Anja Drautzburg

Towards a Poetics of the Mental Health Play

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Universitätsdrucke Göttingen

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Contact
Anja Drautzburg
E-Mail: anja.drautzburg@gmail.com

To
Ursula Drautzburg and Alexander Scherr

Acknowledgments

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1 Introduction: Contextualising the Mental Health Play

The history of madness is about as long as the history of theatre and in many ways both are inextricably linked. To start with, madness can be thought of as theatrical. When in the nineteenth century French neurologist Jean-Martin Charcot exposed alleged female hysterics to medical professionals (among them Sigmund Freud) as well as the lay public in his Tuesday Lectures at the Salpêtrière in Paris, the setup of the lectures resembled a visit to the theatre. Seated in a semi-circular amphitheatre-like lecture hall, the audience was invited to watch the performance of doctor and patient (Showalter, *Hystories* 34). The nature of the lectures was highly dramatic following a script and moving towards a climax, all directed by Charcot, "a showman with great theatrical flair" (Showalter, *Hystories* 31). Some scholars have argued that madness is theatrical in that conditions such as hysteria could be considered as "performative maladies" (Wald; Conroy 63). Throughout the history of the illness, women displaying symptoms of hysteria were often treated like and called actresses (Scull, *Hysteria* 65-66). There appears to have been an exclusive connection between gender and madness that prevails to the present day. Highlighting the theatricality of the condition, Elaine Showalter, for instance, refers to "the great hysterical divas of the nineteenth century" (*Hystories* 9). Others

view critically the powerful notions of voyeurism and entertainment evoked during the Salpêtrière Lectures. While acknowledging the link between madness and performance, Anna Harpin and Juliet Foster, for example, call the juxtaposition "a thorny notion" because it stigmatises pathological conditions of the mind (3). It is clear that from the outset, madness is characterised through various performative dimensions. What is more, theatre has always explored transgression, which is why it is the perfect format for investigating madness in speech and performance.

Mad characters have been present on stage, in narrative texts and poems since antiquity and even in the Bible (Harpin and Foster 5). In theatre history there is by no means a unified concept of madness from ancient Greek drama to present day plays and performances, yet Medea, Hamlet, Ophelia, Macbeth, and Woyzeck still populate contemporary stages as mad characters suggesting that conceptions and tropes of madness are to a certain extent derived from principles that go back to antiquity and still resonate today. Thus, the observation that there have been mad characters on stage throughout all periods of dramatic representation suggests that the theatre has always contributed to shaping and reflecting cultural definitions of madness in its own right.

Over the past few decades, fundamental paradigm shifts have taken place with regard to the term and the concept of 'madness' also noticeable in artistic expressions of mental distress in all its shapes and forms. The origins of these conceptual shifts can be traced back more than 200 years. In this regard, the time of the turn of the eighteenth to the nineteenth century is of the utmost importance, as Gerold Sedlmayr's insightful study *The Discourse of Madness in Britain, 1790-1815* (2011) shows (6). Taking the example of the madness of King George III, Sedlmayr argues that "in the years around 1800, there was a shift from the Enlightenment, or 'Classical', *episteme* – a constellation of knowledge relying on a 'flat' logic of 'representation' – towards the depth of an anthropological thinking which characterised the 'Modern' *episteme*" (*Discourse* 6). What is more, the metaphysical framework, which had served as an interpretative tool for humans in early modern times, was replaced by "the physicality and mental autonomy of the free individual" (Sedlmayr, Introduction 11). So, it can be concluded that the basis for how madness and mental illness is perceived nowadays lies in the transitional times around the French Revolution, when "the term 'humanity' takes on a radically new meaning" (197). As a result, a holistic conception of madness as being located in the mind and in the body emerges, which is still maintained today (3, 12). More precisely, "insanity was now gradually becoming contextualised in organic terms and seen as a medical condition that needed treatment" (Schaff, "Anatomy" 110). This then led to what Michel Foucault called "the birth of the clinic" in his study of the same title. That the theatre at the time responded to this fundamental epistemological paradigm shift, can be seen in the works of rediscovered early Romantic Scottish playwright, poet, and feminist Joanna Baillie, particularly in her dramatic cycle *Plays on the Passions* (published in instalments in 1798, 1802, 1812), in

which she theatrically explored human nature and the connection between the physical and the mental (Schaff, "Joanna" 327; see also Schaff, "Anatomy" 107). In an extensive "Introductory Discourse" preceding the published plays, she formulated an innovative theatre pedagogy in which she referenced moral philosopher Adam Smith's *The Theory of Moral Sentiments* (1759) in order to explain that she wanted to elicit empathic responses and a moral stance towards the passions presented in theatre audiences (Schaff, "Joanna" 330-31). Moreover, unlike many of her contemporaries, Baillie was not interested in making a spectacle of madness, or in glorifying it, but sought a more "holistic approach to character, thus anticipating psychoanalytical concerns *avant la lettre*," as Barbara Schaff points out ("Joanna" 326, 332). Baillie thus anticipated what in the theory of mind is called *qualia*, namely the question how to perceive and respond to someone else's pain if one has not experienced it oneself (Levin 693), which will be referred to in the following case studies.

Madness became mental illness with the advent of psychopharmacology in the 1970s. Recently, activist and survivor groups have started reclaiming madness as a means of destigmatising mental health conditions. Building on the resultant changing conceptual relationship between theatre and madness, this study is particularly concerned with contemporary plays which engage with various forms of mental distress (including suicidal and clinical depression, schizophrenia, and psychosis) as a key to understanding how the stage negotiates the radical shifts in the madness discourse. Along these lines, it explores the institutional set-ups in which knowledge about mental illness aligns with structures of power. The term 'mental health drama/play' is introduced and employed to account for and problematise the plays' innovative dramatic staging and experiments with theatricality as well as their engagement with the aforementioned paradigm shifts.

The term 'mental health play' invites the enquiry of theatre's role as "a counter to [the] 'epistemic injustice' of psychiatry, which favours some kinds of knowledge (i.e. psychiatry's) over other kinds of knowledge (such as clinical psychology's or patients')," as Deborah Bowman and Joanna Bowman suggest (178). Analysing contemporary plays' engagements with psychiatric structures of power is important because psychiatry largely operates with binaries such as illness/health and normal/abnormal. In accordance with philosopher Miranda Fricker, such dichotomies are likely to produce forms of "testimonial injustice," a variant of "epistemic injustice," i.e. the unacceptance of a particular knowledge (1-5).

The relevance of epistemic injustice for the present study is twofold: first, it is highly pertinent for considering how contemporary mental health plays contextualise psychiatry's expert knowledge as opposed to the patient experience in order "to trace some of the interdependencies of power, reason, and epistemic authority in order to reveal the ethical features of our epistemic practices that are integral to those practices" (4). Second, it offers significant reference points for the creation of different kinds of knowledge in theatrical performance as a means of counter-

acting psychiatry's authority. Theatre's role (and the role of the arts more generally) in madness discourses, I argue, is crucial in this sense but often disregarded and "simply jettisoned entirely from the debating chamber," as Anna Harpin has it (*Madness* 4).

One key point the present study draws on is that the relationship between theatre and madness (and medicine more generally) is not unidirectional but inherently reciprocal. This stance is widely accepted now; Shoshana Felman argues, for instance, that "[h]istorically, literary knowledge mirrors psychiatric knowledge and in many ways competes with it" (3). Along the same lines, Bruce McConachie points out that "the theatre is not epiphenomenal, simply reflecting and expressing determinate realities and forces. Relatively autonomous cultural practices like the theatre interact with economics, politics, and a multiplicity of other practices to energize and channel the form and flow of history" ("Reading" 230). Taking for granted this reciprocity and emphasising the aspect of competition Felman mentions, the study at hand shows that mental health drama in particular is increasingly assertive about its capacity to intervene in current mental health debates and to challenge psychiatry's hegemony (see also Harpin and Foster 10). It is therefore perfectly in keeping with Harpin and Foster's call for the appreciation of "theatre's particular capacity to remake realities with an audience and, thereby, recalibrate the continuum of 'normal' experiences" (10). When it comes to refiguring socially hegemonic images of madness, plays are forces to be reckoned with (Thiher 2; Oyebode vi). In order to corroborate the notion that audiences contribute to remaking realities in performances, I follow performance scholar Gay McAuley who states:

> I prefer to see the theatrical event as a dynamic process of communication in which the spectators are vitally implicated, one that forms part of a series of interconnected processes of socially situated signification and communication, for theatre exists within a culture that it helps to construct, and it is the product of a specific work process. (5)

Coming to terms with theatre's role in cultural discourses of mental distress requires us to take into account the very acts of seeing which it facilitates or questions. Bowman and Bowman, for instance, relate the perceptual dimension of the theatre to the act of seeing in clinical contexts and point out that the theatre in its Greek origin is "the seeing place" (167). They go on to explain: "Long before Foucault wrote about the medical gaze, the act of seeing and being seen has been integral to medical care: medicine is where objective observation, subjective interpretation, established sight lines and blind spots collide" (167). In essence, seeing and being seen in a medical context are performative, involve forms of 'staged madness,' and invite acts of gazing. Revisiting Foucault's poststructuralist studies on the power and knowledge-nexus in the context of psychiatry as well as his

coining of the concept of the 'gaze' is instrumental for considering critically the power of perception, and by extension, of psychiatry in the study at hand.

When it comes to considering how in the space of the theatre instruments of psychiatric power/knowledge are utilised, questioned, and subverted, I will argue that reconsidering Foucault's concept of *heterotopia* is fruitful for defining the respective interactions between stage and audience. As seven of the nine plays discussed here have been staged in the round or in a variation at some point, building on Joanne Tompkins' appropriation of Foucault's as well as Kevin Hetherington's notions of *heterotopia* for theatre studies, this study seeks to show that the play's cultural work is inextricably linked with theatrical spaces to produce meaning (Tompkins 24-31).

1.1 Terminological Considerations: Differentiating Between Discourses of Madness and Mental Health

A number of words that have already been used here require clarification regarding their application in this study, among them 'meaning-making' and, most importantly, 'madness' and 'mental health.' According to theatre and performance scholar Erika Fischer-Lichte, 'meaning' is a flexible term because "performance ultimately cannot be 'understood.' It is still possible to ascribe meanings to specific elements, sequences, and processes […]. The performance as such, however, cannot be understood as expressing pre-existing meanings or intentions" (*Transformative Power* 50). Transferred to my study, when meaning-making is thematised, this is not to be understood as audiences deciphering theatrical signs in order to ascertain the one designated meaning of a play but it rather describes a joint process in which both spectators and actors simultaneously consider the performance, their responses, their knowledge and perceptions (Conroy 42).

When it comes to analysing the effects of mental health plays and performances, it is crucial to consider that acts of seeing and not-seeing are not simply physical acts. They are deeply entangled with broader social discourses, namely with the language that governs what is visible and what constitutes a blind spot in a given culture's outlook on madness or mental illness. Language, as will be seen throughout, is a powerful tool in mental health and madness discourses from which ideology cannot be separated. In fact, the paradigm shifts introduced above clearly show how the use of words to describe the phenomenon of mental distress always already reveals a lot about a speaker's convictions and the ideological underpinnings that might influence their thinking.

It has already become clear that in this study, the words 'madness,' 'mental distress,' 'mental disorder,' and 'mental illness/health' are all variously employed but not unquestioningly. Yet it is nigh on impossible to draw up a unified concept of what these words connote without falling into the trap of reproducing normative

configurations that the present study might take issue with, a danger that Derek Russell Davis voiced elsewhere (167). At the same time, it goes without saying that it is impossible to address questions of what in the most general terms might be called mental distress without making reference to the terminology in use, even if this very same terminology is reductive or stigmatising. Or, as Sedlmayr points out, "to ask about madness always also means to ask about the significance of one's own position as the investigating critic with respect to knowledge formation" (*Discourse* 4).

Foucault's concept of 'discourse' or 'discursive formation' first mentioned in *The Archaeology of Knowledge* (1969) and developed and revised in his later 'archaeological' work can serve as a navigation tool in the choppy waters of madness (Lynch 120). In Foucault's earlier understanding, discourse is "not language (in the sense of grammatical rules and a lexicon) but is rather a practice; a discourse consists of all the statements that have been made within it" (120-21). Medical discourse and mental health discourse thus exemplify how "discursive regularities establish who can speak, in what voice, and with what authority" (121). In volume one of *The History of Sexuality* (1976), Foucault developed this idea further and linked it with another notion crucial for the present study, that of 'power/knowledge' (Lynch 123-24; Dreyfus and Rabinow 184, 199). Based on the idea that "discourses are […] sustained by a regime of power/knowledge relations," this study differentiates between two distinct discourses, the madness discourse and the mental health discourse (Lynch 124). It is vitally important for my argument that these phenomena are not the same. The two "discourses are the complex networks of statements that make knowledge possible; that delimit what can be said, or understood, within a particular discourse; and that determine who can speak (or at least speak with authority or be heard) within that discourse" (121-22). At the same time, it is important to remember that in Foucault's sense, power is not static but dynamic and that it is "not meant as a context-free, ahistorical, objective description" (Dreyfus and Rabinow 184).

Jürgen Link's extension of Foucault's notion of discourse is particularly useful for showing how in the theatre, much like in literature, discourses can and do overlap, and that the theatre also actively contributes to them (285).[1] According to Link, it is necessary to differentiate between special-discursive and inter-discursive elements when it comes to analysing what Foucault termed discursive formations and power *dispositif* (285). Theatre discourse can then be regarded as an "inter-discourse" because it correlates with special-discursive formations such as medicine, mental health, and madness, and engages with the power networks that these discourses form (286). According to Colette Conroy, "theatre offers a cultural

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[1]   The passage in the German original reads: "Nicht bloß das von Foucault beschriebene medizinische, auch das entsprechende pädagogische, juristische, prä-biologische und biologische Wissen scheint in vielen literarischen Texten nicht bloß 'vorzukommen', es scheint sie *geradezu wesentlich mit zu konstituieren.*" (Link 285; my emphasis)

space for the meeting of multiple disciplines," so theatre's inter-discursive nature comes to the fore when it allows for conceptualising "difficult ideas, not just about performance but about society and culture as well" (8). Building on the notion of theatre as an inter-discourse, the present study seeks to show how an overlap of the madness and mental health discourses can serve to critically examine constructions of knowledge, trauma, and suffering, and can contribute to forming new kinds of knowledge in the respective discourse.

To start with, the madness discourse is much older than the mental health discourse and the latter developed out of the former. As briefly outlined above, what Foucault calls the "birth of the clinic" can be said to constitute the starting point for the mental health discourse as I understand it here. More precisely, the moment that illness was linked to the body and moved to the clinic in the late eighteenth century, this also enabled the emergence of the concept of mental illness that came into existence in the second half of the twentieth century with the development of powerful psychopharmacological medication. In turn, mental illness automatically brought about the notion of mental health that is now as present as never before in public discourse.

In psychiatric practice, the binary terms 'mental illness' and 'mental health' propose the acceptance of the so-called biomedical model of mental disorder which is practiced in contemporary psychiatry and rests on the conviction that "the essential causes of mental illness lie in disorders in biochemical and metabolic function, for which a predisposition has been inherited," as psychiatrist Derek Russell Davis explains (1). The model is contested and problematic in that it suggests a disregard of "the inner experience of the psychotic subject," as psychoanalyst Darian Leader points out (32). Clinical psychologist Peter Kinderman goes as far as claiming that "[i]ndeed, the entire concept of 'mental illness' is relatively meaningless" (*New Laws* xxi).[2] Instead, countering the biomedical model altogether, he suggests that "[m]ental health problems are […] best understood in human rather than neurological terms" (xx). Interestingly, theatre scholars Ellen W. Kaplan and Sarah J. Rudolph prefer the term 'mental illness' and argue that "[d]istinguishing King Lear from Willy Loman means moving from madness as metaphor to a depiction of mental illness that might shed light on specific diseases, which effect [sic] vast numbers of people" (3). Kaplan and Rudolph's study *Images of Mental Illness Through Text and Performance* (2005) was the first of its kind insofar as it put emphasis on differentiating between the metaphorical uses of madness and the thematisation of mental illness as a pathological condition (3). In this sense, they anticipated the present study's project of drawing up a poetics of the mental health play.

The word 'madness' is equally ideologically charged and contested but has recently undergone a remarkable process of redefinition and reclaiming. While some

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[2] For an insightful analysis of the same idea, see Cooke, "Problems" 329-45.

scholars, such as sociologist Andrew Scull, point to its derogatory connotations in its usage in some contexts, leading clinical psychologist Richard Bentall uses it deliberately in his book title *Madness Explained: Psychosis and Human Nature* (2004) (Scull, *Madness* 1).[3] Theatre scholar Harpin and psychologist Foster actually endorse it:

> firstly, because much of our discussion is engaged with historical perspectives and this is a term that would have been used frequently until recently; secondly, out of a sense of agnosticism towards the medical model; thirdly, in a bid to operate outside the reductive terminology of health and illness in order that we may begin to recalibrate the notion of madness to encompass more than solely 'ill' (that is to say *bad*) phenomena. (3-4)

Harpin's concern for a reconsideration of the term 'madness' is expressed in her consistent use of the word, also, for instance, in her most recent study *Madness, Art, and Society: Beyond Illness* (2018). The majority of studies that focus on the representation of mental distress in literature also operate with the word, including Lillian Feder's and Shoshana Felman's seminal studies *Madness in Literature* (1980) and *Writing and Madness* (first published 1978). Psychiatrists Derek Russell Davis and Femi Oyebode also choose the word for their interdisciplinary studies on mental distress on stage, *Scenes of Madness: A Psychiatrist at the Theatre* (1992) and *Madness at the Theatre* (2012), respectively. The less recent examples focus less on the lived experience of mental distress as on madness as a metaphor or an image. At the same time, mental health activism was not as vocal in the 1980s as it is nowadays, so hardly anyone would have taken issue or considered the term derogatory in the context of literary studies.

In recent studies on the artistic/literary representations of mental disorder, using 'madness' can be taken as a(n implicit) positioning on the discursive spectrum of mental health debates. Madness is now widely reclaimed in activist contexts in which the arts and humanities often work together to break the taboo that still surrounds mental illness. As a consequence, the field of Mad Studies was established, as Canadian Disability Studies scholar Richard A. Ingram, who coined the term in 2007, outlines in "Doing Mad Studies: Making (Non)Sense Together" (2016). Funded by the Art and Humanities Research Council and the Leverhulme Trust, the interdisciplinary Madness and Literature Network was also founded in 2010 to foster critical and inclusive dialogue around madness. A special issue of the journal *Otherness: Essays and Studies* on "Otherness and the Performing Arts" including Emily Hunka's manifesto "Method in Our Madness: Seeking a Theatre for the Psychically Disabled Other" (2016) also follows an activist trajectory. In

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[3]   "Madness is no longer an acceptable term to use in polite company. For psychiatrists, its use is a provocation, an implicit rejection of their claims to expertise in the diagnosis and treatment of mental disorders, and symptomatic of a wilful refusal to accept the findings of modern medical science." (Scull, *Madness* 1)

addition, scholarship in applied theatre and disability studies liberally employs the term 'madness' to move towards a less normative and more appreciative conception of the experience of madness (Baxter et al.; Sutherland). These examples demonstrate a terminological vacillation also discernible among the psy-disciplines – psychiatry, psychology, psychoanalysis, psychotherapy – suggesting that subjectivity is a key feature of the related discourses, particularly of regulatory modes of normativity (Rose 1-21).

At the same time, the examples show that recent scholarship, for instance by Oyebode, Harpin and Foster, and Hunka, utilises madness in order to move away from uncritically accepting the biomedical model of mental health, whereas less recent studies, such as Feder's and Felman's, adopt it to explore madness as a literary motif and a metaphor, and subsume under the banner of madness a large array of matters concerning mental distress. A recent Routledge anthology entitled *The Routledge History of Madness and Mental Health* (2017) even juxtaposes the two terms in order to address varied audiences interested in madness and medicine, mental health and psychiatry. More importantly, the juxtaposition hints at the fact that the madness and the mental health discourse are distinct but inextricably linked.

The divergent application of the term 'madness' over the past four decades reflects how madness and mental health discourses have shifted towards aiming at a more positive, destigmatising, and productive use of the concept. Owing to this tendency, the present study necessarily adopts a flexible use of terminology, i.e. when the term 'mental distress' is employed, this refers to a character's experience of the world as deviating from a norm that can also only be taken as a flexible term depending on context. 'Mental disorder' and 'mental illness' are used when references are made to characters that have already been diagnosed with a particular condition. 'Madness' is used throughout but removed from its derogatory connotations towards a more positive understanding. While I endorse Kinderman's suggestion that it would be desirable not to think in (ultimately) reductive binaries such as mentally ill/healthy, discussions of contemporary expressions of madness and mental illness cannot do without references to terminology currently in use.

