWD* 211)

In a true and tangible sense words *fail* her here, as they do Craig, so frequently in fact, that he no longer speaks up in class (*IKOAFS* 40-41) and his friends have labelled the instances in which he withdraws from them and does not speak over extended periods of time “Craig zone” (*IKOAFS* 5). I would say the visual arts seem to “step in” here to fill a gap and express what language cannot.

Craig begins to actively express himself through art after a recreational art therapy lesson reawakens a passion for drawing he once had. He begins to draw maps, but rather than depicting places in the outside world, like he frequently used to do as a child, he starts to draw his so-called "brain maps", after another patient interprets one of his maps accordingly.

> "Is that somebody's *brain?"* Ebony asks. […] I see how it *could* look like a brain, like if all roads were twisted neurons, pulling your emotions from one place to another, bringing the city to life. A working brain is probably a lot like a map, where anybody can get from one place to another on the freeways. It's the nonworking brains that get blocked, that have dead ends, that are under construction like mine. (*IKOAFS* 292)

The negativity in this last part mentioning the "nonworking" brains is later overthrown when Craig designs personalized brain maps as his parting gift to all the people he met while hospitalized. The artwork illustrates the uniqueness of each individual's mind, focusing on positives and beauty rather than on problems or deviations from what is considered "normal".

> Highways, that's what Armelio has in his head […]. He doesn't have any quiet little streets or parks […]. The highways hardly even connect because Armelio doesn't mix up his thoughts; he has one and does it and then moves on to the next. It's a great way to live. (*IKOAFS* 400)

> Inside Humble's head is industrial chaos.I don't make any small blocks, just big ones […] Then I splash it with highways, erasing the streets and putting them over the top, [...] making the whole thing look violent and random, but also powerful and true—the kind of mind that could come up with some great stuff if you harnessed it right. (*IKOAFS* 403)

Toward the end of the novel, Craig shows his brain maps to Dr. Minerva and through her prompting reveals that this art and its process of creation make him feel successful, happy and enable him to tackle stressful situations (*IKOAFS* 383-391). It occurs to Craig that art can be his "Anchor" and in a revelation of considerable proportion, Craig is made to see that he does not, in fact, need to continue going to the competitive school that causes him so much anguish, that he can actually pursue a different life, and that art will play a major role on this new path.

Readers are faced with just how important art is to Craig and his well-being when he explains his desire to transfer to Manhattan Arts Academy to his parents by openly stating "[t]his is something I *love*" (*IKOAFS* 415). His father raises concerns about the life of an artist being "hard" and says "[i]t's mostly the artists who end up in places like" the psychiatric floor (415), but in the end both parents come to accept Craig's decision.

They may not always understand, they may not always agree but they are willing to support Craig in doing whatever he can and feels is right to improve his mental state.

This leads into my next section, in which I will analyze how the two novels explore the attitudes and behaviors of friends and family towards the protagonists' mental illness, and point out some of the lessons readers can learn by following those characters' journeys of discovery on how to be supportive as an outsider.

4.5. Counternarratives show how others can be supportive

Right from the start of both stories, readers are shown how families and friends are equally concerned and frequently helpless in dealing with the protagonists' mental health problems. We see several characters actively struggling to understand what the narrators are going through, saddened or exasperated by their own inability to aid them. Daisy, for instance, tells Aza "I wish I understood it" (*TATWD* 244) several times in the book, trying to figure out a way to improve the situation: "Like, does it help to be reassuring or is it better to worry with you? Is there *anything* that makes it better?" (*TATWD* 131), sometimes getting frustrated by the knowledge that Aza cannot answer those questions herself either. Throughout *TATWD* Aza's mother is shown to be in a perpetual state of worry. Her way of coping with those fears is checking in on her daughter's state of mind as much as possible, veiling her questions as statements after the therapist tells her not to ask too many questions, because it puts too much pressure on Aza: "[M]y mother hovered, perpetually near, breaking the silence every few minutes with a question-phrased-as-a-statement. Each day is a little better? You're feeling okay? You're improving? The inquisition of declarations" (*TATWD* 236). Her worry makes Aza feel increasingly guilty, as we can observe in this altercation:

> "I need you to be well, Aza. I can't lose–"
>
> "God, Mom, please stop saying that. I know you're not trying to make me feel pressure, but it feels like I'm *hurting* you, like I'm committing assault or something, and it makes me feel ten thousand times worse. I'm doing my best, but I can't stay sane for you, okay?'" (*TATWD* 247)

Craig also feels guilty for the way his mental illness impacts his family, listing all the ways they have tried to help him: "My parents are always looking into new ways to fix me. They've tried acupuncture, yoga, cognitive therapy, relaxation tapes, various kinds

of forced exercise […], self-help books, Tae Bo, and feng shui in my room. They've spent a lot of money on me. I'm ashamed" (*IKOAFS* 38).

Audiences learn here that even the most loving family will struggle to come to terms with and understand an individual's mental illness. While Craig's mother gets emotional, for example crying when he vomits up a meal (*IKOAFS* 46), or blaming herself for not noticing his acute suicidality – "No. No! *I'm* sorry. I was sleeping! I didn't know!"- (*TATWD* 168), Craig's father loses his patience, for instance, during a scene in which he articulates his difficulty of empathizing with Craig's problems of no longer being able to speak up in class.

> "What do you mean you couldn't talk?" Dad asks. […] "Craig, you can't keep doing that." [...] "When you know the answer to something, you have to speak up for yourself; how can that not be clear?" [...]
>
> "Don't jump on him," Mom says.
>
> "I'm not, I'm being friendly." Dad smiles. (*IKOAFS* 40-41)

A supportive environment does not, cannot, instinctively and fully comprehend all the intricacies of someone else's brain, but there are things we can learn from the way the secondary characters behave towards the protagonists. Firstly, the importance of having a family environment that does not stigmatize psychotherapy and psychotropic medication, but instead encourages this treatment, and offers financial resources to enable it, if possible. During Craig's first meeting with his psychopharmacologist, the doctor questions him about his family:

> "Your family supports you coming here?"
>
> "When I told them about it they didn't waste any time. They say it's a chemical imbalance, and if I get the right drugs for it, I'll be fine." […] "They'll sign everything. They want me to get better."
>
> "Supportive family environment," [...]. He turned and gave his version of a smile, which was a slight affirmative [...]. (*IKOAFS* 104-105)

I think Dr. Barney's smile serves as a small indicator of how crucial a supportive family, that is unbiased towards the use of medication, is in the recovery of a person with a mental illness. Readers are further reminded of this when other patients tell Craig just how lucky he is to have a safe environment to be discharged into, seeing as they do not (e.g. *IKOAFS* 221-222). According to a study by Aldersey and Whitley, family environment is a very important contributing factor to a patient's mental health

recovery story. Family has the capacity to facilitate recovery by offering “moral support”, “practical support” and “motivation to recover” (467). However, family can also hinder recovery through, for example, “acting as a stressor” by making an individual feel guilty, or “displaying stigma and lack of understanding” (Aldersey and Whitley 467), which is why I commend Vizzini’s and Green’s construction of multi-layered sub-plots and characters that showcase the significance of family and peer relations for the main characters’ health improvement.

Equally important as supporting the initial sign up for treatment is the praise of successes and progress along the way. Craig’s mother and father make sure to verbally acknowledge his steps towards recovery, such as his ability to finish a meal, for the first time in a long while.

> “Son, that is a big one,” Dad gets up and shakes my hand.
>
> “No, it’s not, […] everybody does it, but for me it’s like a stupid triumph –”
>
> “No,” Mom says, looking me in the eyes. “What’s a triumph is that you woke up this morning and decided to *live. That’s* a triumph. That’s what you did today.” (*IKOAFS* 226)

In a similar scene Craig’s mother commends his act of reaching out to a suicide hotline: “I am so proud of you. [...] This is the bravest thing you’ve ever done. [...] This is the most life-affirming thing you’ve ever done. You made the right decision. I love you” (*IKOAFS* 169).

Sometimes characters use less kind and compassionate language than in these previous examples and end up hurting the main characters. Both books offer scenes in which conflicts featuring the use of insensitive language are resolved, because the characters guilty of causing them apologize for their actions. Daisy apologizes for her characterization of Ayala, as well as for ranting about Aza being “stuck” in her head (*TATWD* 140), and Aaron apologizes for his angry outburst at Craig, admitting he was most likely “projecting” his own mental health issues onto him (*IKOAFS* 297). Craig also has a confrontation with his father about the latter’s sometimes insensitive use of humour as a coping mechanism to make light of Craig’s depression.

> I look at him."That’s really not that funny.”
>
> “What? Oh, sorry,” he says.

> “No, Dad, seriously. It’s not … I mean, this is serious business.”
>
> “I’m just trying to lighten the mood, Craig—”
>
> “Well, that’s what you’re always trying to do. Let’s just, not do it here.”
>
> Dad nods, looks me dead in the eyes; slowly and regretfully, he banishes all the smiling and joking from his face, and for once he’s just my dad [...]. (*IKOAFS* 224)

This last scene is also a great example for the open communication and negotiation that need to take place between a person with a mental illness and their network about how to approach this subject, what language to use, what to do/say, what not to do/say, as this likely varies from individual to individual. Aza and her mother also come to an agreement, regarding their style of communication when Aza finally addresses the discomfort her mother’s frequent use of questions causes her.

> “You feeling anxious?”
>
> “Is there any way we can make a deal where I tell you when I have a mental health concern instead of you asking?”
>
> “It’s impossible for me not to worry, baby.”
>
> “I know, but it’s also impossible not to feel the weight of that worry like a boulder on my chest.”
>
> “I’ll try.”
>
> “Thanks, Mom. I love you.”
>
> “I love you, too. So much.” (*TATWD* 272)

These negotiations, or meta-discussions of how to talk about someone’s mental health condition, also serve to illustrate the fact that sometimes peers do not need to say anything, they need to listen first.

After all these examples involving close friends and family, I additionally want to discuss the impact of structural support coming from school. Both main characters are afraid of what their principals, teachers, and fellow students will say once they find out about their hospitalization; the protagonists’ fears ranging from being expelled for missing too much school time, to everybody treating them differently and gossiping about them once they return. Aza and Craig are then pleasantly surprised to hear their respective principals and peers reaching out to them and offering words of understanding and encouragement. After avoiding it for a while, Aza turns on her

phone, to find she has “over thirty messages – not just from Daisy and Davis […] but also from Mychal and other friends, and even some teachers” (*TATWD* 236), and Aza’s mother informs her that her teachers and friends “all understand” and that they “just want [...] [her] well and will support [...] [her] one hundred percent” (*TATWD* 237).

Craig’s principal calls him personally to say

> “I just wanted to tell you that you have the school’s full support in everything you’re going through and that we’re more than willing to have your semester repeated, or given over the summer, or for work to be provided for you where you are now, if you should miss enough days to warrant that. [...] We don’t pass judgment on our students for being in the *hospital,* my goodness, Craig.” (*IKOAFS* 312)

Showing empathy to a student affected by a mental health problem by reaching out to them and presenting them not only with verbal affirmations and a rejection of stigma to assuage their fears, but also with a certain readiness and flexibility to adapt school work around their condition is one way schools can help promote mental health. The following section will showcase another, namely the incorporation of mental health related YA literature into the classroom.

5. BRINGING COUNTERNARRATIVES INTO THE CLASSROOM

Now that I have analyzed both works of primary literature in depth, I want to explore what discussing such books in the (foreign language) classroom could look like, and also address any concerns regarding the sensitivity of the topic. This section is therefore divided up according to two basic inquiries: *Why* and *How* should(n’t) mental health related YA fiction be brought into the classroom?. The subsections in 5.1 will discuss reasons and arguments for or against introducing the topic of mental illness at school, while all elements of 5.2 offer concrete advice for a successful implementation of this endeavor.

5.1. Why should(n’t) books featuring mental illness be discussed in class?

In the following, I aim to answer this question on three different levels. Before delving into the specifics of working with the topic of mental illness in a foreign language classroom, or examining the details of Austrian school legislature to find out whether and how this theme fits into the curriculum, I need to address the ethical issue of exposing students to sensitive and potentially upsetting subject matter.

5.1.1. Benefits vs. concerns regarding 'taboo topics'

Should secondary school students really be introduced to the topic of mental illness? Are they mature enough for conversations about mental disorders, self-harm, or even suicide? Is school the right place for such discussions? Can teachers be equipped to talk about these issues?

Many advocates for the destigmatization of mental health would argue yes. So would I. In the words of Corrigan, Roe and Tsang "members of society who know more about mental illness are less likely to endorse shameful myths about it" (55). I firmly believe the best weapon against harmful myths and resulting discriminatory practices is education. It makes sense, therefore, to address this topic at school, where information can reach a much larger, broader and more diverse target audience than, for instance individual university or workplace programs could later on. We cannot circumvent this topic until members of society have reached adulthood. First of all, as statistics show[28], by then roughly every 4th or 5th Austrian will already have experienced mental problems, secondly, as Corrigan, Roe and Tsang point out: "Prejudice is not the sin of adults alone; children do it too. Childhood prejudice is evident at a fairly young age" (100). And this prejudice directly affects students' school experience and our classroom environment.

According to Richmond

> [s]tudents in our middle schools, high schools, and colleges who are living with depression, anxiety, or other mental illnesses are at risk of being bullied, and not just in the hallways or on the bus but *in our English Language Arts classrooms*. Therefore, one of the issues that should be at the forefront of English Education is how literature can help young adults better understand—and confront the stigma of—mental illness, especially in an ever-increasing atmosphere of bullying. ("Using literature" 19)

To prevent bullying and discrimination early on, "many advocates believe targeting children should be an essential priority" as a way of "stopping stigma before young ones internalize it" (Corrigan, Roe and Tsang 197).

Teachers may not instinctively feel up to the task of discussing mental illness because they are not trained psychiatrists or therapists. However, in truth, they are important stakeholders in the fight against mental health discrimination. Teachers are among a select range of people that Corrigan, Roe and Tsang refer to as "[o]pinion leaders",

[28] See the previously mentioned 2017 study by Wagner et al. in section 1.

meaning “persons who influence the attitudes of large numbers of people” and can therefore lead their students by example when it comes to destigmatization (102). I am not exaggerating when I claim that by starting conversations about mental health and spreading vital information about access to help, as well as simply “getting stories of mental illness out there, and letting students […] know they are not alone” (Scrofano 15), teachers could save lives.

It has already been established in section 4.4 that reading about mental health problems could help destigmatize them and their treatment by fostering empathy. I have also already shown evidence in sections 1 and 3 that youth are very much a risk group for mental health issues, and that through popular culture and social media they become particularly vulnerable to seeing mental health discussed in unhealthy ways. Talking about mental illness (or even suicide) in the classroom is an extremely serious matter. While the statistics regarding the prevalence of mental health issues among youth inform my staunch belief that mental illness must not be a taboo topic any longer, I have also tried to be as sensitive as possible to any reason why this subject should not be discussed at school.

Elaine Showalter and Jeffrey Berman both talk about teaching dangerous subjects in a literature classroom, and although their experiences are based in the field of higher education, I still think teachers of secondary education can benefit from their insights. Overall, both Showalter and Berman agree that certain content can definitely trigger a strong negative emotional response in students. Berman even goes so far as to say that “sooner or later, every literature teacher confronts the fact that the books we assign can trigger a student's crisis” (B7-B9). I do not claim to have enough experience with teaching literature yet to confidently agree or disagree with this last statement, however, what I am certain of is that we need to acknowledge that the books we study can have a burdening effect and they bear the risk of shocking, upsetting or offending our students (Showalter 126).

Berman provides the example of setting Kate Chopin’s *The Awakening* and Sylvia Plath’s *The Bell Jar* as readings for one of his summer courses. He urged his students to speak to him, if they felt at any point as if the topics were putting them at risk. And sure enough, two of his twelve students came to talk to him about how the assigned books were causing them emotional distress. According to Berman these individuals

expressed they were feeling "anxious and depressed" (B7-B9), and while the severity of those students' mental states at the time cannot be assessed from this one quote, I think what can be observed here is that the literature we assign has the potential to bear a negative emotional impact on our students. This is a very real risk when introducing a book such as *TATWD* or *IKOAFS* into the classroom.

However, when Berman and Showalter discuss such possible adverse effects, they do not come to the conclusion that we should simply refrain from assigning emotionally challenging or demanding works of literature. We cannot and should not try to stay away from texts that tackle the subjects of mental disorder or suicide. After all, and I fully agree with Berman here: “Isn't one of the very strengths of literature that it engages our emotions?” (B7-B9).

Even the grim and difficult subject of suicide should no longer be kept quiet. Showalter links the statistical fact that “the suicide rate among young people has tripled in the past half century” with her responsibility as a teacher who comes face to face with exactly this age group every day (126). In Austria, suicide is the second-most common cause of death for adolescents and young adults between 15-24 (https://www.gesundheit.gv.at/) and I too, see it as my duty as a teacher to address this problem.

In general, mental disorders often manifest themselves between puberty and early adulthood. According to Kessler et al., the “median age-of-onset”, i.e. the age at which a person starts developing or experiencing symptoms of a disorder, falls between the late teens and the early 20s, around fifty percent of all lifetime mental disorders starting by the time individuals reach their “mid-teens and three quarters by the mid-20s” (359). It makes no sense to keep a topic quiet from those it impacts so frequently and so strongly. Mental health issues need to be talked about at school. “But we do need to give more thought to how we do so” (Berman B7-B9).