With regard to the timeframe of the text corpus analysed in this study, the nature of psychiatry's authoritative knowledge and how it has dominated the mental health discourse since the 1970s has to be considered in more detail in order to contextualise the paradigm shifts that have taken place since then. The introduction of Prozac opened what Andrew Scull has called the "psychopharmacological age" and provides the temporal starting point for the analyses in the present study because it revolutionised treatment of and discourses about mental illness (*Hysteria* 104-05; see also Showalter, *Hystories* 17, 81). Two of the most notable twentieth-century developments in the fields of psychiatry and psychology, the "psychopharmacological revolution" and the "therapeutic turn," provide the backdrop for

the following case studies as the most defining recent paradigm shifts that go far beyond psychiatric care and therapeutic intervention.[4]

Norwegian clinical psychiatrist Ole Jacob Madsen has coined the term 'therapeutic turn' as a means to account for the ubiquitousness of matters of the mind in contemporary Western societies and argues that "psychology and the emotional life must be considered the key juncture between the private and the political spheres, where the most important contradictions of modern society now find expression" (1-2). Historically, the current therapeutic landscape Madsen refers to can be said to have its origin in Sigmund Freud and Josef Breuer's 'talking cure' and psychoanalysis. Freud himself has long since entered the popular imagination and the controversies surrounding some of his cases have only added to the myth around him as an analyst and as a person (Gilman et al.). While psychoanalysis is still practiced as a therapeutic process in variations of the 'talking cure,' some of Freud's theories have been under attack and proven wrong (Gilman et al.). Feminist playwrights, in particular, haven taken to the Freud-phenomenon in order to deconstruct him and his interpretations of female madness. Christina Wald subsumes the body of plays featuring Freud and hysteria under the label "drama of hysteria" (27-92). To her and other scholars such as Judith Butler and Elin Diamond, hysteria is a performative malady "which represent[s] the performative quality of gender identity" (Wald 5). Hélène Cixous' feminist *Portrait de Dora* (1976), a retelling of Freud's casework on his patient Ida Bauer (named Dora), who he diagnosed with hysteria in the early twentieth century, has provided a blueprint for other hysteria plays such as Anna Furse's *Augustine (Big Hysteria)* and Kim Morrissey's *Dora: A Case of Hysteria.*[5] Most hysteria plays are attempts at deconstructing the Freud-myth and the gendered underpinnings of his influential conceptualisation of hysteria.[6] At the same time, the plethora of plays is a good example of the reciprocal relationship between theatre and madness and speaks of the fact that psychology is not only "a science [and] a clinical profession" but also

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[4]   Scull sees parallels between the aftermath of the two World Wars and "a massive expansion of the psychiatric profession, the creation of competing kinds of psychotherapists and clinical psychologists, and the beginning of a massive shift in the locus of psychiatric care" (*Madness* 83). See also Madsen.

[5]   Cixous' play's dramatic form invites audiences to ponder that labelling behaviour 'mental illness' is only one way of telling someone's story. See Hanrahan 48-58; Furse 25-34.

[6]   Other dramatic quasi-historical accounts of Freud's life and work include Terry Johnson's *Hysteria: Or Fragments of an Analysis of an Obsessional Neurosis*, which premiered at the Royal Court in 1993, and features the aging Freud and an encounter with Salvador Dalí that took place in 1938. Christopher Hampton's *The Talking Cure* deals with C. G. Jung's relationship with Sabina Spielrein in a Swiss clinic in 1904, and premiered successfully at the National Theatre in 2003. The play highlights how Jung moved forward from Freud's practices and how Spielrein played a crucial part in further developing the eponymous practice. For Freud's demonstration of psychoanalysis on fictional characters, see Freud, *The Interpretation of Dreams;* "Psychopathic Characters on the Stage;" "Einige Charaktertypen aus der psychoanalytischen Arbeit."

"a cultural artefact, with a presence as therapeutic expertise in our culture as never before," as Madsen asserts (7).

The complex and contested discipline of psychiatry is relatively young with a history of around 200 years (Kritsotaki et al. 3). First mentioned in 1808 by German physician Johann Christian Reil (1759-1813) in an essay on the various branches of medicine, the word derives from the Greek words for soul (=*psyche*) and physician (=*iatros*) (Porter 140). After centuries in which madness was understood as a "spirit invasion" or a "humour imbalance," the eighteenth century was the age of the clinics and institutionalising mental illness in Europe, while in the nineteenth century psychiatry became an established research field and mental asylums were opened (Weiner, "Madman, Part I"; "Madman, Part II"). The twentieth century was marked by advancements in the biological understanding of a large number of mental disorders and the concomitant development of powerful antipsychotic drugs, which can be considered as a psychopharmacological revolution, the second major paradigm shift addressed here (D. Healy, "Intersection" 419-37).

After years of relying on electroconvulsive therapy (ECT), lithium, and lobotomies to treat severe mental illness (such as major depressive disorder), the 1950s saw the introduction of antipsychotic drugs, which culminated in the discovery of fluoxetine in 1972, and signified a major advancement in mental health pharmacology (D. Healy, "Intersection" 429; Moncrieff 30). The substance, whose trade name was Prozac, quickly became one of the most influential and notorious drugs to treat depression in the 1980s. Chemists working for the company Eli Lilly discovered that fluoxetine in the form of a hydrochloride salt could be used as antidepressant in 1972 and developed it further to become the first marketed SSRI antidepressant in 1986 (Myers 127-29). Further adding to its notoriety, psychiatrist Peter D. Kramer hailed the drug in his book *Listening to Prozac: A Psychiatrist Explores Antidepressant Drugs and the Remaking of the Self* (1994) and Elizabeth Wurtzel offered a glamourised account of using it in her best-selling autobiography *Prozac Nation: Young and Depressed in America* (1995). Twenty years on, Prozac's reputation has become blighted because the drug is now considered overprescribed and its once-hailed efficacy has been doubted, for instance, by psychiatrist Joanna Moncrieff and by psychiatrist and psychopharmacologist David Healey in his book *Let Them Eat Prozac: The Unhealthy Relationship between the Pharmaceutical Industry and Depression* (see S. Mukherjee). Nevertheless, Prozac changed the treatment and public discourse on depressive disorders and psychopharmacology so drastically that it is impossible to ignore its impact (Lieberman et al. 1256).

Concerns about psychiatry's authority relate to deep-rooted notions of knowledge and power (or what Foucault terms 'power/knowledge') that have found expression in controversies around psychiatry's power tool, the *Diagnostic and Statistical Manual for the Classification of Mental Disorders* (*DSM*), since the mid-twentieth century (Cooper). When fluoxetine was developed, the *DSM* was in its

second edition after its first publication in 1968. Next to the WHO's *International Statistical Classification of Diseases and Related Health Problems* (*ICD*), it was then and still is the most important reference for diagnosing mental conditions and is now in its fifth edition. Since the late 1960s scepticism had been raised with regards to the validity of psychiatry's diagnostic and treatment methods and developed into the "anti-psychiatry movement" (Scull, *Madness* 92). Its most vocal and flamboyant representative was Scottish psychiatrist R. D. Laing (1927-1989). Alongside Thomas Szasz, Thomas J. Scheff, David Cooper, and David Rosenhan, Laing was an often-misunderstood practitioner who wanted to enter new paths in schizophrenia treatment away from antipsychotic drugs. Even though Laing despised the label, his name is inextricably linked with anti-psychiatry (Scull, *Madness* 92).

The year 1973 saw the publication of "On Being Sane in Insane Places," summarising the results of American psychologist David Rosenhan's experiments to determine the validity of psychiatric diagnoses. For the experiment, "pseudopatients" pretended to have auditory hallucinations in an attempt to be admitted to mental hospitals. After admission they were forced to take medication even though they had declared to feel better, but no one believed them (Rosenhan 250-58). In short, Rosenhan tested assumptions regarding the performativity of mental distress. Thus, his focus suggested the same deep scepticism of medical authority and the normal/abnormal binary that Foucault voiced around the same time and that the plays written over the past four decades express in new ways. The corpus of plays selected for this study also reflects the rise and aftermath of poststructuralist thinking, whose role in critiquing social constructions of mental illness can hardly be overstated.

Laing's work, particularly his book *The Divided Self: An Existential Study in Sanity and Madness* raised his profile and has attracted attention among psychiatrists and beyond since then (Scull, *Madness* 92).[7] The significance of the new paths in the treatment of mental disorder introduced by Laing can hardly be overestimated with regard to the critical engagements staged by mental health plays since the 1970s. Laing deemed the contemporary methods employed by psychiatrists incomplete, largely inadequate, and as taking the wrong approach (*Politics* 19). In addition, he suggested that the language used to describe the therapeutic encounter was not sufficient to capture the patient's experience:

> How can one demonstrate the general human relevance and significance of the patient's condition if the words one has to use are specifically designed to isolate and circumscribe the meaning of the patient's life to a particular clinical entity? Dissatisfaction with psychiatric and psycho-analytical words is fairly widespread, not least among those who most employ them. It is

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[7]   Interestingly, the first film about Laing's life with the highly suggestive title *Mad to Be Normal*, featuring David Tennant and Elizabeth Moss, only premiered in January 2017 and received mixed reviews (Child).

> widely felt that these words of psychiatry and psycho-analysis somehow fail
> to express what one 'really means.' (*Divided Self* 18)

Laing criticised medical labels and concomitant stigmatisation – especially how the language of psychoanalysis and psychiatry contributes to excluding patients. In *The Politics of Experience*, he states that:

> In using the term schizophrenia, I am not referring to any condition that I
> suppose to be mental rather than physical, or to an illness, like pneumonia,
> but to a label that some people pin on other people under certain social cir-
> cumstances. The 'cause' of schizophrenia' is to be found by the examina-
> tion, not of the prospective diagnose alone, but of the whole social context
> in which the psychiatric ceremonial is being conducted. (86)

Laing's insistence on schizophrenia being the product of social labelling empha-sises power structures and aligns with Foucault. It is still considered problematic but became one of the tenets of the anti-psychiatry movement, as Roy Porter sums up: "mental illness was not an objective behavioural or biochemical reality but either a negative label or a strategy for coping in a mad world; madness had a truth of its own; and psychosis could be a healing process, and, hence, should not be pharmacologically suppressed" (209-10).

One of Laing's most notorious comments on societies and families making their children mad has found its way into a number of plays analysed here. In 1967 he writes in *The Politics of Experience*:

> A child born today in the U.K. stands a ten times greater chance of being
> admitted to a mental hospital than to a university, and about one fifth of
> mental hospital admissions are diagnosed schizophrenic. *This can be taken as
> an indication that we are driving our children mad more effectively than we are genuinely
> educating them.* Perhaps it is our very way of educating them that is driving
> them mad. (87; my emphasis)

The character that implicitly agrees with Laing on this point is Doctor Martin Dysart in Peter Shaffer's *Equus*. Alan Ayckbourn's *Woman in Mind* and Tony Kushner's *Angels in America* also have overtones that suggest that the family is a contributing factor in developing a mental health condition, as will be explored in chapter 3. Moreover, *Blue/Orange*'s consultant Robert pulls the 'Laingian card' in order to create the greatest possible opposition to his colleague Bruce. In Penhall's play, Laing's work is used in a stereotypical and somewhat one-dimensional way tapping into the controversy surrounding Laing's alternative treatment centre Kingsley Hall Community, memorably evoked on stage in David Edgar's play *Mary Barnes*. Based on the autobiographical accounts of the eponymous schizo-phrenic protagonist, the play, which premiered at Birmingham Repertory Theatre

in 1978, traces how Barnes undergoes alternative therapy at Kingsley Hall, which became notorious for giving mind-altering drugs to its patients.[8]

Despite the fact that anti-psychiatry has never been an undisputed critique of psychiatry, its achievement "has been to offer an interpretation of psychiatry that began with the personal and experiential dimension of the mental patient," Peter Miller concludes (28). Thus, it paved the way for the appreciation of patient knowledge, which is why there is now "a burgeoning reassessment of Laing as a pivotal voice in twentieth-century psychiatry and mad politics," as Harpin asserts (*Madness* 19), and as the analysis of *The Eradication of Schizophrenia in Western Lapland* will show. What is more, it can be argued that the task of raising awareness of "the experiential dimension of the mental patient" Miller mentions, is exactly the kind of cultural work accomplished by literature, including theatrical enactments of such experientiality on stage.

In the 1980s a number of important policy changes in mental health care both in Britain and the United States were underway, which were a direct result of the psychopharmacological revolution. One result was a revived call for deinstitutionalising mental health care by closing the then infamous mental asylums and relocating care into the community (Bartlett and Wright; Kritsotaki et al.). In Britain, the National Health Service's first Mental Health Act in 1959 as well as Minister of Health Enoch Powell's "Water Tower" speech in 1961 had long anticipated these changes (Gould). In the US, the 1963 Community Mental Health Center and Retardation Act also sought to establish an apparatus of community care (Miller 21). The deinstitutionalisation initiative in Britain "constituted a significant philosophical sea change […] [and] was supposed to be a momentous transformation in the relationship between society and the mentally ill, in how mental illness was conceptualised and in how it was treated" (Kritsotaki et al. 4).

Underlying these assumptions was the question if society was ready for increasing the visibility of mental disorders and offering the necessary support structures. The answer is that "this goal has only been partially achieved, demonstrating the ambiguities and inadequacies of government policy towards people suffering from mental illness, which has failed to secure their social and economic equality" (Kritsotaki et al. 5). In 1983, the UK introduced its deinstitutionalising "Care in the Community"-policy.[9] The scheme is based on the belief that someone with a mild mental disorder can better recover as an outpatient in a familiar environment supported by family members and close friends, psychiatrists and social workers (Bartlett and Wright). On the one hand, moving a patient out of mental institutions was supposed to empower patients, yet with increased visibility came stigma. Particularly Joe Penhall attacks the policy and its devastating repercussions, most notably in *Some Voices* (1994) and *Blue/Orange* (2000), suggesting that the height-

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[8]   Irish writer Edna O'Brien also recounts taking LSD under Laing's supervision in her memoir *Country Girl* (2012).

[9]   For a comprehensive history of community care, see Bartlett and Wright's study.

ened visibility of madness had more detrimental than positive effects on patients and carers.

The 2000s, which all the other plays analysed here are situated in, has also been an unsettled time for psychiatry. The current status quo suggests that despite rapid advancements in neuroscience such as CT and MR imaging, i.e. the making visible of the brain, we still do not know more about the etiology of most mental health conditions, while increasing numbers of people are diagnosed with a mental illness (Scull, *Madness* 4-5). Statistics say that in the UK, one in four will experience mental illness at some point in life (Mind). In addition, the psychopharmacological revolution has fallen short of expectations, and taxonomising mental health conditions has escalated as the latest *DSM-V* with its more than thousand pages demonstrates (Porter 214). Psychiatry and clinical psychology are largely still competing disciplines providing different modes of treatment for an ever-growing number of disorders (212).

At the same time, in the arts, mental health problems are as visible and as vocal as never before. In the UK, the two largest funding bodies, the Wellcome Trust and the Arts Council support artists whose work is concerned with health-related topics and ask them to demonstrate public engagement and impact (Wellcome Trust). Examples include the funding of Ridiculusmus' *The Eradication of Schizophrenia in Western Lapland* as the group was an Arts Council National Portfolio Organisation between 2006 and 2015, Duncan Macmillan's *Every Brilliant Thing*, and other collaborative projects like *Ether Frolics*, which brought together artists, anaesthesiologists, and medical researchers immersively exploring the history and practice of anaesthesia in 2005 (Garner 311-28). The Wellcome Trust also commissioned "The Sick of the Fringe"-initiative – part of it was a small festival within the Edinburgh Festival in 2015, 2016, and 2017 – bringing into creative dialogue artists, performers, scientists, and audiences in order to address questions of illness and health, bodies, and disability to increase diversity (The Sick of the Fringe).

Destigmatisation campaigns have amplified the visibility of mental illness, especially since Australian mental health researcher Anthony Jorm has started propagating the term 'mental health literacy,' which implies that "[w]e are 'literate' if we can recognise that certain behaviours are examples of a particular psychiatric illness, if we 'know' that these are biologically caused, and if we 'believe' in psychiatric drugs" (Read et al. 159).[10] It is perhaps the claim of certainty as well as what the psychopharmaceutical industry makes of this supposed certainty that causes problems with the term even if increasing awareness and public knowledge of mental disorders (that is, mental health literacy, in Jorm's terms) seems timely. Yet, this heightened visibility is not universally considered a positive development, as Porter suggests when he claims that the propagation of psychiatry has led to a

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[10] For an introduction to the concept, see Jorm, "Mental Health Literacy" 231-43.

"'victim culture' in which benefits may appear to lie in buying into psychiatric paradigms" (217).

This is where the two paradigm shifts intersect because while "victim culture" might be a stark word choice, Porter nonetheless highlights a current trend not only in the arts but society overall towards a therapeutic culture in which even members of the British Royal family admit to experiencing mental health problems related to bereavement or giving birth, and in which self-diagnosis and self-help with the aid of the internet have become commonplace (Wright; Aubry and Travis; Madsen). This therapeutic culture, Madsen argues, is the product of the therapeutic turn as "'[m]ental life' has quite simply assumed its rightful place within the enormous focus health has come to receive in the daily lives of ordinary people and the media in Western culture" (3). While in the past people were diagnosed by medical experts due to what Michael Bury calls "medical monopoly," now it has become possible to diagnose oneself because the media discourse has changed and because medical resources are widely available (9). At the same time, both information on conditions and mild medication have become much more accessible, thereby seemingly democratising mental health care. Bury explains this "medicalization of everyday life" as an expression of rationalising processes from modernity to postmodernity and states that "once the institutional development of modern medicine [was] established in the shape of the clinic, hospital, laboratory, its practices and perceptions [began] to infuse life in myriad ways" (9-10). Porter's notion of today's victim culture can thus be regarded as the result of this infusion as well as the pervasiveness of the mental health discourse and "medicine's calculating gaze," that is, the ordering into normative categories of ill and healthy (Bury 10). Moreover, Porter's linguistic slip also neatly demonstrates the fine line that dramatic interpretations of mental disorder as well as campaigns to destigmatise mental illness tread between giving a voice to madness and making an overexposure spectacle of it. This fine line is also discernible in all the plays analysed in the following case studies.

1.2 Literature Review

In answer to the paradigm shifts mentioned above, in the past forty years scholarship on madness and mental health has abounded in many fields, and an exhaustive survey of the current landscape would go beyond the scope of this study. Rather, an overview of the most important critical strands at the interface of madness, theatre, and literary studies that have informed this study will be provided in order to substantiate the notion of reciprocity.

In the poststructuralist studies *The Birth of the Clinic: An Archaeology of Medical Perception* (1963) and *Discipline and Punish: The Birth of the Prison* (1975), *Madness and Civilization: A History of Insanity in the Age of Reason* (1988), as well as a lecture series held at the Collège de France between 1973 and 1974 later published as *Psychiatric*

Power: Lectures at the Collège de France, 1973-1974, Foucault draws up a historiography of madness from the Renaissance to the 1970s. Key terms that arise from Foucault's work, such as 'discourse,' 'gaze,' 'power/knowledge,' and 'heterotopia,' resonate in a multitude of fields far beyond the historical context that Foucault refers to. My study appropriates Foucault's notion of discourse on a methodological level while gaze, power/knowledge, and heterotopia are reconsidered in the particular context of the mental health play and its theatrical renderings. While gaze has found widespread application in theatre studies, the concept of heterotopia seems to have been limited to a small number of studies by Australian scholars Gay McAuley (1999), Joanne Tompkins (2014), and Adrian Kiernander (1997), as well as by German theatre and performance scholars Erika Fischer-Lichte and Benjamin Wihstutz (2013).

When it comes to contextualising visual and visible aspects of madness, the work of American cultural and literary historian Sander L. Gilman has been instrumental for decades in providing a vocabulary for the pervasiveness of 'othering.' In particular his studies on aspects of perception and pathology, *Seeing the Insane* (1982) and *Difference and Pathology: Stereotypes of Sexuality, Race, and Madness* (1985), alongside more recent essays on questions of illness and health and the history of pain are key reference points for analysing how the visual histories of medicine and psychiatry are problematised and reflected on in recent mental health drama. In this regard, Gilman's work is specifically helpful for considering how notions of stereotyping and othering that the present study elaborates on in the context of mental illness and its theatrical representations are problematic in their relation to ideas of knowledge and truth.

A small number of studies, anthologies, and essays focus exclusively on madness as represented in contemporary theatre. Examples include Anna Harpin and Juliet Foster's edited anthology, *Performance, Madness and Psychiatry: Isolated Acts* (2014), and a number of critical essays by Harpin, that all seek to contextualise madness as a burning socio-political concern nowadays. Harpin's monograph *Madness, Art, and Society: Beyond Illness* (2018), crosses genre boundaries in order to substantiate her call for appreciating the fundamental role of the arts in recent mental health and madness discourses.

Also situated at the interface of the mental health and madness discourses is Kaplan and Rudolph's study *Images of Mental Illness Through Text and Performance* (2005) in which the authors insist on a reading of mental distress in dramatic representations as mental illness. Ariel Watson's essay "Cries of Fire: Psychotherapy in Contemporary British and Irish Drama" (2008) and Christopher Dingwall-Jones' essay "Mental Illness Between Subject and Object: Radical Empathy and Shared Subjectivity in Two Contemporary Performances" (2017) similarly lay the focus on the pathological aspects of mental distress and can therefore also be situated at the interface of the two discourses that I draw up.

Derek Russell Davis, a psychiatrist at the theatre, as made clear by the sub-title of his interdisciplinary study *Scenes of Madness* (1992), is concerned with the didactic dimension of madness on stage. More precisely, Davis asks what plays can tell audiences, but also psychiatrists, about conflicts in interpersonal relationships and refers to a wide range of plays from ancient Greek drama and Shakespeare's plays to Henrik Ibsen's, Tennessee Williams' and Samuel Beckett's work. Similarly, psychiatrist and poet Femi Oyebode provides an interdisciplinary focus for his short readings of a similar group of plays in *Madness at the Theatre* (2012). Both studies with their calling attention to the reciprocal relationship between madness and theatre have influenced the methodological framework I employ in this study.