Neither Showalter nor Berman provide point-by-point instructions on the proper way to introduce these hot-button issues, because every classroom is different as every student is different. However they do share some general ideas and overarching principles for the introduction of such sensitive content, for instance the importance of “candor and clear labeling – telling students in advance that they may be offended or

upset" and "contextualizing the topic with some sociological or historical background" (Showalter 126).

In addition to warning our students, we must also allow plenty of "opportunities for them to respond" (Showalter 126), such as discussions, reading diaries, essays[29] etc. These tasks can be a very cathartic outlet, as Berman explains by sharing the experience of one of his students:

> And she was grateful that I had warned her about the readings, and that she had had the opportunity to write about her response. She felt that writing the essay was therapeutic, because it enabled her to discover not only the similarities but also the differences between her own situation and those of the fictional characters. (B7-B9)

Furthermore, teachers should "make themselves available to students" who experience distress after reading a certain piece of literature (Berman B7-B9)[30] by offering the opportunity of individual talks, for example during their office hours. While Berman concedes that it "will not always be possible to detect when – and which – students are at risk", he does point out that "it is not unusual for students to tell a teacher that they are 'having problems' with a reading or writing assignment, and a simple question might help open up whether those are intellectual or emotional difficulties". Teachers then need to be sensitive as well to any warning signs students present in their writing assignments or during a conversation and when needed, establish contact with psychological counsellors.

In summary, the concerns raised about teaching sensitive issues need to be taken seriously. They should not discourage teachers from discussing them, but rather must be addressed to make sure students' psychological well-being stays at the forefront of any lesson plan and emotionally triggering effects can be minimized. One way to do exactly that will be discussed in the next segment.

5.1.2. Incorporating mental health education into a foreign language classroom

Even though there are dangers and possible difficulties attached to discussing mental health issues in an EFL classroom (or any classroom for that matter), it has to be said that bringing up this potentially deeply personal and in some cases upsetting subject in a foreign language classroom, rather than in the students' native tongue, could be

[29] See activities in section 5.2.3.
[30] This paragraph is based on and contains quotations from Berman B7-B9.

a way to reduce the affective intensity of the topic. Several studies indicate that using our L2 to talk about a subject makes us less emotionally attached to it.

In a recent study (2017), Morawetz et al. measured self-rated emotional responses to negative stimuli (upsetting pictures) and found that content labelling, i.e. the verbal description of these images as a means of decreasing negative emotional responses, in the participants' L2 (but not their L1) led to a lowered rate of distress. "This effect of L2 use was attributed to increased emotional distance as well as to increased levels of cognitive control during L2 use" (Morawetz et al.).

Results of a study conducted by Iacozza, Costa and Andoni Duñabeitia to find out whether emotionally challenging sentences read in the native and a foreign language triggered identical emotional reaction or not, equally show changes in the responses, which are regulated by the sympathetic nervous system. These findings demonstrated a deeper emotional involvement when the sentence was read in the native, as compared to a foreign language.

In another study Dylman and Bjärta examined, if using a second language (L2) could serve as a useful means of lessening the experience of psychological distress. In their experiment they asked Swedish native speakers to read negative and neutral text samples in Swedish (L1) and English (L2) and reply to questions about them, then requesting the participants to evaluate their amount of distress before and after the questions. These text samples and the matching questions were either "in the same (within-language), or different languages (cross-language)" (Dylman and Bjärta 1284). And indeed, it was revealed that L1 / L1 tests evoked an increase of psychological stress while L1 / L2 tests showed a reduction of the stress level.

While I myself am no expert on bilingualism or the emotional components of language processing, based on these three studies, I would argue that reading about mental illness in a foreign language could be less emotionally demanding on students because the L2 use seems to establish and then maintain a useful distance and thus protects students from treating emergent themes too personally. Pupils ideally delve into the topic for the lesson, but should then also be able to put the book into their bags when the bell rings and head out to recess relatively unburdened.

Of course, students' emotional involvement is also highly dependent on the tasks we as teachers set them to accompany their reading journeys.[31] Writing a book review or a plot summary, for example, is likely to be approached with more emotional distance than a diary entry or letter from the protagonist's point of view. That is not to say tasks that encourage affective engagement should be avoided. On the contrary, the success of using YA literature as a tool to destigmatize mental illness relies on fostering empathy. For each piece of literature and task teachers assign or each theme they want their students to explore, they need to weigh the benefits of promoting emotional involvement against the risks of causing their pupils psychological distress, and then carefully calibrate activities and discussion topics accordingly.[32]

But do the parameters of the Austrian school system even allow for the discussion of mental illness in a foreign language classroom? The next section will explore exactly this concern.

5.1.3. School legislation

When discussing how to put into practice my recommendations of incorporating the topic of mental illness into classrooms, and how to offer a counternarrative to the media's mental health discourse in an English lesson, I am aware of the first questions I would likely be asked back by some skeptical co-workers or superiors: "Can this be arranged or reconciled with a school's general framework conditions, such as the legal education regulations and the subject's curriculum? Can we justify spending time and resources on this topic to students, parents, colleagues or even the school board?" The answer to all of those questions is a resounding yes.

The Austrian ministry of education has declared that the promotion of health is, in fact, an integral part of schooling and should be implemented in every subject, as the policy on health education decrees: "Schulische Gesundheitsförderung ist […] zentraler Bestandteil jeglichen pädagogischen Handelns und sie ist in allen Schularten und Unterrichtsgegenständen zu verwirklichen" (BMBWF "Grundsatzerlass zum Unterrichtsprinzip Gesundheitserziehung"). For that reason "health education"

[31] Additionally, the basic circumstance of framing the reading of a book as a task within a school environment and the factor of graded performance, likely already changes students' involvement from what it would have been, had they read purely for pleasure outside of a school context.
[32] I endeavor to provide guidance for this process in sections 5.2 - 5.4.

["Gesundheitserziehung"] is one of ten so-called overriding "teaching principles" ["Unterrichtsprinzipien"].

The five main goals of health promotion in Austrian schools ["Vorrangige Ziele der Gesundheitsförderung"] are as follows:

- Gestaltung der Schule als gesundheitsförderliche Lebenswelt unter Einbeziehung aller im schulische Alltag beteiligten Personen
- Förderung persönlicher Kompetenzen und Leistungspotentiale der Schülerinnen und Schüler in Hinblick auf gesundheitsbewußtes, eigenverantwortliches Handeln und Wissen
- Vernetzung von Schule und regionalem Umfeld
- Förderung von kommunikativen und kooperativen Kompetenzen der LehrerInnen, Eltern und SchülerInnen sowie der Kommunikationsstrukturen zwischen LehrerInnen, SchülerInnen und Eltern
- Dokumentation und Verbreitung innovativer Projekte und Maßnahmen

(BMBWF "Grundsatzerlass zum Unterrichtsprinzip Gesundheitserziehung")

While the traditional understanding of health promotion was more concerned with nicotine and alcohol consumption, malnutrition or a lack of physical activity, the ministry now acknowledges the need for a broadened definition of health, and has therefore added concerns such as psychological and social health:

> Die neue Qualität der Gesundheitsförderung liegt […] einerseits in einem erweiterten Gesundheitsverständnis, d. h. es berücksichtigt die physische, psychische und soziale Gesundheit, und andererseits auch in der Schaffung eines gesundheitsfördernden Arbeits- und Lernumfeldes. (BMBWF "Grundsatzerlass zum Unterrichtsprinzip Gesundheitserziehung")

School needs to become an environment that promotes not only physiological but also psychological health. The Austrian ministry of education, however, maintains that sometimes the very nature of school can be demanding and downright stressful, thereby possibly adding to an individual's mental problems[33]:

> Kinder und Jugendliche, aber auch LehrInnen sind am Lebens- und Lernort Schule vielfältigen gesundheitlichen Belastungen ausgesetzt wie z. B. schulischem und beruflichem Leistungsdruck, sozialem Anpassungs- und Konsumdruck, Bewegungsmangel, einseitiger Ernährung, Kommunikations- und Beziehungsproblemen, Ausgrenzung als soziale oder ethnische Minderheit. (BMBWF "Grundsatzerlass zum Unterrichtsprinzip Gesundheitserziehung")

The ministry of education recognizes the complex relationship between school and health for students and teachers alike: „Schule wirkt sich […] auf die körperliche, psychische und soziale Gesundheit aller Menschen aus, die sich in ihr aufhalten"

[33] Which can be directly compared to Craig's entire arc of pressure and fear of failure at school factoring in to his depression.

(BMBWF “Grundsatzerlass zum Unterrichtsprinzip Gesundheitserziehung”). This statement, I think, carries a really interesting duality. School can be the place that exposes one to strain, but it should also be the place where one is given tools to deal with any (mental) health issues that occur. These tools need to be relayed across the curriculum.

In the first part of any subject’s curriculum of Austrian secondary schools, the so-called general education goals are discussed. To that end, five “fields of education” [“Bildungsbereiche”] are specified. “Health and Exercise” [“Gesundheit und Bewegung”] is one of them.

> Über das Bewusstmachen der Verantwortung für den eigenen Körper ist körperliches, seelisches und soziales Wohlbefinden zu fördern. Die Schülerinnen und Schüler sind zu unterstützen, einen gesundheitsbewussten und gegenüber der Umwelt und Mitwelt verantwortlichen Lebensstil zu entwickeln. Im Sinne eines ganzheitlichen Gesundheitsbegriffs ist ein Beitrag zur gesundheits- und bewegungsfördernden Lebensgestaltung zu leisten.
>
> Durch die Auseinandersetzung mit Gesundheitsthemen wie Ernährung, Sexualität, Suchtprävention, Stress, Gewalterfahrungen, Sexismus und Gendernormen (zB Schönheitsideale) ist sowohl das körperliche als auch das psychosoziale Wohlbefinden zu fördern. (Lehrplan der Allgemeinbildenden Höheren Schule – Erster Teil: Allgemeines Bildungsziel/5. Bildungsbereiche)

But discussing mental illness in class is about more than just the goal of health education. Another one of the five fields of education is “Mensch und Gesellschaft” [“Individual and Society”], the description of which states that students ought to be encouraged to critically engage with the mechanisms of social inequality:

> Wissen über und Verständnis für gesellschaftliche (insbesondere politische, wirtschaftliche, rechtliche, soziale, ökologische, kulturelle) Zusammenhänge ist eine wichtige Voraussetzung für ein bewusstes und eigenverantwortliches Leben und für eine konstruktive Mitarbeit an gesellschaftlichen Aufgaben. […] Die Schülerinnen und Schüler sind […] dabei zu unterstützen und zu begleiten, sich mit Ursachen gesellschaftlicher Ungleichheitsstrukturen […] kritisch auseinanderzusetzen, um eigene Handlungsspielräume und Lebensperspektiven zu erweitern. […] Die Verflochtenheit des oder der Einzelnen in vielfältige Formen von Gemeinschaft ist bewusst zu machen; Wertschätzung sich selbst und anderen gegenüber sowie Achtung vor den unterschiedlichen menschlichen Wegen der Sinnfindung sind zu fördern. (Lehrplan der Allgemeinbildenden Höheren Schule - Erster Teil: Allgemeines Bildungsziel/5. Bildungsbereiche)

Students should also be inspired to make a difference in society by trying to find solutions to existing problems and to take action when it comes to social justice and human rights issues, which the discrimination against people with mental disorders definitely falls under.

> Es ist bewusst zu machen, dass gesellschaftliche Phänomene historisch bedingt und von Menschen geschaffen sind und dass es möglich und sinnvoll ist, auf gesellschaftliche Entwicklungen konstruktiv Einfluss zu nehmen. Aufgaben und Arbeitsweisen von gesellschaftlichen Institutionen und Interessensgruppen sind zu vermitteln und mögliche Lösungen für Interessenkonflikte zu erarbeiten und abzuwägen.
>
> Der Unterricht hat aktiv zu einer den Menschenrechten verpflichtete [sic] Demokratie beizutragen. Urteils- und Kritikfähigkeit sowie Entscheidungs- und Handlungskompetenzen sind zu fördern, sie sind für die Stabilität pluralistischer und demokratischer Gesellschaften entscheidend. Den Schülerinnen und Schülern ist in einer zunehmend internationalen und multikulturellen Gesellschaft jene Weltoffenheit zu vermitteln, die vom Verständnis für die existenziellen Probleme der Menschheit und von Mitverantwortung getragen ist. Dabei sind Humanität, Solidarität, Toleranz, Frieden, Gerechtigkeit, Geschlechtergleichstellung und Umweltbewusstsein handlungsleitende Werte. (Lehrplan der Allgemeinbildenden Höheren Schule – Erster Teil: Allgemeines Bildungsziel/5. Bildungsbereiche)

Once the connection to the general teaching principles has been established, various specific subject curricula can be examined for links to the topic of mental health.

The curriculum for the first foreign language (in most cases English) “Lehrplan Lebende Fremdsprache (Erste, Zweite)” states in its “didactic principles” [“Didaktische Grundsätze”] that the selection of topics should be as varied as possible and in accord with students’ interests and needs, as well as current events. I suggest that a rise in mental health problems among our youth constitutes such a current event and need and therefore mandates discussion. The curriculum specifically mentions the role of language, the role of the media, current social developments and our attitudes and values as recommended areas of dialogue. It also places importance on the introduction of literary works into the classroom:

> Zur Erlangung eines möglichst umfassenden lexikalischen Repertoires […] sind verschiedenste Themenbereiche zu bearbeiten […] (mögliche Themenbereiche sind zB Ich und mein Umfeld; Arbeit und Freizeit; Erziehung; Rolle der Medien; Lebensplanung; Einstellungen und Werte; Zusammenleben; aktuelle soziale, wirtschaftliche, technische und politische Entwicklungen; kulturelle und interkulturelle Aspekte; Umwelt; Kunst in ihren Ausdrucksformen Literatur, Musik, bildende Künste). Spezielle thematische Schwerpunkte sind jeweils im Einklang mit individuellen Interessenslagen und Bedürfnissen der Schülerinnen und Schüler sowie mit aktuellen Ereignissen zu setzen. Die verschiedenen Themenbereiche sind durch möglichst vielfältige Quellen zu erschließen, wobei bei der thematischen Auswahl fremdsprachiger Texte auch literarischen Werken ein angemessener Stellenwert einzuräumen ist. (Lehrplan Lebende Fremdsprache)

Furthermore the topic of “Health” is explicitly listed as part of the catalogue of topics for the oral Matura in the foreign languages (BMBWF “Die kompetenzorientierte Reifeprüfung Lebende Fremdsprachen”). This means that students need to be

prepared to talk about this general topic, of which psychological health is a significant part.

Of course, the curriculum for "Psychology and Philosophy" ["Lehrplan Psychologie und Philosophie"] also features several links to the topic of mental health:

> Die Schülerinnen und Schüler sollen therapeutische Hilfen und Einrichtungen kennen lernen, es ist aber nicht Aufgabe des Psychologieunterrichts, therapeutische Hilfestellungen zu geben.
>
> [SchülerInnen] eignen sich Wissen und Kompetenzen an, die dem Abbau von Stereotypen und der Förderung von Chancen- und Geschlechtergerechtigkeit dienlich sind.
>
> Die Schülerinnen und Schüler lernen psychohygienische Prinzipien kennen und setzen sich kritisch mit Normalität und Gesundheit auseinander.
>
> [SchülerInnen sollen] [s]eelische Gesundheit und deren Beeinträchtigung diskutieren.

Additionally, the curriculum for psychology and philosophy explicitly highlights the subject's interdisciplinary potential: "Das Fach ist aufgrund der vielfältigen Inhalte und Methoden an sich interdisziplinär."

This will become important in section 5.2.2, where I will elaborate on the value of co-operation for accomplishing a successful discussion of mental health at school. Tackling a subject like mental illness is no easy feat for one teacher alone. As a language teacher, it makes sense to have the class's psychology teacher involved with your lessons to provide factual backup and support during activities. But co-operation does not need to stop with just psychology teachers. For teachers interested in working with colleagues from other subjects, establishing larger interdisciplinary projects or CLIL units, for example, it is helpful to know that different subject curricula such as history or biology also specifically mention the topic of mental health:

> Konstruktionen, Veränderungen und Kontinuitäten zwischen Renaissance und 19. Jahrhundert herausarbeiten (zB […] Umgang mit psychischer und physischer Beeinträchtigung) (Lehrplan Geschichte und Sozialkunde/ Politische Bildung)
>
> Die Kenntnisse über Bau und Funktion des menschlichen Körpers (einschließlich der Themenfelder Gesundheit und Krankheit, Psychosomatik und Immunsystem) sind zu erweitern und zu vervollständigen. (Lehrplan Biologie und Umweltkunde)

With several points of contact throughout various subject curricula and overall educational aims, there is unmistakable evidence that any teacher who wants to tackle the issue of mental health in the (foreign language) classroom will find support and

solid ground for legitimization within the Austrian education system's underlying conditions and parameters.

5.2. How should(n't) books featuring mental illness be discussed in class?

Now that I have established my position that mental health related YAL should indeed be worked with in schools, and given several reasons to justify that conviction, it is time to provide some guidelines on how to actually implement this recommendation.

5.2.1. Selection

The first hurdle any teacher who would like to cover the topic of mental illness in the English classroom via the use of a young adult novel must jump, is the question of which book(s) to choose.

Firstly the base questions of age-appropriateness and language level need to be answered. In the case of *TATWD* and *IKOAFS*, I would recommend reading them in 11th or 12th grade. Not least because at this point students[34] will have also had psychology lessons and have become more familiar with the field and specific vocabulary. Secondly, because this is such a sensitive topic, it might be worthwhile to consider a setup in which not everybody has to read the exact same book. Involving an element of choice (however small, even if it is just between two or three options) could increase motivation and keep students from having to read a book that they absolutely do not want to read (for personal reasons). At the same time a teacher should refrain from recommending books discussing a particular mental health problem to individual students (e.g. knowing a student has anorexia and then assigning a book about that mental disorder specifically to her).