An area of literary and theatre studies that has received extensive critical attention and that resonates with the study at hand is feminist literary scholarship on the gendered aspects of madness, particularly on hysteria. Studies include Elin Diamond's *Unmaking Mimesis*, Elaine Showalter's *The Female Malady: Women, Madness, and English Culture 1830-1980* (1987) and *Hystories: Hysterical Epidemics and Modern Culture* (1997), and Christina Wald's *Hysteria, Trauma and Melancholia: Performative Maladies in Contemporary Anglophone Drama* (2007). Wald extends the focus to also include melancholia and trauma as represented on stage and makes useful additions to Showalter's notion of a 'female malady' based on Judith Butler's work on gender performativity. Patrick Duggan takes the cue from Wald for his study *Trauma-Tragedy: Symptoms of Contemporary Performance* (2012) in which he focuses on how the representational medium of theatre engages with the unrepresentable aspects of trauma. Both Wald's and Duggan's studies provide reference points for how questions of the representational in performance are particularly challenging when it comes to mental distress.

A number of studies on madness and literature take antiquity as a starting point and work their way towards more recent work that thematises madness across all literary genres. Examples include Shoshana Felman's *Writing and Madness: (Literature/Philosophy/Psychoanalysis)* (1978), Lillian Feder's *Madness in Literature* (1980), *Madness in Drama*, edited by James Redmond (1993), Branimir M. Rieger's edited anthology *Dionysus in Literature: Essays on Literary Madness* (1994), and Allen Thiher's *Revels in Madness: Insanity in Medicine and Literature* (1999), who all adopt a (post-)structuralist stance with their focus on how language determines and structures discourse, and are thus in many ways indebted to Foucault's work. All resonate with the present study because of their particular interest in how language has informed the madness discourse ever since antiquity. This includes questioning how concepts of othering, alienation, invisibility, and the real that the present study also mobilises, have found application in recent dramatic interpretations of mental disorder.

Feder and Thiher, who see in madness as it is represented in literary texts a juxtaposition of social and literary history, have inspired the present study's socio-cultural approach. When it comes to analysing how madness influences personali-

ty development, there seems to be a peculiar interest in how madness expresses itself creatively bordering on autobiography and life writing (Felman; Redmond; Rieger). The figure of the literary genius is often referred to as proof of how literary production and authors' mental states influence each other (Gilman, *Difference* 217-38). While biographical background is appreciated as potentially motivating the creative engagement with disordered states of mind, for instance, in the cases of Sarah Kane and Ridiculusmus, the present study is not overtly concerned with potentially self-referential approaches to madness because such a focus would distract from the broader argument that is pursued here.

1.3 Aims and Structure of this Study

This study argues for theatre's key role in addressing, challenging, and renegotiating contemporary models of madness, which differ from archaic terms of madness. What is at stake in the in-depth case studies is the interrogation of theatre's counter-discursive dimensions with regard to epistemic truths about madness created between the poles of today's psychiatric practice and therapeutic culture. In addition, the case studies seek to show how in particular the plays' form and content as well as staging and theatricality problematise madness and the psy-disciplines' power/knowledge nexus with differing intentions and implications.

The idea that form and content have to be considered side-by-side derives from Kirsten Shepherd-Barr's study *Science on Stage* where she states that "[i]t is no coincidence that science plays display a strong correlation between form and content: their questioning stance with regard to vital moral and scientific issues is often packaged in forms that reject dramatic realism and conventional staging methods" (*Science* 5-6). Aspects of production and performance such as the stage design, the seating of the audience, and the use of metadramatic devices in the plays analysed often highlight a critical stance towards concepts such as the biomedical model of mental illness.

The text selection of the study at hand is deliberately heterogeneous in order to show the broad spectrum of British and American plays that deal with non-normative states of mental distress and the changing madness and mental health discourses between 1973 and 2015. The plays considered range from Peter Shaffer's classic *Equus* (1973), Alan Ayckbourn's tragi-comedy *Woman in Mind* (1985) to Tony Kushner's epic two-part piece *Angels in America* (1991/92), from Sarah Kane's experiential *4.48 Psychosis* (2000), Joe Penhall's three-hander *Blue/Orange* (2000), Anthony Neilson's surreal *The Wonderful World of Dissocia* (2004), Lucy Prebble's clinical romance *The Effect* (2012), and Ridiculusmus' devised play *The Eradication of Schizophrenia in Western Lapland* (2014) to Duncan Macmillan's participatory piece *Every Brilliant Thing* (2015) and are brought into conversation with each other to argue that it is precisely their combination of mimetic and experien-

tial/experimental elements that make a substantial contribution to formulating the poetics of the mental health play.

The performance analyses in this study are based on performances that I attended and documented at the National Theatre in London (*The Effect*), Sheffield Theatre (*4.48 Psychosis*), at The North Wall Arts Centre (*The Eradication of Schizo-phrenia* and *Every Brilliant Thing*) and Pegasus Theatre in Oxford (*Every Brilliant Thing*), at Battersea Arts Centre and Shoreditch Town Hall (*The Eradication of Schizophrenia*), and Thalia Theater Hamburg (*Engel in Amerika*), on performance recordings that are available at the National Video Archive of Performance in London (*Equus* and *Blue/Orange*), and a plethora of reviews. While some critics oppose studying performances because of their ephemerality, the present study follows theatre scholars such as Jill Dolan and Gay McAuley who assert that studying and documenting performances is a necessary endeavour in order to substantiate what the theatre can achieve, what effects plays and performances might have beyond the theatrical context, and in order to diminish "the gulf between theatre practice and academic theorizing about theatre" (McAuley 11; see also Dolan 8-10, 15).

The following chapter 2 illuminates the intersections between theatre and madness with a particular focus on the aspects of language, stereotyping, and space. Building on Foucault's work on madness and the gaze in psychiatric con-texts, the chapter explicates Foucault's central concepts and subsequently devel-ops perspectives with regard to how these concepts will inform the analysis of mental health plays. Some of the plays seem to endorse the power of the gaze, while others make the invisible workings of the mind visible, as a means of critique and subversion of psychiatric power. Added to power/knowledge and gaze, Foucault's and Tompkins' notion of *heterotopia* is explored as useful method-ological concept for analysing how the theatrical space, particularly in the round-stages, contributes to the critique mental health plays voice because the emphasis on spatiality, while often still neglected in critical enquiry, is a crucial aspect of the empathetic engagement that the mental health play operates with.

Chapter 3 presents the first case studies and deals with the depiction of gen-dered mental distress in the domestic context of the family, taking as examples *Woman in Mind* and the two parts of *Angels in America*. Madness in both plays is fashioned as a female malady in Showalter's sense, i.e. it appears as highly gen-dered, and both plays operate with 'hystericised realism,' a term Wald coined (49), in order to draw the audience in on the experience of hallucinations. Furthermore, the chapter considers how staging the plays alongside using certain dramatic and epic elements might contribute to othering or to subverting such mechanisms.

The fourth chapter opens the doors of mental hospitals and a clinical trial la-boratory as represented in *Equus*, *Blue/Orange* and *The Effect*, thereby offering in-sights into contemporary mental health drama's contextualisation of psychiatry's power/knowledge nexus. Strategies of undermining authority as well as the power

of heterotopic staging in the round are examined in order to ascertain if and how the plays subvert psychiatry's authority.

In chapter 5 the focus is on plays that lay bare the inner workings of the distressed mind, *4.48 Psychosis* and *The Wonderful World of Dissocia*, on page and stage. Both plays confront theatrically the aforementioned problem of *qualia*. The playwrights' answers to the conundrum can be found in innovative dramatic forms and stagings that seek to provide an experiential understanding of the experience of mental distress. The chapter argues that by making madness visible in experiential ways, the pieces provide dramatic, visceral attempts at countering the epistemic injustice of psychiatric power.

The final chapter is concerned with plays that through innovative dramaturgy and theatricality aim at democratising madness in the sense that they emphasise the shared experience in performance as well as engagement with alternative therapy forms for mental distress and with destigmatisation efforts, respectively. The post-Laingian play *The Eradication of Schizophrenia in Western Lapland* thematises the new treatment form of Open Dialogue in order to make a case for a new understanding of mental distress, in line with recent positions supported by clinical psychologists like Peter Kinderman and Richard Bentall. The participatory *Every Brilliant Thing* highlights the importance of community as set against the isolating, alienating experience of suicidal depression. Both plays are examples of socially and ethically engaged contemporary drama that is influenced by mental health concerns while simultaneously contributing to the mental health discourse both visibly and actively in an attempt to change attitudes toward mental illness.

While it would undoubtedly be interesting to examine the topic of mental illness in non-Western contexts, the focus was chosen because in hardly any other country are the connections between medical and artistic practices as striking as in Britain. Theatrical practices, in particular, are extremely diversified in their relation to the mental health system. Particularly when it comes to the most recent mental health plays, the British context with its changing NHS landscape and mental health policies coupled with a lively theatre (and artistic) scene concerned with destigmatisation and mental health awareness is unique.

To an extent, despite their formal heterogeneity the plays selected for this study share a number of features that show that the mental health play as it is understood here has something decidedly British. While I am not stating that variants of mental health plays do not exist in other national contexts, the plays considered here can be recognised as stemming from modern British dramatic traditions. This includes the only American play, *Angels in America*, which was written in the tradition of playwrights such as Howard Brenton, David Edgar, and others (Borreca 235-36).

A genealogy of the mental health play would have to enlist a number of precursors and dramatic traditions. To start with, due to their focus on the topic of mental health, the practices of psychiatry and medicine, British mental health plays

put emphasis on contemporary socio-historical and political questions. Such an interest has prevailed in British drama since the 1950s and found its continuation in the feminist and political drama of the 1970s and 80s (Innes, *1890-1990* 1). One might think in particular of the 'kitchen-sink drama' of the 1950s and the social realist plays post-1968 with their emphasis on using explicit language and voicing dissatisfaction with the social and/or political status quo (4; see also Kershaw 306). Added to and in line with that, a certain Brechtian influence on British stages is undeniable, and it manifests itself in mental health plays such as Shaffer's *Equus* and Kushner's *Angels*, for example (2). Moreover, 1990s 'in-yer-face' theatre with its focus on experientiality and viscerality has left traces in mental health drama.[11]

In addition to the post-war traditions of British drama just mentioned, it is also helpful to understand the emergence of the mental health play in a broader historical context. Despite their formal differences, all plays analysed in this study share (some more direct, some less direct) references to dramatic realism and naturalism (Gottlieb 420). It is productive not to understand 'realism' narrowly as the realism associated with the work of Henrik Ibsen or as a synonym for 'naturalism.' Rather, it is the plays' realistic focus when it comes to their topics, which is one of the key features of modern British drama, as Christopher Innes explain:

> Given the loosening and merging of stylistic divisions that is one of the hallmarks of modernism, 'realism' only continues to have relevance as a way of defining *focus rather than form*. The key qualities become type of subject and authorial intention, so that the term applies to all playwrights who describe their work as social/socialist realism, even when it does not fit naturalistic criteria. They deal directly with political issues, typically addressing questions of justice or calling revolutionary change. Their aims differ in degree, but are comparable in range: from presenting ethical challenges to the audience to raising ideological consciousness, or from working to correct abuses within the system to inciting violent action against it. (*1890-1990* 5; my emphasis)

Applying Innes' definition to the mental health play, then, realism refers to how many of the selected plays focus on realistic topics as a means to express "a direct social function" in the dramatic tradition of George Bernard Shaw (56). Simon Shepherd helpfully differentiates between 'expressive realism' and 'abstracting realism' in order to account for the way in which modern British stage realism functions (139-58). Shepherd uses, among others, the examples of Terence Rattigan's *The Deep Blue Sea* (1952) and John Osborne's *Look Back in Anger* (1956) to explain expressive realism as a mode that

> creates the conditions in which an audience has the sense of recognising something as the characteristic experience of its own time. The form works

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[11]   For a detailed introduction to the aesthetics and poetics of 'in-yer-face' theatre, see Sierz.

> with a stage image which is familiar, generating emotions which are trans-
> parently communicated, and from here, in the best work, moves to the ar-
> ticulation of a larger feeling about 'society' and 'people' in general. It con-
> structs the audience into a position where they agree to share this feeling
> and recognise its expressive truth. (141-42)

In contrast, abstracting realism, such as it can be found in J. B. Priestley's *An Inspector Calls* (1946) and in Harold Pinter's work "also does images of the real world, but they can feel hard to get hold of. It is realism that has had something done to it, and it produces a troubled range of critical terms for what is going on" (149). All the mental health plays analysed here are in some way or another on the realist spectrum Shepherd draws up.

When it comes to the mental health plays' modes of expressing criticism, most of the selected plays juxtapose comic and tragic elements, which derives from a British dramatic tradition that reaches back to playwrights such as William Somerset Maugham and John Synge and, of course, Shaw (Innes, *1890-1990* 2, 214-15). Despite what Innes calls 'dark themes' (214-15) – psychosis, suicide, or clinical depression – none of the plays selected for this study is outright tragic. Ayckbourn is a prime example of how using a serious topic and turning it into comedy, or 'black farce', can generate social criticism and still be popular with audiences (317; see also Bull, *Stage* 137-55). In fact, John Bull even calls this particular juxtaposition "[v]ery English, [v]ery [n]ational" (*Stage* 137). Joe Penhall, Ridiculusmus' Jon Haynes and David Woods, and Anthony Neilson all work in this dramatic tradition, which incorporates absurd and farcical elements into plays that have tragic elements or a tragic focus. And even Sarah Kane's play is not devoid of black humour.

The present study explores how a number of recent paradigm shifts in the madness discourse as well as the psychopharmacological revolution and the therapeutic turn as part of the mental health discourse are problematised, criticised, and renegotiated by contemporary British mental health plays. Ultimately, it seeks to formulate a poetics of the mental health play.

2 Mental Health Drama as a Counter-Discourse to Psychiatry

The introduction outlined a number of ways in which the relationship between madness and theatre discourses is reciprocal and by extension, then, how the theatre contributes to world-making, i.e. how it actively contributes to the formation of knowledge both in the madness and mental health discourses. Taking Deborah Bowman's comparison between the perceptual practices involved in medicine and theatre as a cue (167), the following will show how aspects of perception, knowledge, and power interact in mental health care practices and the theatre. This chapter seeks to calibrate theatre's contributions to madness discourses and vice versa with a particular focus on theatre's counter-discursive dimensions. In addition, by reconsidering Michel Foucault's work on the historiography of madness, discipline, and power, with a particular focus on the concepts of the gaze and *heterotopia*, the chapter demonstrates how the shaping of medical discourse and practices in the context of the birth of the clinic in psychiatric contexts highly resonates with contemporary mental health plays that often render such perceptual activities ambiguous for audiences in theatrical contexts.

2.1 Considering the Perceptual Practices of Psychiatry and the Theatre

Theatre scholars will point out that power is a slippery concept in the context of theatre to begin with, as collaboration is a vital aspect of the production and performance of a play (Bowman and Bowman 168; see also S. Bennett 86-106; Knowles 72-91). Stanton B. Garner, for instance, observes that "the critics who use this term – influenced by its association with panopticism in [Foucault's] *Discipline and Punish* – have often presented medical observation as a totalizing mechanism of surveillance and control" (322). And, he continues, "[t]his totalizing model proves particularly resistant to the study of drama and theatre, which employ 'multiple and intersecting observations' in decidedly non-totalizing ways" (323). Garner is correct in suggesting that applying the notion of the 'gaze' unquestioningly to spectatorship in performance is problematic because this would disregard the fact that theatre is collaborative. His critique still provides a productive starting point for constructing a number of hypotheses, which will guide my readings of mental health plays and their performances in the further course of this study.

Contemporary mental health plays engage with the gaze in two significant ways: on the level of content, psychiatry's authority is often first established and affirmed by the presence of the gaze both of psychiatrists (for example in *Equus* and *4.48 Psychosis*), but only to be undermined in the course of the play as a means of critique. On the formal level, most of the plays, especially those that have been staged in the round, thematise and often subvert what Garner calls "totalizing mechanisms of surveillance and control" (323). As a result, they contribute to addressing directly acts of meaning-making and knowledge production in performance while providing insights into spectatorship. In this sense, the gaze is not used here to merely describe power relations; rather it is problematised as a concept that can be employed on the plot/content level and subverted on the formal/structural level at the same time. Mental health plays, I argue, can invite "second-order" acts of observation, i.e. they often employ theatrical means that allow spectators to develop critical awareness of their own observations.[12] In so doing, these plays can facilitate the emergence of a metacognitive stance on the part of the spectators. According to Louis J. Moses and Jodie A. Baird, "*metacognition* is any knowledge or cognitive process that refers to, monitors, or controls any aspect of cognition. […] *Metacognitive knowledge* refers to information that individuals possess about their own cognition or cognition in general" (533). Recent audience response research underlines this idea because it found that spectators "use their experience of performance to explore other people's motivation and to re-frame their relationships" (Wilkinson 150).

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[12]   Sociologist Niklas Luhmann coined the term 'second-order observation' as part of his systems theory. See, for instance, Luhmann 257-67.

A second way in which contemporary mental health plays can involve the gaze is by operating within heterotopias. Theatre as an inherently spatial art form highly resonates with the idea of heterotopia and can exploit the concept's full potential by working towards exposing the very structures of power that inevitably form part of any act of gazing, including forms of scientific observation in medical, clinical, and psychiatric contexts. In order to show how a considerable number of plays unfold this subversive potential, it is first necessary to elaborate this argument by shedding light on and critically examine the various intersections between power and knowledge, as theorised by Michel Foucault.

2.2 Introducing a Foucauldian Approach to Madness

Foucault connects with the gaze two fundamental aspects of medical discourse, knowledge and power, which are just as central to psychiatry – that field of medical practice devoted to the diagnosis, monitoring, and treatment of mental illness in certain institutional settings. Variously called "clinical" or "medical gaze," the concept has since been adopted, modified, and contested countless times; it has found application and negation in disciplines ranging from literary studies (particularly feminist writing) to film studies and sociology in order to discuss, among many others, aspects of marginalisation and oppression (Mulvey; Bannerji; Král).

Foucault uses the French term *regard médical* in order to describe a "mutation in discourse" in which madness was reconceptualised in terms of a disease that became locatable on the human body under the scientific gaze of anatomical scrutiny (*Birth* xi). He considers the nineteenth century to be the heyday of the gaze because of advancements in pathological anatomy at the time and argues that

> [t]his period […] marks the suzerainty of the gaze, since in the same perceptual field, following the same continuities or the same breaks, experience reads at a glance the visible legions of the organism and the coherence of pathological forms; the *illness is articulated exactly on the body*, and its logical distribution is carried out at once in terms of anatomical masses. The 'glance' has simply to exercise *its right of origin over truth*. (4; my emphasis)

It is important to note that the gaze became inextricably connected to the corporeal in the nineteenth century ("illness is articulated exactly on the body"). One significant implication of this paradigm shift was that the traditional question of "What is the matter with you?" was replaced by a restructured form of medical anamnesis, now marked by the question of "Where does it hurt?" (xviii).

The present study makes a case for the continuing relevance of Foucault's historical analysis, backing up his claim that the re-organisation of medical knowledge in the late eighteenth and nineteenth centuries marked the beginning of "an era from which we have not yet emerged" (x). The body is indeed becoming ever more visible and transparent nowadays with more and more elaborate scanning

and imaging techniques such as CT and MR. As a result of this, the gaze has also become more penetrating. That the equation of seeing and knowing is often much more complex when it comes to mental illness, however, will be seen in the following case studies, where notions of perception and knowledge in the respective plays are rarely unambiguous to the extent that the gaze is often subverted.

Having alluded to the interrelations between knowing and seeing in medical practice since the late eighteenth century, it is now necessary to take into account a third key concept that is closely connected to the other two: power. Highlighting this fundamental connection, Foucault coined the term 'power/knowledge' in order to emphasise "that all forms of knowledge are historically relative and contingent, and cannot be dissociated from the workings of power" (Downing vii). In a clinical context, perception is always connected to the process of knowledge creation, as Foucault indicates: "The gaze is no longer reductive, it is, rather, that which establishes the individual in his irreducible quality. And thus it becomes possible to organize a rational language around it" (*Birth* xiv). Foucault's statement summarises the process of anamnesis and diagnosis: the doctor examines, i.e. "establishes the individual," the doctor diagnoses, i.e. "organize[s] a rational language" (xiv). In this context, it is important to bear in mind the more general concern of Foucault's theoretical project, which is in essence a critique of reason and rationality. As Gary Gutting and Johanna Oksala have put it in their entry on Foucault in the *Stanford Encyclopedia of Philosophy*, the French thinker's central aim is to unravel "the alleged scientific neutrality of modern medical treatments of insanity," exposing how the latter "are in fact covers for controlling challenges to conventional bourgeois morality" (n.p.). As this statement makes clear, Foucault's analytical interests are in the hidden manifestations of power and control, which are effective precisely because they masquerade as objective knowledge about disease. Historically, the notion of medicine's objective knowledge goes back to the turn of the twentieth century when "the medical profession as we now recognize it came into being" (Bury 6). According to Michael Bury, "[t]his involved the acceptance of an 'objective' view of disease, based on the idea of specific causes linked to discrete and specific diseases, especially infectious diseases and germ theory" (6). It is necessary to consider this claim to objectivity further.