A "booktalk" is what Pace Nilsen et al. call "a short introduction to a book" given by the teacher, "which usually includes one or two paragraphs read from the book. […] In giving it, the booktalker must let listeners know what to expect" (322). Not only does this help to prepare students for the emotional impact a story on this topic may have on them, it also "enables students to learn about and to select books that might cause them embarrassment if they were recommended on a personal basis. […] But if this

[34] There are several school types in Austria in which Psychology and Philosophy is not a subject on the curriculum. In these cases teachers who still want to discuss this topic in a foreign language classroom need to supplement students with all the necessary information to fill any knowledge gaps. Inviting experts such as school psychiatrists or anti-stigmatization activists from outside is even more important for these school types.

book were included among several books introduced to the class and the student chose it herself, it might fill a real need" (Pace Nilsen et al. 324).

Pace Nilsen et al. outline that when selecting what they refer to as "problem novels" for discussion three important ground rules are voluntariness, not introducing such a story during a crisis and not being singled out as an individual and matched up with a book to fix personal issues.

> It is important […] for adults to be careful in guiding students to read and talk about personal problems. No one should be forced to participate in such a discussion, and a special effort should not be made to relate stories to the exact problem that a group member is having. In fact, it would probably be best to avoid matching up particular problems with particular students. When someone is in the midst of a crisis, chances are that he or she does not want to read or talk about someone else in a similar predicament. As a general rule, one would probably get the most from such a discussion before or after – rather than during – a time of actual crisis. (360)

The fact that it will not always be obvious to the teacher whether a student in a class (or several students) are, in fact, in the midst of a crisis makes this last recommendation particularly difficult to follow. What can be said is that teachers need to make an extra effort and take precautions to avoid the danger of triggering vulnerable students, at least as much as possible. This means being especially observant of a class and their dynamics for a few lessons before the planned introduction of mental health related YAL, in order to estimate whether sensitive topics can be discussed in their current classroom climate. It means talking to the other teachers, especially the class teacher, and ask about any concerns they may have regarding the presentation of a particular topic to the class at that moment. It also, once again, means that the aspect of voluntariness of selection needs to be clearly conveyed to the students, even allowing them to switch books once they have started, if they find a story too upsetting. A teacher needs to demonstrate flexibility and a certain emotional alertness to make the most conscientious selection of books and tasks they can. But what criteria should teachers look out for when selecting potential class readings? To make the selection process easier I am including a few general guidelines set by Pace Nilsen et al. (121)[35] on what constitutes a "good problem novel", discussing them with a focus on mental health related literature and adding a few ideas of my own.

[35] The following 3 paragraphs contain quotations from Pace Nilsen et al. 121.

First and foremost Pace Nilsen et al. state that selected stories should have a “strong, interesting, and believable plot centering around a problem that a young person might really have”. The credibility of this plot is negatively correlated to two features that mark a “poor problem novel”, namely the presentation of “facts” which do not correspond to our real world and “exaggerations that result in sensationalism”. I think refraining from bringing in novels that feature these characteristics[36] is crucial in making sure that teachers do not hurt their own cause when trying to select books that destigmatize mental illness.

Pace Nilsen et al. additionally purport that the characters need to come across as authentic “with a balance of good and negative qualities” rather than being characterized through a multitude of stereotypes. I would argue that this guideline is not only important for the realistic depiction of people with a mental disorder in that they are neither devil nor saint, perpetually caught in the role of either culprit or helpless victim[37], as many narratives in popular culture would lead us to believe, a three dimensional characterization is also paramount for readers’ ability to relate to the characters. Here Pace Nilsen et al. also refer to a good problem novel’s capacity to “transport the reader into another person’s thoughts and feelings”. For teachers this means, when choosing mental health related YA novels for classroom use, that they should focus on and analyze all the potential works’ narrative structures and stylistic techniques and answer the question of how they serve to convey the characters’ emotions.[38]

As I outlined in my introduction, YA novels featuring mental health related plots are becoming increasingly popular on the book market. On the one hand, this is beneficial because it means an abundance of works for teachers to choose from, on the other hand Pace Nilsen et al. have identified a risk that comes with such rising popularity, namely that of a medium introducing the theme “only because it is topical or trendy”, resulting in stories that feature generic or “preachy messages”, rather than truly confronting the readers with new insights into life as such, society or themselves, as well as discussing possible solutions to the problems presented (121).

[36] Unless teachers specifically want to draw attention to and discuss problematic representations.
[37] See the “three sets of stigmatizing attitudes” quoted from Corrigan, Roe and Tsang (27) in section 2.2.
[38] I have provided examples of such an analysis for my selected primary literature in sections 4.4.2-4.4.5.

For problem novels that deal with mental health specifically, Kia Jane Richmond has devoted much of her analysis and evaluation of YAL to testing the criterion "whether various disorders are authentically represented in the stories according to descriptions of the illnesses in the *DSM-5*" ("Language and Symptoms"). In the same vein, Diane Scrofano has set up the following guidelines regarding an authentic depiction of mental health issues:

> We need stories of mental illness that focus on the illness as a biological brain disorder, a chemical imbalance in the brain. […] [W]e […] need books that mirror teens' experiences of clinical illness, including visiting the psychologist's or psychiatrist's office, trying out different medications, dealing with side effects, having conflicts with family members, and all the rest that a modern-day diagnosis of mental illness entails. (15)

She further recommends reading stories featuring different points of view: "Teens reading about mental illness have different relationships to it, so it is good that different stories of mental illness are told from different points of view. The story might be narrated from the point of view of the ill person, a sibling, or a child" (Scrofano 16).

Teachers could implement this, for example, by assigning a variety of books, narrated from different points of view, to smaller groups (rather than just one class reading), and then comparing differences of experiences in panels or presentations. Regarding the overall question of whether it is better to assign a book such as *TATWD* or *IKOAFS* as a class reader or as part of an extensive reading project, the approaches need to be weighed against each other in terms of their respective merits and drawbacks. A novel set to be read in its entirety by the whole class has the advantage of allowing for in-depth discussions and activities that everyone can participate in and that include themes and topics presented across the full story, as well as easier monitoring of students' understanding and progress for the teacher. However, it comes at the great cost of losing the element of volition. I have already outlined the importance of not forcing a student to read a story about a mental health issue that is too personal and too painful for them to engage with, which is why, despite its advantages, I would not recommend setting a mandatory class reading for this particular topic.

What I would recommend trying instead, is a synergy of elements from Thaler's "topic approach" and elements of extensive reading projects. For the topic approach "[s]everal books […] on a single issue are read in excerpts" (Thaler 105). An obvious shortcoming of this approach is that students do not get to follow a protagonist's full

arc, which I think is especially important for stories like *TATWD* or *IKOAFS*, and the overall aim of presenting realistic narratives of mental illness that bear the potential for fostering destigmatization and giving hope. I cannot, for instance, imagine my students reading about Aza's severe anxiety attacks but missing out on the part where her condition improves.

Extensive reading comes with the purposes of having students read larger amounts, i.e. an entire novel, for pleasure, and primarily for content (Thaler 66). Therefore, inherent to this approach is the freedom of selection, as well as the mode of "individual", "autonomous" reading (Thaler 67). With those characteristics come the disadvantages of the teacher's reduced monitoring ability and more restricted options on what activities an entire class could participate in. Students can present their novel, but there are limitations of what the rest of the students, who have not read the book, can discuss afterwards. This is why I recommend pre-selecting a handful of different mental health centered YA novels, letting students pick the one they like best after a short book talk, thus forming groups[39], assigning tasks typical for extensive reading such as presentations, reviews, (Thaler 67) etc., but also discussion tasks to be carried out within the group reading the same book, and then assigning excerpts of each of the books to the entire class, so they can prepare for different groups' presentations and ask more detailed, insightful questions.

At this point I would also like to offer a book recommendation to any teacher who needs some more support for the selection of appropriate classroom literature on this topic. *Mental Illness in Young Adult Literature: Exploring Real Struggles through Fictional Characters* (2019) by Kia Jane Richmond is an excellent introduction into the subject which offers information on different mental disorders, as well as plot summaries and analyses of current YAL portraying those disorders, and additionally features extra resources, such as sample lesson plans, to help teachers feel more confident about their choices when bringing this subject up in class.

5.2.2. Co-operation

With regard to confidently approaching this topic in class, I would also, once more, like to highlight the importance of interdisciplinary co-operation. Firstly with colleagues from other subjects (as discussed in section 5.1.3), most importantly psychology

[39] These groups may not be equal in size, which a teacher must be able to plan for and adapt their tasks accordingly.

teachers from the school, who can help by supporting and supplementing the literature class with all the necessary facts (medical and neuroscientific information, the respective country's treatment situation, etc.).