2.3 Theatrical Language versus Psychiatry's Rational Language

Power and knowledge are expressed through language both in theatre and psychiatry. The gaze is also inextricably linked with aspects of language and power, as Foucault states in *The Birth of the Clinic*: "The clinical gaze has the paradoxical ability to *hear a language* as soon as it *perceives a spectacle*" (107-08; italics in original). Thus, there is no observation without bias. Set against psychiatry's (supposedly)

rational language, theatrical 'language' can be said to find expression in the visual and the verbal, in analogy to what Foucault describes as speech and gaze. The creation of a rational language for psychiatry can be considered analogous to theatre's finding a language for depicting madness because both might operate with description in a highly ideological manner. It bears repeating, however, that theatre operates with non-totalising ways of observation, as Garner explains in the quote above (323), and that mental health plays thus have to navigate this ambivalence. Regarding the intersection of language, power, and knowledge in the clinic, Foucault explains:

> It is description, or, rather the implicit labour of language in description, that authorizes the transformation of symptom into sign and the passage from patient to disease and from the individual to the conceptual. […] To describe is to follow the ordering of the manifestations, but it is also to follow the intelligible sequence of their genesis; it is to see and to know at the same time, because by saying that one sees, one integrates it spontaneously into knowledge; it is also to learn to see, because it means giving the key of language that masters the visible. (*Birth* 114)

Put differently, when, just like a physical condition, madness is 'put into words' in the clinic (in the form of diagnosis) and on stage (in the form of a particular representation of a mad character and their surroundings), by virtue of having been described in language, knowledge about madness is claimed *a priori*. We also see that, despite the existence of psychiatry's rational language, objectivity, of both language and knowledge, is a problematic category within the madness discourse. In Foucault's terms, objective knowledge is "the great myth of a pure Gaze that would be pure Language: a speaking eye" (*Birth* 114). The "speaking eye" is a powerful image of the impossibility of such objectivity. It suggests that we cannot see without having knowledge, which means that acts of seeing are entrenched in ideology. If and to what extent this is also partly true for medical knowledge at large is explored in a number of critical studies, particularly sociologist David Armstrong's *Political Anatomy of the Body: Medical Knowledge in Britain in the Twentieth Century* (1983) and *A New History of Identity: A Sociology of Medical Knowledge* (2002), as well as Peter Wright and Andrew Treacher's edited volume *The Problem of Medical Knowledge: Examining the Social Construction of Medicine* (1982), which is also concerned with anti-psychiatry's critical stance on mental illness.

The rational language of psychiatric practice manifests itself in manuals such as the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM*), which appeared in its fifth edition in 2013, and the World Health Organization's *International Statistical Classification of Diseases and Related Health Problems* (*ICD*). These manuals do not simply suggest providing objective knowledge on mental disorders. They rather structure the entire field of psychiatric practice and have major implications for diagnosis and treatment. Criticism of the manuals as diagnostic tools is not only

voiced by psychiatrists but extends beyond the psychiatric context. Anna Harpin, for instance, speaks of "the chimera of scientific objectivity beneath which psychiatry (in the guise of the *DSM*) masquerades" (*Madness* 3). The aforementioned controversies around each updated and revised version of the *DSM*, particularly the addition of new conditions, are further proof that objectivity is not a given in psychiatric discourse. Some argue that psychiatry, like medicine, is still an evolving science and that thus etiology and pathology inevitably become more elaborate and complex (Scull, *Hysteria* 14). Yet the inclusion of "hoarding disorder" to the *DSM-V* is a powerful example of how the rational language of psychiatry pathologises certain behaviour that could also be considered "unwise," as Rachel Cooper convincingly shows (37-38). Rather than negating the importance of revising and introducing new diagnostic criteria, Cooper points out that the mechanisms of how types of behaviour or character traits come to be pathologised are arbitrary and influenced by financial and social factors (37-38).

Medical knowledge, as the *DSM* exemplifies, is marked as decidedly exclusive, which manifests itself in a language not accessible to everyone, only to those who speak the language, as outlined above. The plays analysed in this study confirm this notion when adopting psychiatry's language, especially Penhall's *Blue/Orange* and Kane's *4.48 Psychosis*, in which terminology serves to demarcate power dynamics in the doctor/patient relationship as well as in the highly hierarchical relationships among doctors. While the juxtaposition of seeing, naming, and knowing finds recognisable expression in this context, when it comes to diagnosing mental illness, following Foucault's logic, the power of the gaze is limited as mental distress often remains invisible. What he marks as constitutive of diagnosing physical conditions – "one now sees the visible only because one knows the language; things are offered to him who has penetrated the closed world of words" (*Birth* 115) – cannot be claimed for diagnosing disorders of the mind. Nevertheless, mental conditions are named and diagnosed, and less and less tentatively so, as the 1000-page-long version of the *DSM-V* shows. Based on these manuals, the existence of objective knowledge regarding madness can be assumed, yet the gaze is never pure but always already determined by power. Furthermore, the claim that psychiatry provides objective knowledge does not hold up to close scrutiny. This allows the conclusion that it is time to consider as expertise other kinds of knowledge, for instance, patient knowledge. It will be demonstrated in the following that particularly the most recent mental health plays make a case for the acceptance and appreciation of this kind of knowledge.

2.4 Staging Otherness

Theatre has long problematised the special relationship between the verbal and the visual markers of madness that also inform psychiatric knowledge and power (Thiher 4; see also Fenwick 3-7). Shakespeare's *Hamlet*, for instance, presents the

"most extreme form of verbal/visual dissociations" and is thus a prime example of the metaphorical use of madness, as Jonathan Baldo cogently argues with regard to Ophelia's and Hamlet's madness (148). On early modern stages but also in later performances, Ophelia's madness was often emphasised by costume with actresses having unruly hair, wearing white dresses, and being adorned with wildflowers as markers of madness (Showalter, "Ophelia"). Apart from the fact that the visibility of Ophelia's madness is highly gendered, it is also a good example of how madmen and madwomen have always been (made) visible through stereotypes that emphasised their status as 'others.'[13]

'Otherness' is a pertinent concept for the present study because in the most basic sense it contextualises "what is 'normal,'" as Bill Ashcroft, Gareth Griffiths, and Helen Tiffin have it (154). Mental health plays, as the present study shows, engage with otherness that is either expressed verbally, visually or in both ways, and thus problematise a subcategory of epistemic injustice that Miranda Fricker calls 'testimonial injustice,' "theorizing [it] as consisting, most fundamentally, in a wrong done to someone specifically in their capacity as a knower" (2). In this regard, Harpin and Foster point out that representations of mad characters as others, for instance in popular culture, "reinforce lazy and deeply damaging stereotypes of mental illness, its treatment and its history" (2). In Fricker's terms, mad characters face testimonial injustice when they are reduced to contributing to the creation of a spectacle for reasons of entertainment. The theatre is not always innocent of such practices. In *Equus*, for example, an abreaction scene is highly theatrical, and in *Blue/Orange* and *4.48 Psychosis*, the patients' expert knowledge is denied. What is more, othering might also take the form of intersectionality, namely when more than one discriminating factor affects the mentally distressed character (Crenshaw). Taking the example of how black women often experience the interaction of two discriminating factors, gender and race, Professor of Law Kimberlé Crenshaw coined the term in 1989 in her seminal essay "Demarginalizing the Intersection of Race and Sex: A Black Feminist Critique of Antidiscrimination Doctrine, Feminist Theory and Antiracist Politics," and the concept has since found wide application in feminist criticism and beyond. Some of the mentally distressed characters in the plays analysed in the present study face such discrimination, for instance, when Harper in *Angels in America* is denied agency because she is a woman *and* mad, and when Christopher in *Blue/Orange* faces testimonial injustice because he is mad *and* black.[14]

Considering that theatre in the dramatic realist tradition largely rests on the principle of mimesis, as Aristotle first formulated, the multitude of forms of the mental health plays analysed in my study gestures towards the problems that the

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[13]   Theatre costumes serve a crucial function in this regard and express the broader relationship between (visual) culture and madness. See Showalter *Female Malady* 11; Fenwick 4; Gilman *Seeing*; Maclaurin and Monks.

[14]   On the aspect of intersectionality, see Carastathis.

mimetic features of the realist tradition might pose for mental health drama. Mimesis in Aristotelian terms is "a means of selecting from the particulars of human behavior those purposeful actions which, if imitated appropriately, guide listeners and spectators to the recognition of ethical universals" (Diamond ii). When it comes to mental health plays, the notion of representation as imitation that Elin Diamond also contests in her feminist study *Unmaking Mimesis*, raises the question which supposedly 'truthful' images of madness are being imitated and if such imitations might be stereotypical (iii-iv). According to Diamond, "[t]angled in iconicity, [...] in the visual resemblance between an originary model and its representation, mimesis patterns difference into sameness" (iii). It is precisely this juxtaposition of difference and sameness that all the plays analysed in the following operate with, which finds the most obvious expression in their mixed forms. I would argue that mental health plays rely on formal indeterminacy by incorporating mimesis that, following Diamond, is to be understood as "impossibly doubly, simultaneously the stake and the shifting sand" (v), into other forms – surreal, experiential, epic – that are more openly engaged with processes of making strange.

Returning to the question what to make of stereotypical images of mental distress in mental health plays, then, there are two ways of conceiving of stereotypes, as Gilman points out when he explains that, to an extent, stereotypes are a necessary "part of our way of dealing with the instabilities of our perception of the world" (*Difference* 18). Hence, it is important to differentiate "between pathological stereotyping and the stereotyping all of us need to do to preserve our illusion of control over the self and the world" (18). While it is true that pathological stereotyping can have deeply damaging repercussions and is ethically questionable, particularly when othering serves as entertainment, the use of stereotypes in mental health plays is nevertheless highly revelatory from an epistemic point of view because it can reveal "when a gap in collective interpretive resources puts someone at an unfair disadvantage when it comes to making sense of their social experiences" (Fricker 1). In other words, theatre and performance can directly and indirectly confirm, utilise, renegotiate, and subvert stereotypical representations with varying agendas and the influence of such stereotypical depictions on the recent mental health discourse should not be underestimated.[15]

Following Oscar Wilde's stance that we learn to see through artistic expressions, Gilman draws a parallel between perception and representation relevant for considering madness on stage and beyond that reminds us of Foucault's "speaking eye": "[w]e learn to perceive the world through those cultural artifacts which preserve a society's stereotypes of its environment. We do not see the world, rather we are taught by representations of the world about us to conceive of it in a culturally acceptable manner" (Gilman, *Seeing* xi). The statement reaffirms theatre's important role, as it is *the* representational medium that has the opportunity to

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[15]   This is also true for narrative fiction and poetry. See, for instance, Felman 3.

probe the boundaries of what is culturally and socially acceptable even when on the surface, it seems to maintain madness' otherness. Put differently, if audiences are constantly confronted with images of madness as violent and destructive, for instance, either on stage or in film and on television, this can manifest itself in beliefs that people with a mental health problem in the real world are also violent and dangerous. Ellen Kaplan and Sarah Rudolph convincingly argue in this regard that

> [n]egative images of mental illness permeating media cerebrally formulate collective perspective and attitudes in the audience that are accepted as factual and are often embraced by civic and social institutions to differentiate between normative and aberrant behaviors; and determine how a person will respond to the mentally ill (Preface, n.p.).

Thus the mechanisms of how "cultural artifacts" determine what is "culturally acceptable" echo how the *DSM* stipulates what is 'normal.'

Cultural representations often contribute to othering both visually and verbally. With regard to ancient Greek conceptions of madness, Allen Thiher points out that the concept of *logos* is a good example of how the Greek understanding of madness related to a linguistic breaking with the social world "and the community whose worldview we share through language […]. Outside of these shared social bonds and the language that mediates these bonds lies the plains upon which the mad person wanders, without communication, lost in melancholia" (13). In other words, madness led to exclusion that in Greek terms was expressed verbally or in non-participation in a world based on shared conventions, or, as Thiher has it:

> We exist rationally when we exist with a shared language, which means that we have a socially guaranteed *set of assumptions about the world*. These assumptions make it possible for us to exist as the social animals that we are, in our *shared social world*, the *encapsulating world of logos*. Without this development in Greek thought, it is difficult to see how we would know madness at all, for madness would have no meaning without this view that the sane self is defined by its participation in logos. (16, my emphases)

Mechanisms of exclusion have a firm base in the notion of *logos* as expressing unity through language and a "set of assumptions about the world" that still applies nowadays, as the controversies around the *DSM* demonstrate. If we interpret these shared assumptions as nothing other than knowledge, then it is easy to see that Foucault in his definition of psychiatry's power/knowledge also builds on *logos* but condenses the notion of exclusion towards a small group of experts – psychiatrists – who share a specialist psychiatric discourse and thus, a language that excludes those not initiated. This understanding of *logos* is productive because it can help account for exclusion both in the family and the clinical context, the two focal points in the following case studies.

Most of the plays analysed in this study establish a connection between language and madness by depicting what it means to exist outside "the encapsulating world of logos" (Thiher 16). In *Woman in Mind*, this is taken to the extreme in the play's opening scene where the protagonist Susan has temporarily lost her ability to speak. At the end of the play, Susan exists completely removed from the other characters, she is no longer part of the society on stage, resulting in her breakdown. A variant of the notion of breaking with logos and the "shared social world" (Thiher 16) expressed by speechlessness occurs in Kane's *4.48 Psychosis* when the patient describes a medical examination situation as follows:

Burning in a hot tunnel of dismay, my

humiliation complete as I shake without reason and

stumble over words and have nothing to say about my

'illness' which anyway amounts only to knowing that

there's no point in anything because I'm going to die. (209)

In Kane's play, although speaking and thus not silenced, the self-declared tongue-tied protagonist's statement echoes Felman's idea that the suffering body "cannot say itself" ("stumble over words and have nothing to say about my 'illness'") (3).[16] Moreover, the fact that the word 'illness' is presented in quotations marks highlights that the label has been forced upon the patient (Cooper 38). Suffering "in a hot tunnel of dismay" as well as the expression of humiliation speaks of the patient's position as other and of being outside a society against whose judging eyes s/he feels humiliated. Kane takes the idea of exclusion to the extreme by the final nihilistic line suggesting that only death will terminate this agonising state. The patient refers to the ultimate breaking with the community; a notion of madness known since antiquity but Kane's use of it does not at all amount to stereotyping.

We arrive at a number of preliminary conclusions: firstly, knowledge and objectivity are by no means indisputable categories, neither in a psychiatric nor in a dramatic context. In essence, madness destabilises knowledge because the power that perception holds over the creation of knowledge falls short when it comes to the invisible workings of the distressed mind (Felman 12-13). Secondly, despite or because of this discrepancy, visual and verbal depictions of madness largely confirm normative notions. Such culturally and socially determined conventions and notions often become knowledge. However, when mental health drama operates with visually and verbally stereotyping expressions of madness, it does not necessarily endorse othering. Rather, careful differentiation is necessary to determine if a play reverts to the kind of lazy and damaging stereotyping that Harpin and Foster rightly criticise for effect, or if a play operates with such depictions in order to

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16   "Madness becomes the symptom of a culture, but the symptom is incorporated in a silenced
      body (and a silenced soul) whose suffering cannot say itself." (Felman 3)

criticise and subvert them. The repercussions and implications of what such mental health plays achieve when mixing dramatic forms are entirely different depending on attitudes taken towards madness. At this point, it is significant to consider the spatial dimension that is an inextricable part of theatrical performance.

2.5 The Stage in the Round as Heterotopia

When it comes to calibrating the cultural work and counter-discursive dimensions of mental health plays, it is crucial to consider theatre's methods and mechanisms for creating these dimensions, particularly the spaces in which this work is produced. To recall, knowledge about mental illness is generated in institutionalised heterotopic settings and spaces such as psychiatric hospitals, asylums, or prisons. Theatre as an institutionalised setting in its own right with its own power/knowledge structures is heterotopic because it contributes just as well to such kinds of mental health knowledge. Considering the mental health knowledge production in the theatre space is not to simplistically suggest that theatre is better at depicting the various states of the disordered mind. Rather, I attempt to trace the ways in which the experience of community and immediacy in the shared spaces that often but not always divide up into stage and auditorium, contributes to the emergence of metacognitive knowledge and "can help us both refine and broaden our human and humane capacities of emotional understanding," as Mick Gordon states (45). Arguably, it is the emotional aspect in particular that is mostly absent from psychiatric practice and thus the theatre contributes this important factor to the current mental health discourse. Mental health drama is counter-discursive when mental health plays subvert power/knowledge structures and offer alternatives to psychiatry's hegemonic normativity, or the stigmatisation that often goes hand-in-hand with dramatic or filmic depictions of mental illness.

Studying theatre spaces as contributors to meaning-making and the realisation of politically engaged performances has become increasingly important, as a number of recent studies indicates (McAuley; Tompkins; Kiernander; Fischer-Lichte and Wihstutz; Wihstutz; Wiles). Inspired by and extending on scholarship in fields ranging from philosophy (Lefèbvre; Foucault; Bachelard) to social geography (Hetherington), these studies are concerned with exploring the potentialities of physical theatre spaces and buildings, such as the Globe Theatre in London, as well as the imagined spaces performances create and evoke, and contribute to a configuration and formulation of the politics of performance space.

The focus in the present study is on different types of in the round-stages used for productions of mental health plays (seven out of nine plays analysed here). Building on Tompkins' work, these spaces can be considered with Foucault's concept of heterotopia in order to describe the modes of and challenges to power and knowledge production that emerge from this particular type of stage (Tompkins; Kiernander; Hetherington). Not ignoring the fact that an audience is always

made up of individual spectators, I share Jill Dolan's focus towards considering "the audience as a group of people who have elected to spend an evening or an afternoon not only with a set of performers enacting a certain narrative arc or aesthetic trajectory, but with a group of other people, sometimes familiar, sometimes strange" (10). I am particularly interested in the community that the spatial aesthetics of the arena-type staging in the round create because mental disorder is always a concern of the community. To recall, since the 1980s the UK's Care in the Community-policy has increasingly relocated mentally ill patients from asylums into communities. By dramaturgically reproducing and putting emphasis on community analogous to what the NHS-scheme builds on, as shown in the introduction, in the theatre space, mental health plays have audience members question their own place in communities, within as well as outside the theatre. This again can be considered as a form of metacognitive knowledge produced by mental health plays.

It is thanks to the late French theatre scholar Anne Ubersfeld and her seminal studies *Lire le théâtre* (1977) and *L'École du spectateur* (1981) that it is now widely-recognised that "the theatrical presentation of place necessarily incorporates a sociopolitical commentary" (McAuley 18). The positioning of the audience is an integral factor in this regard. Fischer-Lichte, for instance, argues along similar lines that since the "performative turn" in the 1960s

> short-lived transient theatrical communities of actors and spectators are particularly relevant for an aesthetics of the performative. First, they clearly highlight the fusion of the aesthetic and the social. The community is based on aesthetic principles but its members experience it as a social reality – even if uninvolved spectators might perceive it as purely aesthetic. (*Transformative Power* 55)

One of the key methodologies of dramatically making visible related to audiences as "temporary communities, sites of public discourse" and "participatory publics" and adopted on both the content and the discursive/analytical level is the differentiation of looking *at* as opposed to looking *with* madness (Dolan 10-11). According to McAuley, following Ubersfeld, "spatial organization of the fictional world is always to be perceived in terms of ideology (the playwright's, the production's, the spectator's own)" (18). Rachel Clements refers to this dichotomy when describing *Blue/Orange* as looking at madness "from the outside in" (xxxvi). There is a crucial ideologically charged difference in representation that Harpin points to in the Notes section to her essay "Dislocated: Metaphors of Madness in British Theatre" (212), and that she makes a central concern of her study *Madness, Art, and Society: Beyond Illness*. She states:

> [P]erformance as a methodology is always with and thus resonates with a key intervention of this volume regarding the centrality of looking *with* not *at* madness. This methodological 'withness', while not collapsing particulari-

ty, is marked by *gestures of commonality rather than exception*. Such gestures are starkly political in the context of madness. (*Madness* 12; italics in original; third emphasis mine)

Harpin does not directly refer to Foucault's concept of the gaze, but parallels suggest themselves to the politics of the gaze as determining power and knowledge as well as inclusion and exclusion ("gestures of commonality and exception"). While film can adopt the method of conveying a sense of 'withness' – the sharing of a mad character's perspective, as seen, for instance, in the film *A Beautiful Mind* – only the theatre can create the commonality Harpin refers to by virtue of enabling bodies to interact with bodies.[17]

My concern here relates to how the actual physical performance space, the stage, serves as a carrier of ideologies and truths of madness that the plays' dramatic form either determine or anticipate. A few basic premises of the relationship of spectators and actors that the present study builds on have to be addressed before the importance of staging can be explored fully. When attempting to formulate an aesthetics of the performative, Fischer-Lichte uses the term *autopoiesis* to describe a particular interaction, the "bodily co-presence of spectators and actors in performance" (*Transformative Power* 38).[18] To substantiate the notion that performance functions just like a self-organising system, Fischer-Lichte points out that "performances are generated and determined by a self-referential and ever-changing feedback-loop. Hence, performance remains unpredictable and spontaneous to a certain degree" (38). Added to that, Jacques Rancière's notion of the "emancipated spectator" is crucial for understanding the role of the audience in mental health plays advanced in this study. To Rancière:

> [e]mancipation starts from […] the principle of equality. It begins when we dismiss the oppositions between looking and acting and understand that the distribution of the visible itself is part of the configuration of domination and subjection. It starts when we realize that looking is also an action that confirms or modifies that distribution, and that "interpreting the world" is already a means of transforming it, or reconfiguring it. The spectator is active, just like the student or the scientist: He observes, he selects, he compares, he interprets. (277)

Fischer-Lichte's notion of an 'autopoietic feedback loop' and Rancière's idea of the 'emancipated spectator' highlight the fact that spectating is active and that performance can be transformative. In addition, recent audience response re-

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[17] In the biographical film *A Beautiful Mind* (released 2002, directed by Ron Howard), viewers share the perspective of the schizophrenic mathematician John Nash (1928-2015).

[18] The term *autopoiesis* as it is now used in numerous critical discourses derives from cognitive biologists Humberto Maturana and Francisco Varela's studies *The Tree of Knowledge: The Biological Roots of Human Understanding* (1987) and *Autopoiesis and Cognition: The Realization of the Living* (1980).

search has shown that during performances, spectators also have to negotiate "sets of unspoken but shared cultural value, with powerful emotional and social significance" (Wilkinson 142). The following case studies build on these assumptions to argue that mental health plays have a significant counter-discursive dimension when they are staged in ways that go beyond stigmatising madness. I argue that staging in the round complicates and, by extension, intensifies these effects.