Hayn and Kaplan also suggest inviting "interdisciplinary cooperation" but go one step further by recommending to venture outside of the school structure and "encourage the participation of community stakeholders" such as "local nonprofit organization[s]" (206), thereby "bridging the disciplines of English, health, and social studies in the process" (212). They suggest organizing a panel discussion after reading mental health themed novels:

> Schools can invite a panel of representatives of the various resources and agencies involved in supporting individuals with mental health issues to talk about their roles and responsibilities. […] [A] school psychologist […], a special educator, a school nurse, a family practitioner, licensed social worker, and a psychiatrist would all be helpful members of such a panel. […] Students should have questions prepared, based on the novels they have read and the research they have conducted, that will help them use the panel members to better understand whether or not their readings provided a true depiction of the various problems experienced by their characters. (212)

As an ESL/EFL teacher in Austria, it is important to remember that Hayn and Kaplan's proposition must be adapted for an L2 background. Most likely not all the invited guests would be comfortable or fluent enough to participate if the discussion were solely held in English, which is why I recommend setting up this particular task as part of a bilingual unit, with a second or several other subject(s) involved, such as Psychology, Biology, History, etc., and the choice of which language to use left completely up to the individual parties. For me, the use of German (by students and experts alike) would be completely acceptable in this context because it facilitates the achievement of the overriding goal of co-operation with mental health professionals.

A panel discussion is only one of many possible pre-, while-, or post-reading activities for novels that address mental illness. The next section will explore some more.

5.2.3. A few ideas on activities and class discussion themes

Before deciding on individual activities, a teacher should establish what kind of lessons they want to plan around this topic or the assigned piece of literature. Do they want to do "subject units", "project units" or "thematic units" (Pace Nilsen et al. 382) or a combination of them, and which of these types of units is most useful at what stage of the work with the topic and the novel?

> Ideally, a thematic unit will bind together a number of […] elements, including literature, language, media, and popular culture. […] The project unit has a clear end product, with all the steps that lead up to that end. [e.g. a class play, a booklet, a poster presentation, a portfolio, or the previously discussed panel-discussion] and a subject-centered unit consists of a body of information the teacher feels is important for the class […]. (Pace Nilsen et al. 382)

Personally, I think a combination of all three types of units (if time and resources allow) would be best in this case: Students require subject-centered units to provide them with all the factual knowledge they need to discuss mental illness, they need thematic units to make sure that many different aspects of the topic are addressed (stigma and language use, representation in the media, depiction of mental illness in the books, stylistic devices etc.), and I also think they would benefit from some kind of end-product (as created in a project unit) they could take away from the experience.

Another point of consideration at the beginning stages of designing activities is determining the types of communicative tasks students will be asked to perform through them. Within the framework of "task-based language teaching/learning", which lends itself very well to the topic, due to its "primary focus on meaning" and "non-linguistic outcome[s]" (Ellis 9-10), Prabhu has defined three types of task, namely "information gap", "reasoning gap", and "opinion gap" tasks (46-47). Briefly, the first type of task "involves a transfer of given information from one person to another – or from one form to another, or from one place to another" (Prabhu 46). The second type, "involves deriving some new information from given information through processes of inference, deduction, practical reasoning, or a perception of relationships or patterns", and the third task type encompasses all activities aimed at "identifying and articulating a personal preference, feeling, or attitude in response to a given situation" (Prabhu 47). Echoing my earlier recommendation for a combination of subject-centered, thematic and project units, I also advise balancing these three types of tasks in fairly equal ratios across the lessons. This ensures that by the end of working on the topic, students have negotiated various kinds of meaning which require, build upon and support each other, as opposed to, for example, constantly being asked to express opinions or attitudes without performing tasks that accumulate the necessary information to do so.

Once those decisions have been made, the teacher must determine the following:

> A list of sensible objectives or learning outcomes, a list of vocabulary words related to the unit topic, to be talked about and perhaps tested, a way of beginning the unit that

> grabs students' attention and interest while focusing on the theme (short film, quote, newspaper article, etc.), a way of wrapping up the unit that ties all the strands together (not necessarily a test, maybe a student evaluation, response journal, art project etc.), a way of dealing with and anticipate the problems that the unit – and students – may encounter. (Pace Nilsen et al. 383)

The first point, sensible objectives, is extremely important, and therefore will be given its own subsection[40]. However, I personally find that for this particular topic the last two steps also require most careful consideration and extra attention. A teacher needs to ask him/herself: "How do I close down this topic, not just content-wise intellectually, but emotionally?", and hopefully come up with a more wholesome answer than a pop-quiz. Equally, when anticipating difficulties students may have with the book, a certain passage or an activity, I would say that while we still need to focus on the language aspect of that question (e.g. what vocabulary do students need to talk about this, etc.?), we additionally need to take into account the component of students' affective response and need to be prepared for difficulties arising in this area as well.

Before going any further, I want to mention that I firmly believe any theme I have addressed in the theoretical or analytical parts of my paper could be adapted to fit into a secondary school's lesson plan. While including full lesson plans for both books would go beyond the constraints of this paper, I do want to add a few more concrete ideas on activities a teacher might want to try when tackling this subject in class. I have found plenty of inspiring and useful activities in a free teacher's resource titled "Talking about mental illness" published by the Canadian Centre for Addiction and Mental Health (CAMH).

To start with, and to ease students into the topic, I would recommend an exercise proposed by this guidebook, called "Free association" (CAMH teacher's guide 22-23). This task functions as an "icebreaker" and a way for teachers to gauge how much students already know about mental illness and which misconceptions they may have, or have heard of. Students are asked to write down everything that occurs to them in the first place when thinking about mental illness or people affected by it on pieces of card. It is crucial to tell them that there are no right or wrong contributions, and that the exercise serves merely as a starting point for the discussion. Students need to be told that it is not important whether they actually are persuaded of or go along with all the ideas they come up with. Pupils should write down as many ideas as possible, then

[40] See section 5.2.4.

the teacher will collect the cards and stick them on the board or a wall. As a next step students should group their responses into the following categories: “myth (widely held, but false idea)”; “misconception or misunderstanding”, “hurtful or disrespectful language”, and “factual information” (CAMH teacher’s guide 23). Interestingly enough, the guide does not mention a category for personal associations (for example “My mother is depressed”). In my experience with teaching, it is quite plausible that students would share personal stories during this exercise. My recommendation, therefore, is to open up an additional category titled “personal”. It goes without saying that, like all the others, any response from this category needs to be addressed, and if necessary, teachers might want to use this opportunity to already share the contact information of counselling services.

According to the guide, most of the contributions will fall into one of the first three categories. It is essential to deal with all of the students’ contributions under consideration of stigma by unmasking myths, explaining fears and misunderstandings, as well as exposing their respective roots. To that end the teacher should open up a discussion that encourages students to reflect upon the origins of such ideas, for example the impact that media, cinema, literature and one’s own biography have on the development of notions, opinions or convictions about mental illness (CAMH teacher’s guide 23).

What I especially like about this task, is that students are really at liberty to write down whatever comes to mind with no shame, since they write anonymously on cue cards. At this stage there are no wrong answers, but it is important that this activity is followed up by some form of a “myth-busting” exercise. Again, the CAMH teacher’s guide provides a sample activity for this, called “Fact or fiction?” (40-43). Statements such as “Mental illness can be cured with willpower”, “Drug use causes mental illness”, “Mental illness is contagious”, or “People with mental illness never get better” are projected onto an overhead or PowerPoint slide. Students are asked which of these statements they think are true or false. The teacher then gives the correct answers using the answer key provided. Alternatively, students could also try and find answers in the library or on the internet and discuss their findings in plenum afterwards. They could also relate the statements back to the characters in the books they have read (e.g. Craig’s doctor explicitly tells him that a chemical imbalance in his brain causes his depression, he does get better at the end, but he needs medication to do so, rather

than just willpower). Corrigan, Roe and Tsang also highly recommend reviewing a mental illness fact sheet with students, perhaps even inviting persons with a mental illness to join in on this exercise and share their experiences (100).

A question that might pose itself to teachers at this stage is whether or not it is advisable to bring in their own experiences regarding the topic of mental health. On the one hand, sharing something so personal may be a very effective way to demonstrate genuine belief in one's own cause – i.e. promoting the idea that a mental health problem is nothing to be ashamed of. On the other hand, there is a considerable risk with offering such intimate information to an entire class, and by extension possibly also their friends and parents, which can put the teacher in a vulnerable position. The benefits of breaking through the "us" vs. "them" mentality by "outing" oneself as part of the latter, stand in direct opposition to the concerns of endangering one's professional image and exposing oneself to possible stigma.

Ultimately the decision will be up to the individual teacher and depend on the trust relationship they have established with a class, the support they receive from the head of school as well as staff, and most importantly their own feelings about whether or not they want to share. In my opinion, there is no right or wrong answer to this; teachers can do the aforementioned "Fact or fiction?" exercise with or without inserting their personal stories into the conversation. Either way this "point-by-point contrast of myth and facts" can be "a powerful addition to an education program" (Corrigan, Roe and Tsang 94) since "common myths […] are the foundation of stigmatizing attitudes" (Corrigan, Roe and Tsang 91).