The OED defines in the round-stage as follows: "A form of theatrical presentation in which the audience is placed around a central acting area or stage, as in a circus or boxing match" (Baldick 361). Apart from the well-known arenas and amphitheatres of ancient Greece and Rome that were also popular in the United States and in France, Stephen Joseph did pioneering work with his 'Theatre-in-the-Round' in Scarborough in the second half of the twentieth century on which Ayckbourn's *Woman in Mind* premiered in 1985 (Wiles 165). While there is critical historical work on arena theatres, research on the particularities of staging in the round is sparse – which is surprising given that Joseph's stage became a success across the UK and still provides the ideal space for innovative staging and for exploring acts of watching (Auld). David Wiles underlines the stage's potential when he points out that Joseph favoured a rectangular stage over the circular stages used in France and the United States for two practical reasons, the first being focus and the second being "unsympathetic to the spaces which plays most commonly represent: rooms, fields and so forth" (165). The idea that a rectangular stage allows for presenting different focal points rather than a single one (such as the centre on a circular stage) (165) becomes particularly obvious in Penhall's *Blue/Orange* which, rather than having one point of view, is highly ambiguous and dialectical.

Not ignoring the fact that physically perceptible energy always circulates between stage and auditorium, as McAuley (246) and Fischer-Lichte (*Transformative Power* 59) note, regardless of the stage set-up, I suggest that, due to their spatial particularities on stage and in the auditorium, in the round-stages constitute heterotopias that enable the "intensification of knowledge," to follow Robert Topinka's notion (70). It is important to clarify that knowledge about madness is constructed in institutionalised spatial units (such as psychiatric hospitals and asylums) and that this constitutes a heterotopia in Foucault's sense. Topinka convincingly argues in this regard that "heterotopias problematize received knowledge by destabilizing the ground on which knowledge is built" (54).

The theatre can thus also be conceptualised as heterotopia in which the notion of knowledge is challenged. Building on Tompkins' assumption that the theatre as heterotopia leads to "conclusions one might make from such world-making [that] may affect our understanding of cultural impact and our interpretation of the actual world" (6), the following case studies explore mental health drama's im-

portant cultural work of challenging audience's assumptions about madness and subverting stereotypes.

Foucault's concept of heterotopias renders them pivotal spaces for contextualising the other and otherness because heterotopias are

> sites with no real place. There are also […] places that do exist and that are formed in the very founding of society – which are sometimes like counter-sites. […] Places of this kind are outside of all places, even though it might be possible to indicate their location in reality. Because these places are absolutely different from all the sites that they reflect and speak about, I shall call them, by way of contrast to utopias, heterotopias. ("Other" 24)

The stage in the round (and its variants) can be considered heterotopic because it forms a 'counter-site', a site of resistance, when mental health plays are staged in a way that "all the other real sites that can be found within the culture, are simultaneously represented, contested, and inverted" (24). While Foucault is vague on what "all the other real sites" encompass, with regard to the plays analysed here, they can be said to include the family home (including the garden), the mental hospital, the psychopharmaceutical trial unit of a hospital, and the distressed mind.

Mental health plays staged in the round set in mental hospitals further complicate this renegotiation, as psychiatric hospitals constitute what Foucault calls "heterotopias of deviation," i.e. spaces in which society contains all that is considered divergent from the norm (24). Tompkins helpfully extends Foucault's vague concept and convincingly shows that the "enactment of space in performance has the capacity to demonstrate the rethinking and reordering of space, power, and knowledge by locating world-making spaces and places tangibly, albeit transiently" (6). Considering the enactment but also the *non*-enactment of the mental hospital space allows for making statements regarding the challenge of psychiatry's power/knowledge nexus and the related norm(s) Foucault mentions. In particular the rectangular in the round-stages used for various productions of the plays analysed embody perfectly the ambivalences of the mental health discourse because of the specific relationship of stage and auditorium as a "form of social organisation" (McAuley 19).

Related to the heterotopic potential of stages in the round is the deliberate evocation of lecture halls and operation theatres with a plethora of connotations ranging from observation to teaching and learning (consider, for example, Charcot's lecture hall). The boxing ring reference Chris Baldick makes in his definition (and that is used in Penhall's *Blue/Orange*, for instance) alludes to staging debates in the round. Most importantly, such a positioning of the audience plays with the gaze when actors turn their backs to the spectators and play to other actors on stage. Foucault in *The Birth of the Clinic* and *Discipline and Punish* refers to Jeremy Bentham's *panopticon* as a spatial metaphor for locating power and knowledge (*Dis-*

cipline 205). While there are significant differences between staging a play in the round and an actual *panopticon* building, a metaphorical connection can be made to how a particular positioning in performance can suggest to the spectators and tentatively establish certain power relations.[19] Tompkins similarly argues that "[h]eterotopias have the capacity to reveal structures of power and knowledge: a potential outcome of a study of heterotopias is, then, a more detailed examination of locations in which cultural and political meanings can be produced spatially" (1). In this sense, the heterotopic in the round-stage has the capacity to negotiate psychiatry's power relations and make statements regarding the dramatic reception of these relations in mental health play.

It is important to point out the potentiality as well as the limits of heterotopic theatre's intervention, as Tompkins states: "a heterotopia cannot directly intervene literally in the actual world. Rather, it affords glimpses of what might be; the transitoriness of such glimpses matters little" (6). In other words, rather than enable direct intervention, heterotopic in the round-stages invite self-reflexivity, and spectators of mental health plays enter into a metacognitive process of anamnesis and diagnosis, not only of the characters on stage but also of themselves, as the in the round-stage permits to return the gaze from stage to audience and between spectators. Such a stage actively and productively actualises Fischer-Lichte's notion of *autopoiesis* to account for the constitutive aspect of co-creation (of audience and actors/performers) in performance (M. Carlson 9). This way, the stage contributes "to a rethinking of spatio-political structures in cultural practices at large" (Tompkins 11). Building on what Dolan has noted for "utopian performatives," the "temporary publics" that in the round-stages create "might encourage them [spectators] to be active in other public spheres, to participate in civic conversations that performance perhaps begins" (11). Along these lines, mental health plays' spatial aesthetics can foster metacognitive understanding and the questioning of one's own assumptions and convictions. In this sense, they are not necessarily immediately transformative on a large political scale but certainly on an individual, affective level.[20] As a consequence, mental health plays do not so much

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19   For a description of the *panopticon*, see Foucault, *Power/Knowledge* 147.
20   Following a similar notion philosopher Herbert Marcuse voices in his critique of Marxist aesthetic, Dolan convincingly states: "Perhaps instead of measuring the utopian performative's "success" against some real notion of effectiveness, we need to let it live where it does its work best—at the theater or in moments of consciously constructed performance wherever they take place. The utopian performative, by its very nature, can't translate into a program for social action, because it's most effective as a *feeling*. Perhaps that feeling of hope, or that feeling of desire, embodied by that suddenly hollow space in the pit of my stomach that drops me into an erotics of connection and commonality – perhaps such intensity of feeling is politics enough for utopian performatives. Perhaps burdening such moments with the necessity that they demonstrate their effectiveness after the performance ends can only collapse the fragile, beautiful potential of what we can hold in our hearts for just a moment" (19-20).

create utopias, *perfect* worlds, as they are involved in making and remaking the world that we currently inhabit (Hetherington viii).

2.6 Chapter Conclusion

A number of claims can now be made for twentieth- and twenty-first-century mental health plays. The plethora of forms from experimental, experiential, surreal, naturalistic, to participatory problematises the fact that the production of truth in mental health contexts is not straightforward. The complex aesthetic and ethically challenging web around mental health plays has at its centre the epistemological question what truths and beliefs we all hold regarding what is 'normal' or dubis'aberrant,' linking back to the discussion of Foucault's power/knowledge nexus and the dissemination of truths in the clinic. The heterotopic in the round-stage (and its variants) provides a frame for such representations and therefore offers visual commentaries on questions of observation, power, and knowledge in mental health discourses as contextualised in the respective plays. By extension, stage and auditorium in conjunction with each other, by virtue of being part of an autopoietic feedback loop, have the capacity to subvert the pervasive mental distress-related episteme that madness equals otherness, and to create new mental health knowledge that goes beyond pathologisation and stigmatisation.

The following case studies calibrate what truths about mental disorder contemporary mental health plays convey in order to ascertain in what ways such plays hold the potential for counteracting the testimonial injustice both in the mental health and madness discourse that they depict and contest. I argue that mental health drama has the capacity to radically redefine power and knowledge-discourses on and through heterotopic spaces in the round because it problematises psychiatric objectivity as well as socio-political normativity through scenarios that foster immersion and empathic engagement.

3 Staging Domesticity: The Gendered Underpinnings of Madness in Mental Health Drama

Taking Alan Ayckbourn's *Woman in Mind* and the two parts of Tony Kushner's *Angels in America* as examples, this chapter explores how theatre has located female madness as a 'performative malady' (Wald 4) within dysfunctional domestic structures and how it has put emphasis on the notion that the family is not the place for healing. Historically, the family was where madness first emerged and where it was controlled (and sometimes treated) before mental asylums provided systematic management of madness from the eighteenth century onwards (Thiher 293). Previous studies (such as by Elaine Showalter and Christina Wald) have convincingly shown that madness is always gendered. Building on these studies, I argue that such gender dynamics are at work not only in clinical but also in domestic contexts, namely in the family. More precisely, I show that this connection can be traced in theatrical representations that are highly reminiscent of hysteria, the 'female malady' *par excellence*, in Showalter's words. Focusing on the intersections of two of theatre's staples, the family and the female hysteric, is essential for examining critically the pervasiveness and overlap of power structures and ideology in mental health drama.

Hysteria has not been officially recognised as a medical condition since, in the *DSM-III-R*, "hysterical personality disorder" was renamed "histrionic disorder" in 1987 (Showalter, *Hystories* 102). The renaming shows, though, that what was once considered a typical 'female malady' has still not disappeared from the current psychiatry landscape. What is more, the word 'hysteria' is often derogatorily employed to explain women's behaviour. Even in contexts where the term itself might not be used explicitly, certain behaviours are often deemed female, showing a questionable attitude towards women's demeanour and a clear gendering of madness.

In critical discourse, hysteria seems to be surprisingly present. Many feminist critics have long taken issue with the aforementioned damaging stereotyping, while others have redefined hysteria and used it, for instance, as a means of expressing resistance (Showalter, *Hystories* 7). In this respect, Showalter states: "As hysteria has moved from the clinic to the library, from the case study to the novel, from bodies to books, from page to stage and screen, it has developed its own prototypes, archetypes, and plots" (6). In theatre studies, particularly for the analysis of late eighteenth- and nineteenth-century melodrama with its prototypical fainting "damsels in distress," hysteria has provided an enduring metaphor (A. Mukherjee). A whole body of plays, which Wald subsumes under the term 'drama of hysteria' historically and critically engages with the juxtaposition of hysteria and femininity, and provides insights into how instrumentalisations of hysteria as female malady have been contextualised dramatically (27-92).

The two plays analysed in the present chapter engage with hysteria's alleged biological origins (Greek *hystera*=womb) based in antiquity and going back to Hippocrates, Galen, and other Roman writers. Plato located hysteria in the uterus, Hippocrates created the pervasive image of "the wandering womb" as the origin of female disease (Scull, *Hysteria* 15-16, 47-48) which is taken up in the plays with their thematic concerns for female sexual desire (in both plays) and false pregnancy (in *Angels in America*). In addition, they thematise the stereotypical notion that hysteria is caused by ennui and unhappiness with a life confined to the domestic sphere particularly propagated in the nineteenth and early twentieth century (16). Ayckbourn, in particular, sets up these aspects to undermine them and to show the devastating consequences of gendering and pathologising behaviour in this way.

As the introduction to this study demonstrated, theatre's relationship with hysteria goes beyond the representational. To recall, hysteria plays often engage in a subversive double-take with what was and still is claimed to be the performative aspects of hysteria. The cliché that hysteria is 'mere performance' goes back to neurologist Jean-Martin Charcot who furthered the lasting impact of stereotypes by taking some of the first photographs, the *Iconographies*, of female hysterics (Showalter, *Hystories* 31, 36). In so doing, he added to the biased iconography of madness that his male clinician's gaze produced as well as to now deep-rooted

ideological underpinnings regarding hysteria as a female condition (Gilman, "Image" 358-59). Nineteenth-century melodrama with its fallen women and female characters prone to dramatic fainting fits also contributed persistently to such stereotypical imagery (Showalter, *Hystories* 101).

Both plays complicate negative and gendered notions of hysteria by making use of dramatic strategies of looking *with* mental distress rather than simply *at* it. Therefore, both seemingly provide ambiguous perspectives on hysteria as a female condition by means of their dramatic form and staging. In this regard, it is important to consider that both were written by male playwrights and that they represent what Nicholas Grene calls "the male-imagined home on the stage" (12). If these strategies counteract criticism that theatre and performance, in an attempt to be subversive, recreate the very normative structures they intend to subvert (Puchner 17), will be explored in the following.

The plays analysed in this chapter present the domestic space as a contributing factor to the gendering of madness on stage. It is important to trace the emergence of Foucault's concept of power/knowledge in the family as the original site of madness in order to provide insights into how the family has come to determine some of the authoritarian structures later recreated in mental asylums. In his Collège de France lectures of 1973-1974, Foucault places the family within the power discourses outlined in *Birth of the Clinic* (1963) and *Madness and Civilization* (1964) and points out that "the family is […] an […] essential component of the disciplinary system" (*Psychiatric Power* 80-81). This disciplinary system encompasses medicine and all other fields that Foucault subsumes under the term "psy-function, that is to say, the psychiatric, psychopathological, psycho-sociological, psycho-criminological, and psychoanalytic function" (85). These are never fully separate from the family even though the asylum-structure "does not favor the family's powers. On the contrary, it divests the family of its traditional powers. In juridical terms, therefore, there is a break between the asylum and the family" (97). This break is recognisable in plays featuring mental illness set in asylums and in which family members are either absent or marginalised as minor characters, as we will see in chapter 4 of this study. What the asylum and the family share, however, is the dubiousness of the ability to heal; as Foucault concludes, power relations within the family "are incompatible with the cure of madness" (100). In other words, the structure of a family must be considered as a potential factor for the emergence of madness in one (or more) of its members. Or, as Walter A. Davis points out:

> the family isn't an eternal verity with love, recognition, and mutual concern guaranteed immediately and a priori, but the place where the deepest psychosocial disorders are nurtured, because closeness to one another is the condition that breeds them. The family is the necessary site of ideological interpellation because it fosters and sustains the internalizations whereby subjects police one another at the deepest psychic register. (105)

Davis' wording evokes an understanding of the family as a Foucauldian heterotopia in which subtle but effective mechanisms of power and surveillance are at work. In this account, the family – a bourgeois institution *par excellence* – must be examined with regard to the ways in which it fosters the very 'internalisations' of power through which deviant behaviour, marked as hysterical, is stigmatised as 'mad.' This surprising logic is what mental health plays can help to expose.

The theatre has long explored the relationship between madness and domesticity (Feder 3). Greek tragedy has provided some of the most enduring portrayals of family conflict and feuds culminating in destruction, madness, and murder – one might think of Aeschylus' *Oresteia* or Euripides' *Medea*. Madness in these plays often surfaces in the family as a reaction to a conflict with the respective prevalent social order rather than an individualised condition, as mental illness is understood in clinical contexts nowadays (Feder 90-93; Fenwick 5). To recall, as Thiher states, madness then meant a break with *logos*, meaning shared language and "the bond of intersubjective relations" (13, 17). Shakespearean drama such as *Hamlet*, *King Lear*, and *Macbeth* also builds on this understanding (Showalter, "Ophelia"). In Henrik Ibsen's plays, too, madness is "domesticated," thereby clearly indicating that a conflict within the family is the culprit of the mental distress experienced by such characters as Hedda Gabler and Nora Helmer (Oyebode vii). British drama of the 1960, for instance, Joe Orton's *Entertaining Mr Sloane* (1964), Harold Pinter's *The Homecoming* (1965), and Edward Bond's *Saved* (1965), is also characterised by a "critical view of family which is very much of its period" (Shepherd 154). American family drama of the 1940s and onwards, such as Eugene O'Neill's *Mourning Becomes Electra* (1931, an adaptation of Euripides' *Electra*), or Arthur Miller's *Death of a Salesman* (1949) also "brought madness into domestic situations and showed how ordinary people might be afflicted despite their ordinariness" (Oyebode viii). Along similar lines, Grene makes a connection between "naturalist domestic dramas" and "dysfunctional families" (9). I argue that it is necessary to reconsider the crucial connections of gendered madness in domestic contexts in mental health drama when analysing the ideologically charged instrumentalisation of madness.

There are a large number of theatrical representations of the madness/family nexus in which laden gender implications manifest themselves that resonate with the two plays analysed in the following. Consider, for example, the relationship between parents and their children, particularly between mother and child. Since *Medea* entered the stage for the first time, the troubled mother as a type in the widest sense has featured prominently on stage as well as in narrative fiction, film, and popular culture. *Woman in Mind* calls to mind the dysfunctional mother-child relationships (Creed 50) in such varied texts as Shelagh Delaney's *A Taste of Honey* (1958), Martin McDonagh's *The Beauty Queen of Leenane* (1996), Alfred Hitchcock's *Psycho* (1960) and *The Birds* (1963), and more recently, Brian Yorkey's Pulitzer-

winning Broadway rock musical *next to normal* (2008).[21] The notion that a baby might save a marriage, as explored, for instance, in Ibsen's *Hedda Gabler*, is a variation of the dramatic mother/child trope and features in *Angels* (Esslin 81). In a similar way, the baby as a relationship stabiliser in *Angels* is a case of "triangulation" (a stabilising third) and reminiscent of the unborn baby in Williams' *Cat on a Hot Tin Roof* (play 1955, film 1958) and the imaginary son in Edward Albee's *Who's Afraid of Virginia Woolf?* (play 1962, film 1966) (D. Davis 156).

The two plays studied in this chapter draw profound connections between hysteria and family relationships, framing the latter as a significant context for the emergence of gendered mental distress. Madness emerges out of conflicted family situations and manifests itself in stereotypically hysteric symptoms in what Grene calls "drama of the interior" (33), which in this chapter connotes both the interior of the home and the interior of the mind.

3.1 The Desiring Woman as Hysteric in Alan Ayckbourn's *Woman in Mind* (1985)

Alan Ayckbourn is one of the most popular and productive contemporary British playwrights whose work is rarely associated with the topic of mental health problems. The British theatre scene of the 1970s and 1980s was marked by the political drama of Howard Brenton and David Hare, Caryl Churchill, and David Edgar who all responded to political and societal crises before, during, and after the Thatcher years (Gottlieb 412-25). While critics argue that Ayckbourn is not part of this group but of mainstream theatre, and Ayckbourn has spoken out against didactic political theatre, the play analysed here, *Woman in Mind*, engages indirectly with the consequences of political and societal circumstances at the time.[22] The focus is on an individual, protagonist Susan, "a twentieth-century Everywoman," sitting in her suburban garden, which in its bleakness embodies Susan's mental decline (Bull, *Stage* 140; see also Kalson 90).

Some critics claim that due to his popularity, "there remains a suspicion that somehow Ayckbourn is not to be taken seriously as a playwright" (Bull, *Stage* 137). Others have a more nuanced opinion, for instance, Alexander Leggatt, who states that Ayckbourn "has never ceased to entertain: but it is through (not as well as or in spite of) entertainment that his work provokes and disturbs us, hits us where we live" (269). And indeed, a large number of Ayckbourn's plays provide comments on serious topics such as the issue of women's rights or the human condition more generally, and voice social criticism within the framework of comedy (Page, "Serious Side" 36-46). Thus, there is a notable terminological indecisiveness of critics, as Albert-Reiner Glaap states: "Some critics refer to Ayckbourn's plays

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[21]   For an in-depth analysis of the musical, see Harpin, *Madness* 96-103.
[22]   The play will be referred to as *WiM* from here.

as 'comedies of embarrassment,' others place them between 'comedies of man-
ners' and 'comedies of menace' (this in the Pinteresque sense of the term) or call
them farces" (353). Ayckbourn himself calls his plays "black farce" to account for
the juxtaposition of the comic and tragic in most of his work (Innes, *Twentieth*
383). *WiM* also bears traces of "tragicomedy, […] "in which serious and comic
elements are combined throughout the action," and can thus also be called black
farce or "comedy of pain" (Glaap 353; see also Page, "Ayckbourn" 21). As Paul
Allen states, it "is a tough and dangerous play which, in performance, often leaves
some women sobbing in the stalls after the rest of the audience has gone home
relatively cheerfully" (106). Laughter, one of the key features of Ayckbourn's
plays, sometimes bordering on hysterical laughter, is always ambiguous and often
serves the purpose of exposing audiences to great suffering and playing with spec-
tators' expectations (Innes, *Twentieth* 380, 383). While Ayckbourn puts emphasis
on the seriousness of the subject matter, a character like Susan can also become
the object of laughter, such as Ophelia, for instance, who "in her madness, has a
role close to that of a fool," as Bridget Escolme observes ("Madness" 171). In this
sense, Ayckbourn borrows from early modern depictions of "the mad, who ap-
pear […] as figures of comedy and of pity, and significantly as both" (Escolme,
Emotional 69). It is, however, part of his dramatic strategy that this juxtaposition
serves to substantiate his exposure of false societal expectations.