In addition, establishing an informational baseline, the way the previous task does, is an absolute prerequisite of discussing any personal accounts of mental illness (factual or fictional) and cultivating empathy, which is why I recommend setting this task at the very beginning stages of working with the topic, before reading the novel, or at least very early on into the first few chapters. According to the CAMH teacher's guide "[m]any students do not know basic facts about mental illness; furthermore, they may have misconceptions that need to be corrected" (39). "[L]earning about the causes of mental illness and the kinds of treatments available to people", as well as "[u]nderstanding some of the basic terms related to mental illness" is vital in order for students to "tune into the personal aspect" or fully grasp the emotional impact of

someone's experiences, and "it also makes students feel more comfortable and encourages them to ask questions" (CAMH teacher's guide 39).

During the first stages of topic exploration one should also define key concepts such as "Stigma" "Prejudice" or "Stereotype". Students can research recent dictionary definitions, but as the CAMH teacher's guide suggests, it might also be a good idea to let students read definitions of those terms from "different sources and from different historical periods" (25-26). Students need to be clear about the meaning of these words, if they are to use them later on in panel discussions, essays, presentations, book reviews etc. In addition, engaging with these terms and their definitions "may stimulate discussion about the origins of stigma and the use of the term in relation to mental illness" (CAMH teacher's guide 23).

Now that concepts such as prejudice or stigma have been defined, I would argue it is absolutely crucial to question where our stereotypes come from. At this stage, I would recommend an activity, the CAMH teacher's guide calls "Analysis of media coverage" (67). The point of this exercise "is to highlight the role media plays in influencing public understanding and perception of mental illness, and to help students evaluate media messages about mental illness". Pupils are asked to search various newspapers and magazines for content that discusses mental illness, "or provide[s] an account of an incident involving a person with mental illness". They then form groups "in order to analyze and compare the way each article depicts mental illness or people with mental illness". Students should pay particular attention to instances "of stigmatizing or stereotypical images and language" and "think of alternative ways of reporting the story that would not perpetuate stereotypes of people with mental illness". This last part of the task effectively asks students to construct counternarratives themselves. At the end of the discussions, groups can share their findings with the rest of the class (CAMH 67).

In terms of written assignments, I would propose a Reading Diary or Journal, a Book Review or a "Personal Essay" the way Berman describes it. For his summer course, he told his students "that they could write the formal essay assigned not on a book but on how it was upsetting them […]" (B7-B9), the therapeutic effect of which has already been discussed in section 5.1.1. I recommend including some form of writing task for this particular purpose, as well. As discussed in section 5.1.2, different tasks establish

different degrees of emotional distance, the Book Review and the Personal Essay for example, standing on rather opposite ends of the spectrum, and I would argue that here again, a certain element of choice on the part of the students is paramount. If they want to work on something more personal to tap into the cathartic effect writing can have, there should be a medium for them to do so. However, there should also be an alternative for those who do not feel comfortable with writing from such an intimate perspective.

Regardless of the format or mode of discussion, it is important to come up with themes and guiding questions that help explore the topic of mental illness in literature in a productive and safe way. Hayn and Kaplan offer the following suggestions:

> After learning about […] various mental health issues through reading […] students can examine collectively questions such as "What is normal?" "When is labeling useful and when can it hurt?" "What are our responsibilities if a friend or classmate is suffering from what we suspect may be an undiagnosed mental health problem?" (212)

In addition to themes already mentioned in previous activities, Scrofano recommends that "[t]een readers can discuss […] how to combat the stigma, why the characters [in the novels] feel compelled to hide their [own or their] loved one's illness, and what other solutions might be possible" (17). In the psychology classroom or a combined CLIL session, students could focus on current treatment options, and for example "discuss the controversies surrounding the question of medication versus or combined with psychotherapy" (Scrofano 17).

When bringing up a book such as *IKOAFS* or *TATWD* in a foreign language classroom, teachers should also focus on the power of language as it relates to social injustice and oppression, as Richmond states:

> By examining terms such as disturbed, nuts, psycho, spastic, crazy, and mental, students can question why those with mental illness are marginalized and bullied. […] Reading books about mental illness can motivate students and teachers to be aware of the power of language choices and to become empowered to confront the stigma associated with mental illness and confront bullying of those struggling with depression, anxiety, and others living with mental illness. ("Using Literature" 24)

Furthermore, I think pupils can be entrusted with tasks that critically reflect on the narratives of mental illness they have encountered in the assigned YA novels. Scrofano suggests the following guiding questions for this activity:

> What do the teens think of the current literature of mental illness? Are the endings of the books too tidy? Are the adults given too much power? Do the novels leave us

> wondering about characters' lives beyond their initial diagnoses or once the crisis is over? What kinds of stories of mental illness should be told in the future? (20)

When the time comes to close down the topic, the panel discussion outlined in section 5.2.2 is one way to do so. Another (additional) activity for the class to do towards the end of the unit is "Awareness posters" (CAMH teacher's guide 71)[41]. The purpose of this art project is "[t]o engage the students in a creative response to combating stigma in their school and community". Using materials such as "[p]osterboard, newspapers, magazines, paints, glue and other art supplies" pupils are asked to "design a poster that will create awareness about a mental health issue". The teacher could suggest a few issues or topics to choose from such as "the impact of stigma on the lives of people with mental illness; facts about a particular mental illness; the important contributions of people with mental illness; stereotypes of people with mental illness, etc." Once finished, the posters should be "display[ed] prominently" all over the school building.

I also found a very interesting exercise in Pace Nilsen et al. called "Banned Book on Trial" (393), which seems perfectly suited for closing down a story like *TATWD* or *IKOAFS* in class. The premise is simple: Students break into small groups, forming a jury, attorneys for the prosecution and one group as attorneys for the defense. Then they conduct a mock trial as if the particular book were on trial for being unsuitable and might be banned i.e. never read at school again. Here students get to form and express their own opinions on "dangerous" topics, censorship, the overall discourse of mental health, and whether or not this is a subject that should be brought up at school.

Of course, teachers need to be prepared for all the possible different outcomes of this trial. If the prosecution wins, should teachers automatically take this to mean that reading the book in class, or assigning it to a group, was a mistake, and that they shall never work with it in another class? Perhaps one group won simply because their speaker had more convincing rhetoric and body language? Rather than focusing on the result of the trial, what actually matters here is the arguments students from all sides introduce to the debate, which is why it makes sense to plan a reflection task after this trial to really discuss the individual claims and ideas presented and get a

[41] This paragraph is based on and contains references to CAMH teacher's guide 71.

feeling for the class' true attitudes towards the books they have read and the overall concept of addressing mental health at school.

Last but not least, I advocate for a portion of the lesson plans being dedicated to giving students practical advice for encounters with mental health problems in their own lives. This kind of micro-activism, as I would call it, involves helping students "learn how to take action against stigma", "show[ing] students how to change their own behavior"; teaching them how to "help others learn about stigma and mental illness; be supportive to someone they know who has a mental illness; and how to find help for themselves if they think they have a mental health problem" (CAMH teacher's guide 65). As a minimum, teachers should supply their pupils with "some general information on ways to get help", such as a handout featuring a list of the mental health counselling services available to them in their region and ways of contacting these organizations (CAMH teacher's guide 66).

These are just a few suggestions from a vast pool of ideas and exercises teachers might want to try. I highly encourage my fellow colleagues to be creative, however I also want to caution against being carried away by unrealistic expectations.

5.2.4. Realistic outcomes

As the last and most important part of the classroom practice segment of my paper, I want to make clear that any teacher must know and specify realistic aims and outcomes for what they want to achieve by covering the topic of mental illness and bringing books addressing this issue into a classroom. We should not be carried away by idealism, and we must not expect too much from our students. As Mechthild Hesse points out, "[t]he effect of reading is not always immediately visible" and "as teachers we should not expect […] immediate attitudinal changes among our learners" (79). Pace Nilsen et al. remind us: "Teenagers are not trained adults"; they "are not psychologists, and they are not social workers or philosophers. Literature may be as close as they will ever come to discussing the kinds of problems dealt with in these fields" (360). Equally, teachers are *not* psychiatrists, therapists, or social workers. They need to understand what is possible through their work and what is not before designing their lesson plans and introducing the material to their students. To help with setting up achievable goals, I personally have found Pace Nilsen at al.'s guidelines on the "Powers and Limitations of Young Adult Literature" very useful:

> What literature cannot do:
>
> 1. It cannot cure someone's emotional illness.
> 2. It cannot guarantee that readers will behave in socially approved ways.
> 3. It cannot directly solve readers' problems. (360)

However,

> What literature can do:
>
> 1. It can provide a common experience or a way in which teenagers and adults can focus their attention on the same subject.
> 2. It can serve as a discussion topic and a way to relieve embarrassment by enabling people to talk in the third person about problems with which they are concerned.
> 3. It can give young readers the confidence that, should they meet particular problems, they will be able to solve them.
> 4. It can increase a young person's understanding of the world and the many ways that individuals find their places in it.
> 5. It can comfort and reassure young adult readers by showing them that they are not the only ones who have fears and doubts.
> 6. It can give adults as well as teenagers insights into adolescent psychology and values. (360)

Perhaps most importantly, literature can serve as a mirror of society through which students can observe and critically engage with social injustices. For every activity and every piece of literature a teacher assigns, they need to remember that the overall realistic goal of introducing the topic of mental illness to students is a simple but powerful one. As Corrigan, Roe, and Tsang frame it, "[t]he goal of education sessions is not for the listener [or student] to learn the extensive literature on mental illness. This kind of effort takes professionals many years to master. Rather, the goal is to provide listeners with some simple facts so that many of the public myths about mental illness crumble" (91).

6. CONCLUSION

In this diploma thesis I have investigated the significance, context and impact of the stigma around mental health both in the past as well as in the present. Historical and current instances of stigmatizing and discriminatory practices in our (popular) culture have been analyzed with a focus on the power these narratives impose on the way we as a society perceive and treat individuals with mental disorders. I then proposed that mental health related YA novels can serve as counternarratives (or counter-

discourses) which offer alternative perspectives to the long-held prejudices still widely propagated by the media. I justified my hypothesis by inspecting two YA novels for the potential they bear to deconstruct harmful narratives, replace them with more realistic and positive ones and, most importantly, help foster empathy for those affected through a variety of stylistic choices and techniques. The last segment of my paper was dedicated to illustrating not only why but also how YA literature featuring mental illness should and could be discussed in a foreign language setting at school and I endeavored to give guidance regarding teaching goals, literature selection, connection to the Austrian curriculum, as well as a few concrete ideas for activities to support any teacher interested in furthering the cause of destigmatizing the topic of mental illness as much as I possibly can.

In a way, the various subsections of my thesis each showcase different facets of the power of language. I have established how words can be used to stigmatize, ridicule, label, misrepresent, embarrass, hurt, isolate, and oppress. Certain passages of the primary literature under analysis have also pointed out the frequent imprecision of language resulting in the narrators struggling to express their pain, thus depicting what words cannot do. However, I hope I could also illustrate in equal measure that words can be used to educate, to apologize, to question, to connect, to draw up images in the mind, to foster empathy, to empower, to open someone's eyes against prejudice, to make each other strong, and to take ownership of one's own narrative. The immense power of words is perhaps most poignantly and beautifully expressed in the final scene of *IKOAFS*, when Craig shows readers that his act of "choosing words" means nothing less than choosing to live, because it means choosing to continue his story.

> Run. Eat. Drink. Eat more. […] Make art. [...] Tell people your story. Volunteer. [...] Help people. […] Travel. Fly. Swim. Meet. Love. Dance. Win. Smile. Laugh. Enjoy. Take these verbs and enjoy them. They're yours, Craig. You deserve them because you chose them. You could have left them all behind but you chose to stay here. So now live for real, Craig. Live. Live. Live. Live. Live." (444)

I set out to write this paper because I was devastated by current statistics telling me a large portion of my future students were struggling with serious mental health problems including anxiety, depression and even suicidality and, what is worse, is that many of them were going through this completely alone – too afraid of being ostracized to speak up and seek help. As an educator I feel a responsibility to do my part in

raising a generation comfortable with talking about mental health, and after writing this paper, I cannot wait to put everything I have learned across my research to good use in future classrooms.

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8. DEUTSCHE ZUSAMMENFASSUNG

Diese Diplomarbeit beschäftigt sich mit der Thematisierung von psychischen Erkrankungen in englischsprachiger Jugendliteratur, mit besonderem Fokus auf der häufigen Stigmatisierung psychischer Krankheiten. Eine Studie von Wagner et. al. mit dem Titel “Mental health problems in Austrian adolescents: A nationwide, two-stage epidemiological study applying DSM-5 criteria” (2017) hat offenbart, dass nahezu jeder vierte Jugendliche in Österreich von psychischen Problemen betroffen ist. Gleichzeitig nehmen viele der Betroffenen, aus Angst vor Stigmatisierung in ihrem Lebensumfeld, niemals professionelle Hilfe in Anspruch. In den letzten Jahren konnte in der Jugendliteratur ein Trend beobachtet werden, der eine ganze Reihe neuer Bücher hervorbrachte, die sich mit Fragen der psychischen Gesundheit auseinandersetzen. Zwei von ihnen wurden für die Analyse ausgewählt, und zwar Ned Vizzini’s *It’s Kind of a Funny Story* und John Green’s *Turtles All the Way Down.* Beide Romane weisen Ich-Erzähler auf, wobei sich das erste Werk mit Depression beschäftigt und das Zweite Einblicke in die Psyche eines jungen Mädchens vermittelt, das unter Zwangsstörungen leidet. Basierend auf der Auseinandersetzung mit diesen beiden Romanen, ebenso wie mit einer Reihe von Texten der Sekundärliteratur aus unterschiedlichen Forschungsgebieten, angefangen von Psychologie, über Geschichte, Kultur- und Medienwissenschaften, Linguistik, bis hin zur Literaturdidaktik und Unterrichtsmaterialien zur Förderung eines Bewusstseins für psychische Gesundheit, verfolgt diese Arbeit drei Hauptforschungsziele: Erstens untersucht und erklärt sie die Bedeutungen des Stigmas der psychischen Erkrankung, sowie die sozialen Mechanismen, die diesem zugrunde liegen, und bettet diese Mechanismen in ihren historischen Kontext ein. Ebenso gibt die Arbeit konkrete Beispiele solcher Stigmatisierung aus den heutigen Medien und demonstriert, wie diese die Lebenswelt der Teenager beeinflussen können. Zweitens werden Möglichkeiten, wie Jugendliteratur durch die Themen, die sie anspricht, aber auch durch die verwendeten Stilmittel und Erzähltechniken, als Gegenkraft zu dieser Stigmatisierung wirken kann, beleuchtet. Schließlich beschäftigt sich die Arbeit mit Ideen, wie die ausgewählten Primärwerke zu diesem Zweck im Klassenzimmer (z.B. im Englischunterricht) eingesetzt werden können. Einwände im Zusammenhang mit dem Ansprechen von Tabus oder kontroversen Fragen in der Schule werden diskutiert und gegen die Vorteile einer Befassung mit solchen Themen, die zu einer Entstigmatisierung von

psychischen Erkrankungen beitragen und gleichzeitig das Verständnis für und die Empathie mit Erkrankten fördern soll, abgewogen. Zusätzlich werden Richtlinien in Bezug auf Unterrichtsziele, Literaturauswahl, Anbindung an den Österreichischen Lehrplan, sowie einige konkrete Unterrichtsvorschläge angeboten, um interessierte LehrerInnen in ihren Bemühungen zu unterstützen, eine Generation von Jugendlichen heranzubilden, die frei und offen über psychische Gesundheitsthemen sprechen kann.

9. ABSTRACT

This thesis analyses the topic of mental illness in Young Adult Literature, with a special focus on stigma. A recent study by Wagner et al. titled “Mental health problems in Austrian adolescents: A nationwide, two-stage epidemiological study applying DSM-5 criteria” (2017) revealed that nearly every fourth adolescent in Austria faces psychological problems, yet many of those suffering never seek professional help for fear of stigmatization by their environment. In the last years a trend in Young Adult Literature could be observed that brought forth a variety of new books, which discuss mental health issues. Two of them have been selected for analysis, namely Ned Vizzini’s *It’s Kind of a Funny Story*, and John Green’s *Turtles All the Way Down*. Both books feature first-person protagonist narration, the former dealing with depression, the latter giving insight into the mind of a teenager that has OCD. By working with these two novels, as well as a range of secondary literature from various research fields including psychology, history, culture and media studies, linguistics, literature didactics and mental health awareness and education programs, this paper endeavors to fulfill three main research aims: First, it explores, historically contextualizes, and explains the meanings of and social mechanisms behind the stigma of mental illness, as well as gives concrete examples of such stigma in today’s media and demonstrates how this can impact the lifeworld of teenagers. Secondly, it showcases all the ways in which Young Adult novels, through the themes they address, as well as the stylistic devices and narrative techniques they employ, can act as counterforces to that stigma. Finally, the paper focuses on how the chosen primary literature could be used in the (English language) classroom. Concerns about raising taboos or hot button issues in school are discussed and weighed against the advantages of working with these topics to destigmatize mental illness, as well as foster understanding and empathy. In addition, guidelines regarding teaching goals, literature selection, connection to the Austrian curriculum, as well as a few concrete ideas for activities are introduced to support any teacher interested in furthering the cause of raising a generation comfortable with talking about mental health.