   This combination of serious and comic modes is important when considering
why recent productions have been received differently than in 1985, when the play
premiered in Scarborough's Stephen Joseph Theatre in the space called 'The
Round' before transferring successfully to the West End in 1986. The theatre
space in the round highly influenced the first production of *WiM* and continues to
contribute to the play's theatricality (Bull, *Stage* 139). There have been several suc-
cessful recent revivals including a critically acclaimed BBC Radio 3 adaptation in
2000, and a revival at the Stephen Joseph Theatre in 2008, one at the Vaudeville in
London in 2009, and one at the Dundee Rep in collaboration with the Birming-
ham Rep in 2014. The respective recent productions have added significantly to
reshaping the play's context and with this, the reception of the play has changed.
In a comparatively short period of time, the play has undergone a radical redefini-
tion as mental health play.

   The two-acter is in many ways the continuation of Ayckbourn's thematic ex-
plorations of three of theatre's staple topics: madness, the role of (married) wom-
en, and the family. It depicts Susan, an unhappily married woman, who, knocked
unconscious after stepping on a garden rake, hallucinates an imaginary perfect
happy family, her husband Andy, daughter Lucy, and brother Tony, which stands
in stark contrast to her dreary real-life circumstances with her unloving husband
Gerald (a vicar), their estranged son Rick, and her widowed sister-in-law Muriel.
As the play progresses, Susan's mind disintegrates to the point of a complete men-
tal breakdown at the end. Even if the term is never mentioned, the markers of

Susan's mental distress are reminiscent of the stereotypically hysterical symptoms that Charcot's *Iconographies* perpetuated. Although such features are part of Ayckbourn's aforementioned dramatic strategy, they require close critical scrutiny when considering *WiM*'s potential as a mental health play because they are crucial in determining the play's subversive dimension.

Ayckbourn had developed and refined the character of Susan over a number of earlier plays providing the character with a multifacetedness that has had a significant impact on the play's redefinition as mental health play (Page, "Serious Side" 36-46). Examples include Eva, who in *Absurd Person Singular* (1972) nearly has a mental breakdown over her unfaithful husband and tries to kill herself in many different, absurd ways; Vera, who collapses mentally in *Just Between Ourselves* (1976); and minor character Louise in *Joking Apart* (1978) (Kalson 95, 99-106). The idea that a happy relationship is to be found in imagination rather than in reality was already explored by Ayckbourn in the aptly titled *Absent Friends* (1974), in which Colin is the only character among a group of miserable couples who happily indulges in memories of his relationship with his recently drowned fiancée (Kalson 97). In the same play, Diana has a breakdown over unfulfilled dreams and the drab reality of her existence, much like Susan. In all these examples, Ayckbourn's tone oscillates between comic and serious, creating a sense of ambivalence that also permeates *WiM*, and that goes beyond exposing female characters to laughter. What is more, the recurring topical concern exemplifies Ayckbourn's serious interest in how patriarchal domestic structures have detrimental effects particularly on women.

3.1.1 Ayckbourn's Theatrical Perspective on Madness

Situated within an ordinary family that is troubled under the surface, middle-aged Susan, along the lines of what Showalter claims for Ibsen's Nora, is confined "to the doll's house of bourgeois femininity" (*Female Malady* 5). The opening scene suggests that one 'accessory' of this bourgeois lifestyle, the garden rake, has quite literally hit back at her. This way, the garden rake foreshadows how Susan's life will collapse in the course of the play.[23] To start with, borrowing Showalter's term, mental distress is very much a 'female malady' in the play even if Ayckbourn's theatrical strategy offers a more nuanced approach to the topic. Part and parcel of this strategy is a heterotopic staging in the round first used for the world premiere in Scarborough (that he also directed) and the way in which he lets the audience share Susan's perspective while at the same time unsettling perceptual conventions.

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[23]   Other interpretations add to this the allegorical function of the garden as a marker of middle-class life and the garden rake handle (in the shape of a snake) as "a symbol of her sexual deprivation" (Kalson 111).

Following the theoretical framework introduced in the previous chapter, the in the round-stage seems to provide audiences, in the style of a reversed *panopticon*, with privileged access to the characters and the actions on stage, where every actor is exposed to the audience's gaze at all times. Yet, Ayckbourn's dramaturgy counteracts this notion because the fact that the stage is rectangular means that, unlike a circular stage which is vectored and has a single focal point in the centre, it provides multiple focal points and highlights the artificial situation at the theatre, as the spectators also look at each other (Wiles 165). Ayckbourn supports this on the plot level when he builds in the first twist right at the beginning. The play's "fictional place" that is visible as such in the "onstage fictional space," in McAuley's terms (24-35), a suburban garden, is designed to direct the audience's expectations by evoking a familiar domesticity while at the same time constituting a heterotopic microcosm on which Susan's mind will be laid bare. Confronted with a woman regaining consciousness and a man uttering gibberish, audiences are left puzzled regarding what has happened before the lights came up and simultaneously have to negotiate their and the other spectators' gazes.

What the spectators do not know at this point is that their confusion mirrors Susan's experience, as the first stage direction indicates: "Throughout the play, we will hear what she hears; see what she sees. A subjective viewpoint therefore and one that may at times be somewhat less than accurate" (*WiM* 9). Even the stage lighting mimics Susan's own sensory experience such as the waking up at the beginning and her blackouts indicating the end of a scene throughout. When Tom Stoppard experimented with the same technique in *Travesties* in 1974 (revived in London and New York between 2016 and 2018), he made a point about the reliability of memories, whereas Ayckbourn uses it for creating what Wald calls "hystericised realism," a "walking in the mad character's shoes" by using stage technology (49).[24] Harpin and Foster see in this particular directing of dramatic perspective theatre's capacity to make and remake realities and they extend Wald's notion of 'hystericised realism' by stating that it also "recalibrate[s] the continuum of 'normal' experiences" (10). In other words, with this particular technique, Ayckbourn implements one of the key features of heterotopia by raising what Phillip Zapkin calls "epistemological uncertainties" (306-26), which permeate the entire play and engage the spectators immersively by challenging them to constantly re-evaluate what they perceive and what thus seems to be real.

As the audience's viewpoint is solely determined by Susan's perspective (and stage lighting responds accordingly), the audience's seemingly superior position provided by the staging in the round is undermined. By letting the audience "see

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[24] Tennessee Williams envisaged a similar technique involving the sense of listening that director Elia Kazan realised when in the first production of *A Streetcar Named Desire* in 1947 only Blanche DuBois and the audience were able to hear the sound of a Varsouviana polka as a marker of Blanche's mental distress and trauma but also to establish a connection between protagonist and audience that was supposed to increase sympathy with her (Grene 118-20).

with madness" (Harpin, "Dislocated" 212), Ayckbourn subtly directs the audience's emotional and affective engagement because the fact that the audience sees what Susan sees suggests that the spectators might side with her as it is (almost) impossible to evade the resulting subjectivity, particularly once it has become clear that the spectators share her viewpoint.

In fact, the first act fashions Susan as a victim of her circumstances and places her in the long line of unhappily married and sexually frustrated wives, such as Ibsen's Nora Helmer and Rita Allmers or Williams' Maggie in *Cat on a Hot Tin Roof*, that theatre audiences then and now might be familiar with. Set against her husband Gerald, a vicar of all professions, and his sister, the frigid Muriel, Susan appears to be wanting more from married life, which finds expression in her hallucinating another perfect family for herself. In this sense, the play's hystericised realism operates with a stereotyped notion of madness and indeed femininity rather than recalibrate what counts as a 'normal' experience. While the perceptual framework forces the audience to adopt Susan's perspective, it is doubtful if, after it has become clear that there are in fact two families in Susan's mind, the audience will still accept the imagined family as a 'normal' one. Depending on production decisions, the play loses some of its effectiveness and impact (in Harpin and Foster's sense) if the revelation comes too soon, i.e. if Susan is confirmed as mentally unstable. I will return to this point below when the play's potentiality as mental health play is discussed.

3.1.2 Hysteria Revisited

A closer look at the ways hysteria was fashioned and dramatised by Charcot in his lectures provides a reference point for exploring how Ayckbourn utilises and extends images and notions of hysteria even if the word itself is not used. As was said in the introduction, the lectures at the Salpêtrière were highly dramatic and dramatised following Charcot's directions, thereby putting emphasis on the hysteric's body as an instrument of performance. Critical accounts of the lectures highlight the event character and the notions of theatricality attached to them (A. Mukherjee 5; Showalter, *Hystories* 9).

First of all, Susan's repeated fainting fits when she is under emotional stress evoke hysteria's history as a nervous disease and strongly resemble these of the hysteric women Charcot brought to the stage (Scull, *Hysteria* 22-31; Showalter, *Hystories* 33). What is more, Susan's fits are accompanied by either "a terrible moan," a "long drawn-out cry," or a "despairing wail" (*WiM* 22, 50, 92) before she sinks into oblivion thus recalling nineteenth-century melodrama that Ayckbourn draws on. Such obvious references put even more emphasis on aspects of the performative and dramatic. Depending on production decisions, this can either amplify Susan's otherness or serve to expose the damaging repercussions of simplistic gendered madness. Structurally, however, each fainting fit has significance as an example of what Patrice Pavis calls "rupture [which] comprises a con-

nection that is interrupted, obliging the observer to shift perspective immediately and to account for jumps in meaning" (246). Pavis' concept is analogous to Wolfgang Iser's notion of 'blanks' in narrative text, that is, Iser posits that the interaction between readers and text is based on readers creatively making "missing connections between the text's diverse components, segments and viewpoints" (Counsell and Wolf 179; see also Iser 106-19). The fact that it is Susan's physical responses that demand such involvement from the audience renders the notion of Susan being 'merely hysterical' ambivalent.

Secondly, Ayckbourn establishes the aspect of physical needs and desire by yet again borrowing from notions of sexual repression leading to hysteria in nineteenth- and early twentieth-century hysteria discourse (Showalter, *Hystories* 14). More precisely, Ayckbourn is deeply concerned with female sensuality and sexuality as 'dangerous instincts,' in a nod to Ibsen's work (Esslin 79). In *Hedda Gabler* and *A Doll's House*, female sexuality is considered dangerous because "its suppression by the demands of society force[s] the individual into false or inadequate integrations of his [or rather her] self," as Martin Esslin explains (79). In *WiM*, 'dangerous' female sexuality is one symptom of the disintegration of Susan's self, but it is also always a response to the family's falling apart. As a prime example of gender stereotyping, Freud and Lacan in particular believed that hysteria was an expression of a woman's struggle with her sexual identity (Showalter, *Hystories* 47). Accordingly, in conversations with Gerald, Susan is fashioned as sexually frustrated: "We don't kiss – we hardly touch each other – we don't make love – we don't even share the same bed now. We sleep at different ends of the room" (*WiM* 26). While Susan's thwarted physical love might have easily moved her into the category of hysterical woman in the nineteenth century, to a contemporary audience, her feelings must come across more ambivalently. She is a woman who, although it is never made explicit, is probably menopausal. It is not surprising that menopause is not mentioned directly, as Shepherd-Barr notes: "In fact, the uniquely female physiological experiences of menstruation, childbirth, breast-feeding and menopause rarely figure directly on stage even to this day" (*Theatre* 170-71). Worse even, Gerald, in the most patronising manner, wishes to silence Susan's needs and expects her to comply with the marital life they lead: "GERALD: [...] I thought that when a woman got to – our age – she more or less … switched off. SUSAN: Well, yes, I'm a freak, Gerald. I'm afraid you married a freak" (*WiM* 27). Ayckbourn's invocation of another nineteenth-century theatrical mode, the freak show, by no means communicates that Susan is actually "a freak." On the contrary, her outbreak asks the audience to disagree and recognise how unjust Gerald's demands are. Surely, at any age a woman has expectations and needs – needs that are then met by the imagined husband Andy who expresses all the adoration and love that Gerald denies her. But even in the seeming fulfilment of her needs, the audience is confronted with one of Susan's predicaments and the fact that opposing forces are at work in her mind. When she gives in to Andy's kisses, a jolt back to reality

that is suggestively realised on stage by "a tremendous clap of thunder" makes her shout: "Oh, dear God! I'm making love with the Devil" (76). Susan really is trapped in a patriarchal moral framework set up by Gerald as much as by her spatially limited and emotionally limiting environment in which she now denies herself sexual desire. Along the same lines, Ankhi Mukherjee in her study on aesthetic hysteria notes that "[d]esire is radically contentless, so there is no cessation of movement in fulfilment, and the subject turns away from the ideal goal in symptoms of disgust" (14). Because Susan is making love with her *imagined* husband, her desire is doubly contentless and ultimately unfulfilling, mirroring the notion of "hysterical conversion" brought to the discussion by Mukherjee with reference to Lacan's understanding of finding no satisfaction when desire achieves its goal, that is, the sexual encounter in the scene (14).

Apart from the physical aspects, hysteria's sociocultural history, in particular, feminist criticism of the condition, provides an important reference point to *WiM* in its exploration of the instability of Susan's identity and her slipping away into madness. In the first act, Susan complains about having lost her purpose in life:

> I don't know what my role is these days. I don't any longer know what I'm supposed to be doing. I used to be a wife. I used to be a mother. And I loved it. People said, Oh, don't you long to get out and do a proper job? And I'd say, No thanks, this is a proper job, thank you. Mind your own business. But now it isn't any more. The thrill has gone. (*WiM* 24)

It is crucial that Ayckbourn fashions Susan as a woman who is not against a traditional life as mother and wife *per se* even if it is patriarchal structures that oppress her (Hardison Londré 90). Ayckbourn also touches upon ongoing discussions about whether women ought to be remunerated for their work as mothers – a question already posed by G. B. Shaw in *Getting Married* (1908) and *Back to Methuselah* (1922) much earlier.[25] That this discussion was still ongoing in the 1980s when *WiM* was written and first staged, can be seen in social scientist Jane Lewis' comment that "[t]he concept of social citizenship within the modern welfare state has remained profoundly gendered with no way being found effectively to value women's unpaid contributions to welfare through their work of caring" (9). Unlike in the nineteenth century, when leading psychiatrist Henry Maudsley pointed out that fewer choices in life and confinement to the domestic sphere led to hysteria (Showalter, *Hystories* 16), the picture is more complex in *WiM*. It is not only that in society in the wider sense Susan seems not to be respected as a housewife but also, as Act I suggests, in her small family cosmos (i.e. the play's equivalent to society) little value is ascribed to her care work. To complicate matters, in drawing up a troubled relationship with her son Rick, Ayckbourn questions Susan's ability to care altogether, as Act II brings to the fore.

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[25] For a discussion of the plays and how Shaw portrayed the emerging discourse on women's roles at the time, see Shepherd-Barr, *Theatre* 143-44, 178.

Following the play's logic, the imagined family life represents Susan's wishes so it follows that she longs for the recognition that is lacking in her real life. In her imagination, Susan is a loving mother to daughter Lucy as well as a celebrated writer and heart surgeon – both jobs that would come with that recognition and a stable identity. Ayckbourn suggests then that recognition is not just a financial matter but also a question of the other characters' attitudes towards Susan. The imagined family respects her because she is not just a brilliant mother, wife, and sister but also has a successful career.

However, there is not just the absence of a job and purpose but, more fundamentally, the fact that Susan is separated from herself/her self and experiences a deep-rooted identity crisis. Although we perceive her as one person, one body (i.e. an actor) on stage, we witness and take part in her separation and ultimate breakdown. The fact that Susan is torn is picked up on a 'paratextual' level. Exemplifying Gérard Genette's concept of a mediating 'paratext,' the script published by Faber and Faber in 1986 serves as a 'threshold' between the inside and outside of the performance (and, by extension, the play) (Genette), and functions as an interpretative tool for the audience in this regard (Fodstad 159). It shows a woman whose upper half of the body holds a champagne glass and wears jewellery and a pink dress, whereas the lower body is dressed in slippers and plain clothes. Next to the chair stands a bucket, pointedly signalling Susan's position as housewife. More significantly, this part of the picture is colourless. In the play, Ayckbourn constantly and visibly juxtaposes the bland and the colourful, which is not just reflected in the notes on costume and in the way the garden and surroundings are envisaged and lit but also in the characteristics of Susan's respective families. Ankhi Mukherjee sees in such complex questions of identity a defining feature of hysteria: "The flashing question impersonated by hysteria – 'Who am I, and what do I want?' – is, in inversion, its most substantiated definition: the hysteric is being as nothing, a void in the place of the object, a being of lack, and what she wants is the lack of desire, not its cause" (10). The use of words such as "nothing," "void," and "lack" echoes the dramatic process of Susan's gradual disintegration, which is marked as slow disappearance.

When Susan's mind increasingly takes over towards the end of the play, her two families are on stage together in a farcical racing scene that is put together from confusing pop cultural references. Most of the conversation makes hardly any sense to the audience even though or precisely because they share Susan's perspective. Significantly, Susan is less and less in control of the figments of her imagination. As the scene progresses, the stage directions indicate her disappearance: "She is ignored. In fact, from this point on, people appear to be less and less aware of SUSAN. As if she herself were slowly slipping from the dream whilst it carries on without her" (*WiM* 88). She asks for recognition by voicing: "Remember me?" but none of the other characters respond (81). Although she manages one final time to attract everyone's attention by shouting, "Why won't you look at

me? (*Very loudly*) LOOK AT ME ONCE! DO YOU HEAR ME? ALL OF YOU!!!," she more and more turns into a ghost on the stage of her own mind, if not yet on the actual stage (89).

Her final breakdown is marked by a loss of speech while being doubly surrounded by the audience and all other characters. Exposed to everyone's gaze, including the spectators who have finally also separated from Susan and her perspective, Ayckbourn borrows from the ghost of Hamlet's father's injunction not to be forgotten. The fact that Susan now utters unintelligible words presumably announcing her disappearance and wanting to be seen is the indicator for the separation of the audience's and her perspectives, still it is possible to make out that her question "December bee? December bee?" (92), which is also the subtitle of the play, is an echo of Shakespeare's line "Remember me" (*Hamlet*, Act 1, Scene 5). One can argue that thus Susan breaks with *logos* in the play's final scene. French feminist literary critics, among them Hélène Cixous, link hysteria and language to explain that hysteria discourses are often marked by voicelessness or speech distortion on the side of the hysteric. Ayckbourn already experimented with an almost silent woman, Eva, in *Absurd Person Singular*, who tries to kill herself quietly while the other characters are bustling around the kitchen (Page, "Serious Side" 38). While Susan's distorted speech at the play's opening can be explained by her accident, her loss of intelligible speech at the end is a clear marker of her mental distress.

Ultimately, the stage directions indicate that the other characters do not see or hear Susan anymore implying that she has become 'all mind' and hence invisible because the mind is invisible. A similarly chilling scene features in *Just Between Ourselves* but the aspect of invisibility is reversed: after her breakdown, Vera sits in the garden surrounded by the other characters telling her that she will get better but she does not move or speak and appears not to notice the others (Page, "Serious Side" 41). When Susan's mind has broken down, a blackout ends the play; her body finally also disappears from the audience's gaze, indicating that, much like in hysteric states, according to Ankhi Mukherjee, "the mind-body dualism collapses" (xii). In the play, this collapse equals Susan's double disappearance, first from the play world as a character, then as a body from the stage. In other words, she is at the same time marked as other – in the audience no one shares her perspective – and made invisible – stage and auditorium are dark after the blackout and on stage the other characters "appear neither to see or hear her" (*WiM* 92).

The nightmarish scene, which might at the same time entice hysterical laughter from the audience, fashions Susan as a modern-day Ophelia, to follow up on the *Hamlet* intertext: "victimized, she has no one to avenge her, to feel for her and with her, unless it be the audience" (Kalson 112). While it is true that Susan is in parts of the play presented as a victim, in the second act, the picture gets more complex due to one of the key features of mental health plays, ambiguity.

Susan's ambivalence as a character is highlighted by the introduction of Rick in Act II. When Rick returns home, he has not spoken to his parents for a couple of years because he joined a cult-like organisation allegedly forbidding him to speak. His vow of silence subverts the hysteric speech distortion Susan experiences with the crucial, highly gendered difference that Rick confidently chooses not to speak. Moreover, his letters are all addressed to his father, suggesting a family constellation in which the mother "becomes an abject at that moment when the child rejects her for the father who represents the symbolic order" (Creed 45). Although Rick admits that his father is also to blame for his leaving the family, only the conflict with his mother is staged, thereby ascribing it more importance.[26]

Rick's appearance tests the audience's credulity. Because at this point of the play the audience is used to real actors playing imagined characters, it is not certain at first if Rick is 'real' – even more so because Susan's losing her temper with family doctor Bill Windsor and the imagined family taking over precede his entrance. As with the other fantasy family members, the imagined daughter Lucy embodies everything that Rick is not. According to Susan, Rick is afraid of sexuality and women and even after two years of silence, she scolds him for it. The estrangement between mother and son exacerbates Susan's distress, as she is no longer able to delude herself about the joys of motherhood lived out in the hallucinations with Lucy. In fact, Rick's visit rings in Susan's final breakdown bearing signs of traditional tragedy because his candour hits her where it hurts, as the following dialogue exemplifies:

> RICK. Well … I remember how you used to be with girls I used to bring home.
>
> SUSAN. I remember, too. We got on terribly well.
>
> RICK. No, you didn't, Mum. I mean, frankly, you used to embarrass the hell out of them. Didn't you know that?
>
> SUSAN. Nonsense.
>
> RICK. You did. You used to get them into corners and start going on about – I don't know – contraception methods and multiple orgasms … I mean, I'd hardly ever kissed them, you were asking them for their medical histories.
>
> SUSAN. Nonsense, they were sixteen, seventeen-year-old girls who needed to know these things … I wasn't having a woman going out with a son of

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26   Rick is such an important character that he inspired Charlotte Jones to provide a play version from the son's re-invented perspective, *Humble Boy* (2001). With its setting in a garden, a mother and son who have grown apart, and a brilliant but mentally troubled young protagonist who considers suicide, *Humble Boy* provides a powerful counterpoint to Ayckbourn's play because it favours the anguished son's perspective.

mine who didn't know what she was about. You'd have thanked me for it later … You? You didn't know a thing till I told you. (*WiM* 55)

In this exchange, Ayckbourn gives us startling insight into Susan's character that seems liberated and radical, talking about contraception and sexuality. From Rick's perspective, however, his mother appears encroaching and embarrassing. Ayckbourn's decision to make Gerald a vicar as well as Rick's escape to a quasi-religious sect suggests that both characters operate within a moral, religiously motivated framework. Within the moral patriarchal framework of the play's male characters, Susan's insistence on the importance of sexuality is marked as morally wrong and flawed. Susan's desire is comically set against Gerald's passion for his project of writing a chronicle of his parish, whereby Ayckbourn echoes Ibsen's *Little Eyolf*, in which Rita Allmer's "exaggerated sexual drive may well spring from her husband's equally disproportionate commitment to his ideal, his work as a philosopher" (Esslin 79). Gerald's involvement is a repeated source of mockery in the play and therefore serves to uncover how emotional and sexual neglect in *WiM*, as in *Little Eyolf*, leads to disaster.

In sum, although the word 'hysteria' is never mentioned, Ayckbourn aligns Susan's symptoms closely with a set of stereotypical and thus recognisable hysteria traits. This, however, does not serve to simply pathologise Susan as suffering from the female malady *par excellence*. Rather, Ayckbourn employs a theatrical strategy that provokes a critical stance towards such simplistic and damaging categorisations. It can be argued that this strategy reveals Ayckbourn's serious concern for women's mental health and for exposing that women's behaviour is all too often pathologised unquestioningly not in psychiatric practice but at home. It will be seen in the following that Ayckbourn's critical negotiation extends to the little health care Susan receives.

3.1.3 The Family Doctor as Flawed: Medical Authority Undermined

The changing critical reception of the play raises the question what Ayckbourn's attitude to madness and mental illness is, and why this shift in criticism has occurred between 1985 and now. As was noted in my study's introduction, in the 1980s, Prozac had already been on the pharmaceutical market and was a widely prescribed drug in the United States. In the UK, the NHS was still in the process of deinstitutionalising mental health care and went from crisis to crisis despite Margaret Thatcher's statement "The NHS is safe only with us" (Thatcher; see also Gottlieb; Laurence). The representative of this system in the play, Bill Windsor, does not provide any such reassurance but is actually responsible for many of the play's farcical elements. In fact, Ayckbourn's including a family doctor in the *dramatis personae* and configuring the doctor-patient relationship as highly problematic provides an indirect comment on the British medical system. In the tradition of Oscar Wilde and G. B. Shaw, the play's farce and comic elements are used to

deploy ethical criticism. In a variation of Molière's *Le Malade Imaginaire* (1673), a dramatic predecessor in which doctors encourage their hypochondriac patient to believe in his imagined ailments, Windsor tries to talk Susan *out of* her condition and concerns. Like the analyst in Kim Morrissey's comic hysteria play *Dora: A Case of Hysteria* (1994), the only medical authority in *WiM* does not deserve the title. While bearing the grand name of Windsor, the doctor's professional skills are hardly worth mentioning and mostly provide slap stick elements, thereby adding to the play's comic tone, for instance, in the first scene when he fails to open his black bag and can only offer an NHS staple to help Susan: a simple cup of tea. His suggestively named wife, another Nora, despite the fact that she is only mentioned twice, also equips Windsor with a questionable domestic background, giving the overall impression that he is neither a skilled doctor nor a loving husband.

Despite the fact that Windsor is inept as a doctor, a Foucauldian power discourse with strong patriarchal traits is played out through him. In this way, Ayckbourn extends the negative male influence that Susan experiences in her family. To start with, all medical examinations take place in the garden, which in the first scene is justified by Susan's accident with the garden rake but which becomes increasingly dubious. Yet even more problematic is that, on his second visit, the doctor does not question Susan about her wellbeing but Gerald, who is all too happy to respond for her. Susan is thereby denied any agency over her condition. The exclusion of female madness from *logos* is first expressed through her silence in the scene but subverted when Bill addresses her confidentially about an even more taboo topic:

> BILL. […] Everything else working normally, is it? Waterworks? Other bits?
>
> SUSAN. I've no idea. You'd better ask my husband.
>
> BILL. (*Puzzled*) Sorry?
>
> SUSAN. (*Moving away from them*) I'm fine now, Bill, absolutely fine … . (*WiM* 34)

The scene emphasises that Susan is granted agency over her body as her bodily functions are taboo but when it comes to her mind, others decide for her, in accordance with Foucault's power/knowledge nexus that stretches as far as the family in *WiM* and hence also works outside of a clinic. What is more, Susan's sarcastic response "You'd better ask my husband" shows that she is aware of the testimonial injustice (Fricker 2) done to her because she knows that her own assessment would not be taken seriously. All three characters are thus part of a power discourse in which "[o]ne doesn't have […] a power which is wholly in the hands of one person who can exercise it alone and totally over the others. It's a machine in which everyone is caught, those who exercise power just as much as those over whom it is exercised" (Foucault, *Power/Knowledge* 156). In fact, rather than naming

Susan's body parts, Windsor's metaphorical language borrowing from mechanics ("waterworks," "bits") confirms Foucault's notion of power as a machine. That the multilayeredness of power relations is established much earlier in the play and also features in the mother/son relationship explored above only adds to the overall sense of ambiguity.

Windsor is the only character informed about Susan's hallucinations and thus stands between her real and her imagined world. The knowledge of her hallucinations should, within the established power structure, give him power (certainly the power to help her), but Bill's interpretation of and response to this power is not conducive to Susan's wellbeing. Ayckbourn also subverts the notion of knowledge equalling power by making Bill go to extremes in order to show Susan that she is in fact *not* mad. Furthermore, Bill's behaviour suggests a touch of megalomania because he believes that it is within his powers to convince Susan that she is *not* unwell. Triggered by inappropriately declaring his love for her, in a comic adaptation of Edgar's feigning madness in Shakespeare's *King Lear* (Act 2, Scene 3), he acts mad in order to make an attempt at 'seeing' the imagined family to make her feel better. Susan desperately trying to hold on to reason and Bill unhelpfully producing a bottle of sleeping pills precedes the scene because, to him, Susan still appears "a mite keyed up" (*WiM* 65). This gross understatement once again confirms that Windsor's medical authority is practically non-existent because he underestimates the extent of Susan's suffering. In addition, with its stiff-upper-lip mentality, Windsor's discourse is almost exaggeratedly British. Ayckbourn, therefore, comments more widely on a culturally specific set of attitudes embodied in linguistic habits. Windsor's over-enthusiasm and sprightly language trivialise Susan's experience and distance his own investment in it.

The theatricality of Bill's performance of madness is simultaneously one of the most comic and devastating scenes in the play. Ayckbourn often operates with farcical effects to "serve the purpose of revealing the frustrations, the disappointments, and the cruelties of some of the characters," as Glaap points out (363). The scene's intense theatricality uncovers Bill's inadvertent cruelty and forces the audience to re-evaluate their perception of Susan's madness and the play's normalcy/aberration binary. The doctor's attempt at making the invisible visible is rendered futile and mocked in the invisible world by Lucy and Tony, both visible to the audience, poking fun at Bill when he "*crouches slightly to one side of* LUCY *and talks to the air*" (*WiM* 71; italics in original).

The representative of the medical profession is ironically fashioned as mad in the play, most notably, by the figments of Susan's imagination, but also, due to the theatrical rendering, by the audience who is confronted with Bill's farcical behaviour. The following exchange between Susan and Lucy, while Bill keeps acting, emphasises Susan's and, by extension, the play's confusing reality:

LUCY. [...] Mother, who is he? What does he want?

SUSAN. Nothing, darling. You're not to worry. He's just someone who –
sees things …

LUCY. How extraordinary. Is he mad?

SUSAN. Possibly. One of us is anyway. And I'd sooner it were him. (*WiM*
72)

The dialogue serves as an implicit reminder and a question to the audience. Following the play's logic, by adopting Susan's perspective through hystericised realism, albeit involuntarily, the audience has temporarily been mad, too. The fact that
Ayckbourn sets a useless doctor who acts stereotypically mad in a farcical scene
against Susan's 'real' madness puts emphasis on the instability of conceptions such
as normal and abnormal when these are based on visual perception. Madness is in
fact no laughing matter and Ayckbourn's dramatic strategy of forcing the audience
into identification with Susan takes hold with full force here before her complete
breakdown ensues. Moreover, through Bill Windsor, Ayckbourn expresses a deep-
rooted distrust of the medical profession and its power/knowledge.

3.1.4 From Domestic Farce to Mental Health Play

When engaging with theatre, we must never lose sight of the performance aspect.
WiM's production history shows the varying agendas of different productions and
reveals how within around thirty years a significant shift has taken place in this
regard. To an extent, owing to the shift, *WiM* is now located at the intersection of
the madness discourse and the mental health discourse.

   Despite the fact that Ayckbourn in the stage directions is explicit about when
Susan's madness is revealed, some of the recent productions have decided to highlight her condition from the start. On the one hand, this others Susan early on.
On the other hand, it brings to the fore the play's mental health dimension. Ayckbourn's stage directions demand a subtle change of the stage lighting in order to
establish an atmosphere of hystericised realism when the imagined family is first
introduced: "*The garden grows imperceptibly bigger and lighter*" (*WiM* 12; italics in original). The word "imperceptibly" suggests that the setting does not necessarily have
to give away when Susan's mind takes over and that the shift should not be too
obvious. One could argue that Ayckbourn's intention is to initially create an atmosphere of uncertainty in order to amplify the shock of the discovery of Susan's
disordered state later in the play.

   The play's world premiere in 1985 stayed true to Ayckbourn's original configuration. Significantly, most of the first night reviews retrospectively linked Susan's
state to the accident with the garden rake and to her general unhappiness rather
than to an underlying mental health condition (Hoyle; Thorber; Flint). While some

reviewers of the first production mentioned in passing the aspect of mental distress, only a few critics discussed it further. Joan Smith in her review of the 1986 London production called the play "a lesson on [R. D. Laing's] theory of a family's mental health" (qtd. in S. Carlson 115). Without going into much detail, Smith touched upon connections with Laing's book *Sanity, Madness and the Family*, which was then more than twenty years in print, yet possibly no longer at the forefront of psychiatric discourse or known to a wider audience. Another reviewer tentatively hinted at a mental health context by stating that "[e]xamined line by line, Mr Ayckbourn could have been said to have written the world's first psycho-analytical comedy" (Anon.). The mention of psychoanalysis echoes the play's allusions to hysteria and highlights the aspect of externalising the inner workings of the mind but does not go into any details regarding the implications of the comic tone and effect on the audience.

In contrast, and supposedly due to the current sea change in the mental health discourse, recent reviews focus more on the mental health aspect not least because the focal point has been shifted by the recent productions of *WiM*. In his review of the Vaudeville production in 2009, critic Michael Billington uses the words "madness," "nervous breakdown," "crisis," and "mental distress," (Review *WiM*) while Mark Fisher talks about Susan's "troubled mental state," "mental breakdown," "mental ill health," "inner torment" and "emotional terror in a review on the Dundee Rep/Birmingham Rep production" ("Tremendous Production"). This shift has led to an increased acknowledgement of Ayckbourn's status as a serious writer (Page, "Serious Side"). Most importantly, the play's recent reception is testament to the therapeutic turn that Ole Jacob Madsen in his study attests to the contemporary mental health discourse because it suggests a familiarity with mental health terminology and concepts that would not have been present in the 1980s when mental distress was still kept behind closed doors.

The collaborative Dundee Rep/Birmingham Rep production in 2014 can serve as an example of how this altered context of mental health awareness campaigns and a thriving self-help industry is reflected in production decisions. As a manifestation of Susan's mental state, the production uses a linguistic device to highlight her troubled state of mind. Although the play has repeatedly been called "quintessentially English," Susan's actual life in the Dundee production is set in Scotland, suggesting a sense of familiarity with the surroundings – at least for a Dundee audience (J. Macmillan). However, Susan's hallucinations take her to "a semi-mythical England," "a pristine English accent included" (M. Fisher, "Tremendous Production"). By drawing up these notable differences, the production clearly marks Susan's condition as other from the start. It can be argued that the changes in attitudes towards mental health account for the Dundee Rep/Birmingham Rep production decisions because marking Susan so obviously as ill gives priority to the play's mental health dimension.

Highlighting Susan's condition does not, however, automatically add more clarity to the question what is real and what is a hallucination when the play is performed. Oliver Sacks's definition of hallucinations summarises precisely what happens on stage and in the auditorium. To him, hallucinations are "something concocted by my brain or mind, and imperceptible to you or anyone else. To the hallucinatory, though, hallucinations seem very real; they can mimic perception in every respect, starting with the way they are projected into the external world" (Sacks ix). As the analysis has demonstrated, Susan's hallucinations are 'real;' on stage the 'reality' of the imagined family does not differ from the 'real' family. In other words, because the audience shares Susan's perspective, they hallucinate, too. In fact, Ayckbourn's goal is this shared confusion. He states:

> Increasingly, too, her grasp of the real and the imagined becomes shakier and shakier, till we become as confused as she does as to what is real and what isn't. I was actually breaking the rule of consistency: positively trying to muddle and confuse the audience, so that they could have some inkling of what it must be like to lose all touch with reality, as Susan's delusions grow. (*The Crafty* 31)

The play is staged most effectively when keeping up the suspense regarding Susan's confusion for as long as possible. Kalson argues along the same lines that "[w]hat makes the play effective in its movement from naturalism to expressionism is that the protagonist, until the onset of madness, is a seemingly average human being, ordinary but troubled" (90). It is worth pondering if the Dundee Rep/Birmingham Rep's decision suggests that mental illness has become more ordinary and that it is thus acceptable to clarify that the play is about a mentally distressed woman from the outset. Ayckbourn's original dramatic strategy certainly encouraged audiences to think about the moment when things went wrong, that is, when things were not 'normal' anymore, and why this might be the case. By extension, encouraging such considerations can be seen as an invitation to renegotiate the acceptance of a normativity that can easily lead to stigmatisation and exclusion.

The fact that the play has come to be seen as theatrically rendering the subjective experience of mental distress by making the audience share the uncomfortable sense that nothing is what it seems, indicates that indeed what is perceived as 'normal' outside of the theatre has changed over the past forty years. Ayckbourn suggests in the play that madness can follow a trajectory from being Everywoman to being caught in the nightmares one's own mind concocts. By making the audience share Susan's perspective, employing the strategy of hystericised realism and a heterotopic in the round-stage with multiple focal points, the play targets experientially the ontological question if and to what extent we are masters of our minds. In performance then, following Fischer-Lichte, "aesthetic, social, and political aspects are inextricably interlinked […]. Such a connection is not established

by political issues or agendas alone; the fundamental bodily co-presence of actors and spectators engenders and guarantees it" (*Transformative Power* 44). In addition, Ayckbourn's dramaturgy highlights an aspect Fischer-Lichte also relates to performance, namely that "[t]he invisible link between the aesthetic and the political may always have been acknowledged implicitly" (44). Despite the fact that Ayckbourn has been denied the status of a political, or even a serious, writer, the recent radical redefinition of *WiM* as mental health play reveals a profound sociopolitical relevance of his work that has become increasingly visible and utilised. Moreover, Ayckbourn's use of a heterotopic in the round-stage can be considered as highly influential for other mental health plays that set out to dramaturgically problematise notions of perception, knowledge production, and power/knowledge not only in the clinic but also in the family as the place where madness first emerged (Thiher 293).

3.2 Mental Distress and Domestic Confinement in Tony Kushner's *Angels in America: A Gay Fantasia on National Themes* (1991/92)

Tony Kushner's *Angels in America: A Gay Fantasia on National Themes* shares with *WiM* the localisation of gendered madness within the family.[27] It stands out from the corpus of the case studies analysed in the present study because it was written by an American playwright and is set in the United States in 1985 while also encompassing allusions to key moments in American history, from 'manifest destiny' and the Mormon expansion westward to the 'red scare' and the execution of Ethel and Julius Rosenberg. Its epic form differs from most of the other plays' forms explored here. As will be seen, however, its epic elements produce effects similar to what staging in the round can achieve.

When the first part of *Angels*, *Millennium Approaches*, premiered in London in 1992, it had already had successful runs in the United States. It was first produced in San Francisco by the Eureka Theatre Company and directed by Oskar Eustis in 1991, moved to the Mark Taper Forum in Los Angeles, and then to the National Theatre in London in 1992. In 1993, it successfully transferred to Broadway and Kushner won both a Tony Award and the Pulitzer Prize for it. The second part, *Perestroika*, followed in 1993 and was just as successful. Since then, the play has had numerous successful revivals internationally and was turned into an opera and a highly acclaimed film directed by Mike Nichols, starring Al Pacino and Meryl Streep, which was also broadcast as a 6-part miniseries by HBO in 2004.[28] The play also sparked controversy and protest in a number of Southern states such as

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[27] The play will be referred to as *Angels* from here.
[28] For a discussion of the differences between the play and the film (or mini-series) with special emphasis on the representation of AIDS, see Pearl 761-79; Holland.

Texas, Florida, Michigan, and North Carolina when it was first performed there (P. Healy). The outrage ahead of a production in Charlotte, North Carolina, in 2007 was so immense that a play entitled *Southern Rapture* was written by Eric Coble afterwards, capturing the event and antagonistic mood at the time (P. Healy).

The play features in the analysis here despite its decidedly American context for several reasons. It was and still is immensely successful in Britain. Art Borreca in his review of the London premiere argues that it is so popular in the UK because it is "the sort of play British playwrights (for example, Howard Brenton, David Hare, David Edgar, Caryl Churchill, and others) have been writing since the 1970s" (235-36). He goes on to explain that the historical plays written by these writers have influenced Kushner both in the way he depicts American history but also in how his dramatic strategy makes the audience see that "the individual cannot be seen in any other way than his or her social and historical context" (236). Unlike *WiM*, with its focus on Susan's suffering in the domestic sphere, individual suffering in Kushner's work, even if it stems from a conflict within the family – a flexible term in the play, as we shall see – becomes a larger concern. Or, as Ricarda Klüßendorf in one of the few monographs on Kushner's work puts it: "The personal and the political are intricately intertwined so that the psychological conditions of the characters, their suffering, and their attempts at dealing with the world around them are always emblematic of the larger socio-political scope also tackled directly in the plays" (23).

Angels is the piece in the present study's corpus that might at first glance sit most uneasily with the term 'mental health play' for a number of reasons. First and foremost, compared to the other plays, *Millennium Approaches* and *Perestroika* deal with a plethora of topics, from HIV and homosexuality, America's situation in the Reagan years, Mormonism and religious pressures, and the Rosenberg trial, to questions of identity, and the human condition in times of instability and change. Some critics have interpreted the play as "a compelling framing of the political, moral, and sexual issues confronting Americans at the end of the twentieth century" (J. Fisher 44). However, within its partly apocalyptic setting, *Angels* also offers musings on the topic of hysteria. While the variant of hysteria in *WiM* is a private matter, in *Angels*, in line with its long list of the socio-historical, social-political, and medico-cultural topics addressed, hysteria also becomes a larger phenomenon.

Showalter's concept of 'hystories' offers productive reference points for analysing how hysteria has turned from a medical condition into a metaphor with a much wider reach (*Hystories* 4-5). Her interpretation of hysteria as a contemporary socio-cultural phenomenon can usefully be applied to *Angels*:

> Hysteria not only survives in the 1990s, it is more contagious than in the past. Infectious diseases spread by ecological change, modern technology, urbanisation, jet travel and human interaction. Infectious epidemics of hysteria spread by stories circulated through self-help books, articles in news-

papers and magazines, TV talk shows and series, films, the Internet and even literary criticism. The cultural narratives of hysteria, which I call hystories, multiply rapidly and uncontrollably in the era of mass media, telecommunication, and e-mail. (*Hystories* 5)

As one of the key concerns in Kushner's play, HIV affects all the characters in various ways and indeed spreads rapidly. In all his works, Kushner thematises how rapid change (socio-economic, personal, physical) has an impact on his characters (see Klüßendorf's study). However, while *WiM* is marked by change for the worse culminating in Susan's mental breakdown, the female 'madwoman' in Kushner's play, Harper Pitt, despite her mental problems, surprisingly undergoes change for the better.

Harper is deeply affected by dystopian scenarios perpetuated by television and radio programmes – a clear hint at how mass epidemics emerge and are sustained on an individual level. Tellingly, she ultimately escapes her life by plane, assigning travelling by jet an altogether more positive connotation than Showalter, who gives jet travel as one reason for the spread of infectious diseases. It should not go unmentioned that Showalter has been criticised for adapting and extending the concept of hysteria, and was accused of running the risk of ignoring the long history of the suffering of patients, mostly women, who were diagnosed with the condition (Wray; Tavris; Love). Applying her concept to *Angels*, however, does not at all negate the damage that a diagnosis of hysteria caused in the past, and, in fact, it can be analysed against Harper's mental state in order to uncover in what ways Kushner operates with notions and stereotypes of the hysteric woman.

As in the first part of this chapter, my focus is on mental distress in the family. For this purpose, the traditional concept of the nuclear family has to be extended to include relationships that resemble contemporary familial patchwork structures because the play's family structures largely deviate from the traditional concept. Rather, AIDS is a common denominator of such family structures, as Hilton Als suggests when he claims that Kushner "brings out a new and hitherto unexplored empathy for a family that is not biological, let alone chosen" (n.p.). Als makes a reference to the discursive links Kushner creates between all the male characters that contracted or will contract HIV in the course of the play. The statement also reveals a notable exclusion of the play's female characters from this family as none of them have AIDS, which requires further attention in the following. As the family structures break down and are renegotiated, most of the characters experience mental distress, and this includes Harper.

Rather than exclusively employing hystericised realism as a means of rendering madness dramatically, the play is marked by Brechtian epic features: Kushner operates with non-linear narrative expressed in episodes and split scenes between the homes of HIV-patient Prior Walter and his partner Louis, who leaves him because he cannot stand the pain of watching his lover's condition deteriorate, and the flat of Joe and Harper Pitt. The Pitts are both Mormons trying to come to

terms with Joe's closet homosexuality, which is uncovered in the course of the play. Moreover, the two parts of the play are interspersed with scenes in which Roy M. Cohn features, the real-life right-wing lawyer who came into the public eye during the espionage trial of Julius and Ethel Rosenberg in 1951 and was responsible for their conviction and the resulting death sentence. He was secretly gay and contracted AIDS, extending the play's range to encompass the historical dimension Borreca mentions.[29]

3.2.1 Questioning Madness and Gender Politics

Angels is the most overtly political play in my corpus. In no other play examined in this study is madness so obviously linked to aspects of the politics of the time in which it is set, while at the same time being expressed on the bodies and minds of the characters. The conservative Reagan administration in the 1980s for a long time ignored the existence of HIV and, when asked to respond, did not react; AIDS was made invisible through official governmental discourse even though a large number of people already carried the visible signs of the disease and it had become an epidemic (Vanity Fair). While Kushner thematises and openly criticises the repercussions in *Angels*, when it comes to gender politics, his stance is less unequivocal.

On the one hand, aspects of gender, performance, and mental distress, as well as questions about how these are played out on the mind and on the body, are constantly juxtaposed. What is more, Harper is by no means the only distressed character; Prior Walter, Roy Cohn, and the 'Homeless Woman' (one of the many minor characters) all deal with mental disorder and instability in their own way. According to Ken Nielsen, all these characters express the desire to

> escape one's own identity through performance [which] runs through the central, ultimately liberated, characters in *Angels in America*; Prior and Belize both found (and find) escape in doing drag, while Harper escapes into fantasy and imagines herself in different versions – a migrating Mormon mother, a woman in Antarctica and being pregnant, for example. (8)

Returning to Showalter's notion of hysteria, it can be argued that in *Angels* the condition is "a cultural symptom of anxiety and stress" (*Hystories* 9). On the other hand, while all the characters, including Harper, are anxious and under pressure in the face of the raging chaos, especially the male characters' states of mind are in the widest sense the result of the socio-political shortcomings at the time. In the same way as shell shock (now PTSD) was denied and silenced after World War I, AIDS in the 1980s was ignored, as Mark Micale explains ("Hysteria" 200-39; see also Micale, *Hysterical*). Due to the Reagan administration's ignorance, there were

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29   In 1992, the film *Citizen Cohn* (directed by Frank Pierson) traced Cohn's life and career as one of Joseph McCarthy's most important attorneys ('chief counsel') and as dying of AIDS (Clune).

no HIV-awareness campaigns in the early 1980s and it seems that Kushner created both Prior Walter and Roy Cohn as representatives of the large group of homosexual men who suffered the consequences. It is significant that Prior's and Roy's bouts of madness are only ever linked to their physical states. Power-hungry Roy Cohn's self-denying insistence that he suffers from liver cancer is another case in point for efforts to render invisible the disease. As a result, their madness has very different, certainly less negative, connotations than Harper's because there is a physical reason for it.

Although there is no complete absence of female characters in the play as is in much recent AIDS literature, Kushner notably treats Harper very differently from the male characters, marking her as negative (Foertsch 57-72). Most notably, she is characterised only by her mental state when she is introduced as a woman, "immersed in an incessant battle against disease, loss, or the unavoidable painful" (Byttebier 298). While many characters in *Angels* hallucinate and see ghosts, thus are on the verge of or are already mad, only Harper is openly pathologised. According to David Savran, the play "launches a critique of the very mechanisms that produce pathologized and acquiescent female bodies; [but] represents yet another pathologization and silencing of women" (208). Savran's critique also resonates with productions of Ayckbourn's *WiM* in which audiences might laugh at Susan's predicament rather than evaluate critically the reasons behind her mental distress. Therefore, considering the gender representations in *Angels* that Savran criticises provides a useful starting point for interrogating the play's subversive aspects.

At the beginning of the play, Harper is stereotypically contextualised in the domestic sphere. The audience learns that agoraphobia confines her to the flat she shares with her husband Joe. Unlike Susan in *WiM*, who cannot face going inside, Harper cannot go outside. This domestic confinement resonates with other literary women characters that find themselves locked away, such as Bertha Mason in *Jane Eyre* (Gilbert and Gubar 336-71). But Harper is neither an 'Angel in the House' nor *the* Angel of the play's title. On the contrary, with her inability to become pregnant or fulfil the classic role of housewife determined by her religion, she is the polar opposite of the idealised domesticity purported by Coventry Patmore's famous nineteenth-century poem. Harper's escape from the physical confinement is hallucinations.

Kushner's ambivalent gender politics find expression in a difference in 'quality' between male and female hallucinations. When comparing Harper and Prior Walter, the testimonial injustice Harper experiences is particularly striking because, to put it in Fricker's terms (2), her authority as a knower is questioned. On the surface, the two characters share a number of features, as they are "most sensitive to the forces of destruction around them. Both of them anxiously anticipate a terminal catastrophe, their imaginations tied to the national and global threats of their time: environmental collapse, nuclear explosions, and AIDS" (Klüßendorf 76).

When Harper and Prior meet in the "threshold of revelation"-scene in *Millennium Approaches*, the stage directions indicate that this is a "[m]utual dream scene," but the initial situation of the meeting is both gendered and simultaneously highlights a dichotomy of physical and mental distress because Kushner specifies that the meeting takes place in Prior's *dream* but in Harper's *hallucination* (*Angels* 36; my emphasis). The two terms have different connotations because a dream is a 'normal' occurrence (everybody dreams every once in a while) whereas a hallucination is unusual and often connoted negatively. Even though Prior is an ultra-feminine character (he does drag, wears make-up etc.) and is thus not necessarily a representative of patriarchal domination (Foertsch 61), Foucault's notion of power/knowledge is still at work in the scene and has thus once again left the clinic. This is coupled with the male character belittling the female character: Prior is more empowered because he claims ownership over the situation by answering Harper's question regarding his presence by stating: "I'm not in your hallucination. You're in my dream" (*Angels* 37). Moreover, he looks down on Harper when he asks patronisingly: "Aren't you too old to have imaginary friends?" (37). Natalie Meisner aptly remarks that "[t]he male characters in the play gain power through the performance of a homoerotic, homo-social, and homo-political engagement," while she attests Harper a "troubling female corporeal presence" (178). While both of these aspects are exemplified in the scene, it is not only Harper's corporal but also her mental presence that is troubling. In Fricker's terms, Harper, by virtue of being a woman, is the victim of "identity prejudice" because as a "speaker [she] suffers in receiving deflated credibility from the hearer [Prior] owing to identity prejudice on the hearer's part" (5).

The play's character conceptions corroborate the notion that Harper experiences prejudice, as Meisner emphasises how, unlike in Harper's case, Prior's hallucinations (that are called dreams here) always have a cause. After all, he already bears the visible signs of AIDS on his body and his status of 'prophet' is part of his condition, which cannot be said for Harper's. It is not just that the play suggests that Prior's hallucinations are better because he is a male character but because they are also the result of his *physical* illness. Harper's hallucinations, on the other hand, are the result of her *female mental* distress. Added to that, Kushner never makes it explicit where the origins of Harper's condition lie but contextualises her madness within the domestic, part of which is Joe's closet homosexuality (Sigall). In this sense, Harper can serve as a case for feminist literary critics who read "hysteria as a product of women's social circumstances" (for example, Showalter, *Hystories* 11). Meisner concludes that Kushner treats his female characters "disdainfully" (186). While "disdainful" is too absolute a word – after all, there is also Hannah Pitt, Joe's mother, who is a hands-on woman undergoing a remarkably empowering development in the course of the play – with regard to the hallucinations presented, Kushner indeed empowers Prior at the expense of Harper who experiences intersectional bias.

There is more ambivalence about the threshold of revelation-scene when considered against *WiM* because, to an extent, Kushner gives Harper a distinct voice. Unlike Susan, Harper is able to reflect on her situation and to express that she lives within the confines of both a moral framework imposed by Mormonism and the condition of her mind: "Valium. I take Valium. Lots of Valium. […] I'm not addicted. I don't believe in addiction, and I never … well, I never drink. And I never take drugs. […] It's terrible. Mormons are not supposed to be addicted to anything. I'm a Mormon" (*Angels* 38). The lyrical quality of her statements is achieved by the repetition of the words "Valium," "never," and "Mormon(s)," and the "addicted/addiction" polyptoton, and ties in with her elaborate monological musings on her existence and identity in the scene. However, the fact that these are all part of her hallucination and that they are probably induced by medication denies them some of their gravitas and adds to the impression that Harper is a victim of testimonial injustice.

3.2.2 Epic Theatre as Othering-Machine: Harper and Performance

In performance, the notion of testimonial injustice is visible in Kushner's use of Brechtian epic elements coupled with theatrical spectacle that serve a similar purpose of problematising gendered aspects of mental distress to staging in the round. One of the key features of epic theatre is the 'making strange' of a reality familiar to the audience, which is not unlike hystericised realism. Applying epic elements such as the 'V-effect' (*Verfremdungseffekt*), the making strange can find expression in dramatic exaggeration, in the making bigger or bolder of stage props, costumes, or characters. The most significant difference between epic elements and 'hystericised realism' is that Wald's notion is directed at the experientiality of madness for the audience (49), whereas Brecht's, and, by extension, Kushner's dramaturgical approach is supposed to *prevent* the audience from empathising. It is important to note here that the Brechtian approach is not designed to be "cold and impersonal" but "refer[s] to an aesthetic process that renews our powers of cognition" (Brecht 5). The technique of 'hystericised realism' Wald describes (49) is similarly directed at the audience's powers of cognition but the learning takes place on an emotional level, whereas Brechtian drama is directed at intellectual engagement and emotional distance. Brecht states: "So that the particularity of situations and behaviour that the theatre presents may emerge and be criticized in a playful manner, the audience creates in its mind additional situations and ways of behaving, and, while still following the plot, compares them to what the theatre presents" (284). In other words, Brecht was interested in telling a story from which the audience as observers could draw conclusions about their own social realities, whereas plays operating with hystericised realism target emotional engagement with characters and their predicaments; Kushner operates with both strategies in the play. Both these dramaturgical approaches demand an active and emancipated audience in Jacques Rancière's sense.

A German production of *Angels* (*Engel in Amerika*) at Thalia Theater Hamburg in 2015/16 achieved the sense of distortion to which this mixing of approaches might lead by placing a large round scrim above the entire stage. The round scrim was variously used as an intermedial projection space for filmed close-ups of the actors' faces, as a mirror, and as a giant hole reminiscent of the porous ozone layer Harper refers to at one point (*Engel* performance; see also Thalia Theater production photo gallery). I suggest that it is precisely the play's dramatic and theatrical politics and Kushner's utilising of distancing elements coupled with a strong focus on the gender binary explored above that contribute to othering Harper, thereby treating female madness in radically different ways from Ayckbourn. Kushner's dramatic strategy highlights Harper's state as other from the start when he utilises an epic element to introduce her but the Thalia production digressed from his character conception and thus revealed a discrepancy between *mise-en-page* and *mise-en-scène* (Hauthal 367-68; see also Worthen 11), a feature of mental health plays that will be explored further in the following chapters.

On the page, in a self-reflexive act, Harper breaks the fourth wall and turns to the audience because there is no one else to talk to, since Joe stays away from home as much possible to avoid confrontation:

> People who are lonely, people left alone, sit talking nonsense to the air, im-
> agining … beautiful systems dying, old fixed orders spiraling apart …
> When you look at the ozone layer, from outside, from a spaceship, it looks
> like a pale blue halo, a gentle, shimmering aureole encircling the atmos-
> phere encircling the earth. […] But everywhere, things are collapsing, lies
> surfacing, systems of defence giving way. (*Angels* 22-23)

Speaking in riddles and fragments, Harper is fashioned as a modern-day Ophelia or a female Hamlet but the breaking of the fourth wall disrupts the dramatic illusion. As a consequence, the epic element puts emphasis on the fact that, unlike in scenes of hystericised realism, "observation is never the same as experience," a statement Foucault made in the context of the clinic (*Birth* 108). In other words, the fact that Harper is exposed to the audiences' gaze draws attention to her being different and slightly strange, and prevents the audience from empathising with her. Deborah Geis reads the lines as a juxtaposition of theatricality and insanity. She claims that "to speak monologically is a form of insane, or 'deviant' discourse, but it is also an inherently dramatic act" (200). In theatre productions, costume and styling often underline the aspect of deviance, for instance, when Harper's hair was tousled and her clothes showed neglect in the Thalia production. At the same time, the fact that the production placed the central scrim over the stage can be interpreted as drawing attention to the importance of Harper's first mono-logue. After all, when the otherwise invisible ozone layer is visible to the entire audience, this calls into question what is 'real' and what is not, and leads back to the conundrum of who hallucinates after all.

Throughout the play, most of Harper's monologues oscillate between prophetic and dramatic utterances. However, her prophetic nature is never acknowledged in the story world. By actualising the ozone layer, the Thalia production softened the notion of testimonial injustice that Harper experiences on the textual level. On the textual level, while she does not break entirely with *logos* (such as Susan), many of her lines still lack coherence, and thereby linguistically mark her as other. Harper exhibits behaviour reminiscent of the *Oresteia*'s prophetess Cassandra, although Harper's prophecies are only ever called hallucinations, while Cassandra's prophecies, tellingly a curse inflicted on her by the god Apollo, were considered "a special form of madness, a perception of reality unavailable to the rational mind" (Feder 85). So, even though Cassandra's prophecies seem to be connoted more positively than Harper's hallucinations, both characters are ostracised and the male-centred society of *Angels* echoes the *Oresteia*'s chorus' statement: "We want no prophets in this place at all" (Fenwick 5). The important addition in *Angels* is the word 'female' as female prophets do not exist in the play's homonormative universe. In short, Harper is no Cassandra, and yet Kushner plays with the age-old notion that "madness fascinates because it is knowledge" (Foucault, *Madness* 21-22). This particular kind of knowledge of chaos and disintegration, however, has scant significance within the play's homosocial world.

Another notable gender-related alienating factor is Harper's imaginary friend, travel agent Mr. Lies, who brings her to Antarctica, a heterotopia, because while there is a real reference point to it as a place, it exists entirely in Harper's imagination. Crucially, it is yet another male character who helps Harper to get there. Being confined to a small flat in which she does not feel safe, it comes as no surprise that a spatial component is added to her hallucinations insofar as she wishes herself as far away as possible. According to Savran, "Harper's hallucinations are crucial to the play's articulation of its central themes, including questions of exile […]" (215). While Antarctica represents this desire for exile, when she finally gets there in a hallucination in *Perestroika*, it does not hold what she was hoping for. Therein lies a parallel to Susan's ideal family developing a menacing life of their own, which is also not what Susan had hoped for. Harper's trip to Antarctica is marked by a costume change many theatrical productions adhere to. The all-white ski suit suggested in the stage directions can be seen as yet another reference to early modern madwomen such as Ophelia, whose white dresses were markers of their mental states (Showalter, "Ophelia"). At the same time, the weather-appropriate ski suit serves as a material reminder of Antarctica's heterotopic real and unreal aspects, i.e. of being a place that can be indicated in reality but that exists completely "outside of all places" in the stage world (Foucault, "Other" 24).

In a brief moment of hystericised realism and thus in a move away from the epic, the audience shares Harper's perspective and is possibly left wondering who they see when Harper's imaginary friend Mr. Lies appears. Harper is just as surprised ("Oh! You startled me!") (*Angels* 23), which echoes Sacks' comment that

"[h]allucinations tend to be startling" (x). The appearance is an instance of seeing *with* madness in Harpin's sense and a moment of intense theatricality. Kushner gives directors clear guidance explaining what he wants to happen the moment a theatrical illusion is called for:

> The moments of magic – the appearance and disappearance of Mr. Lies and the ghosts, the Book hallucination, and the ending – are to be fully realized, as bits of wonderful *theatrical* illusion – which means it's OK if the wires show, and maybe it's good that they do, but the magic should at the same time be thoroughly amazing. (*Angels* 11)

Depending on the financial resources of a theatre production and the technical equipment at hand, these magical moments can be realised in different ways. At the same time, there is a way of achieving the creation of theatrical illusion with minimal effort because Kushner only demands a "pared-down style of presentation" (11). Illusion is a decidedly non-epic element because, according to Brecht, it distracts the audience from their focus on the plot (177).

The audience is nonetheless alienated because they see what Harper sees and the alienation is highlighted by Harper's self-reflexive comment on the artificiality of her hallucination. By that time, the audience has most likely worked out that Mr. Lies is not 'real' although – just as with the hallucinations in *WiM* – a very real actor plays him. What spectators continually experience is a sense of doubt in what they see and, as a result, a sense of disorientation as to what to believe. In this respect, in *Angels*, seeing does not equal knowing. Maaike Bleeker points out that "[i]f vision can no longer automatically be associated with truth and objectivity, this means we can be misled by what we see, either because of our own subjective limitations, or because of purposeful deceit" (*Visuality* 4). Therein lies significance both on the story and discourse level. Harper is unable to trust her perception both under the influence of and without taking pills. Because as audience, when Kushner employs hystericised realism, we take up her viewpoint and see what she sees, we are also unsure as to what is real in the stage world and what is not. Kushner seems to have "purposeful deceit" in mind in order to invite the audience to renegotiate established preconceptions about conventions of perception. Such a challenge inevitably includes the question how we judge people in real life and how we arrive at the conclusion that someone is mentally ill. Thereby, like Ayckbourn, Kushner invites a tentative challenge to established notions of psychological normalcy despite the fact that madness is so obviously gendered in the play.

It is almost comic when Harper questions the credibility of her hallucination which raises the question if we laugh at or with the character and thus, if we laugh about the representation of mental distress. She voices what Mr. Lies tells her later, namely that "[e]ven hallucinations have laws" (*Angels* 108). Meisner comments critically that "the type of humor generated by Harper's dialogue is more

consistent with a theatre of the ridiculous since on a textual level, audiences are encouraged to laugh *at*, not *with* her" (180). She substantiates her critique by claiming that "[t]he force of Harper's speech acts is diminished considerably given her propensity to parrot television or radio discourse that frames her as insane" (185). However, as the following quotation underlines, the play gives reasons to relativise the force of Meisner's critique because it also reveals a deep sense of reflection and insight inherent in Harper:

> I don't understand this. If I didn't ever see you before and I don't think I did then I don't think you should be here, in this hallucination, because in my experience the mind, which is where hallucinations come from, shouldn't be able to make up anything that wasn't there to start with, that didn't enter it from experience, from the real world. Imagination can't create anything new, can it? It only recycles bits and pieces from the world and reassembles them into vision. … Am I making sense right now? […] So when we think we've escaped the unbearable ordinariness and, well, untruthfulness of our lives, it's really only the same old ordinariness and falseness rearranged into the appearance of novelty and truth. Nothing unknown is knowable. Don't you think it's depressing? (*Angels* 38)

Although the monologue starts with negations, Harper voices several crucial aspects of her hallucinations and mental state. First of all, she reflects on the evolution of hallucinations in a very sophisticated way resembling her first prophetic musings in the first act. To a certain extent, Harper diagnoses herself with the aid of a self-reflexive twist. The oscillations between such insight and her vagueness in other scenes ultimately serve to alienate the audience from Harper. She, like Susan, is familiar and strange at the same time. Yet, the conclusions she draws have philosophical resonance and touch upon profound epistemological uncertainties. In the secluded and ordinary domestic space she never leaves, Harper has generated a deep insight into the nature of knowledge as fragmented. What is more, she alludes to what has widely been described as the postmodern condition, namely that original (artistic) creation is now impossible, that the world at large is a collage of already existing fragments, and that experience is increasingly simulated, as suggested by Jean Baudrillard's use of the term *simulacrum* (Bury 3).

   Mental health plays *per se* draw attention to the body with their focus on distressed minds and so, too, in epic theatre, the actor's body is an important instrument. As we have already seen, Kushner operates with body and mind-centred dramatic rhetoric and imagery by juxtaposing HIV and madness as responses to socio-political chaos and upheaval in the US in order to highlight how the political invades the most private. While HIV invades the male bodies in the play, the female body is inhabited by a distressed mind. Geis makes a careful attempt at diagnosing Harper by stating that "[a]lthough Harper is not schizophrenic in a clinical sense, her images of tears or holes reflect the schizophrenic confusion of surface

and depth that Gilles Deleuze, Fredric Jameson, and others have characterized as part of the postmodern condition" (201).

Harper's distressed mind results in rejection she experiences in the dysfunctional relationship with her husband. Joe rejects Harper, both physically and emotionally, which finds expression in the second act of *Millennium Approaches* when Joe returns from work to find Harper in her usual state. The stage directions indicate: "*Harper is sitting at home, all alone, with no lights on. We can barely see her. Joe enters, but he doesn't turn on the lights*" (*Angels* 55; italics in original). The audience sees hardly anything but has no power to change this because the actors remain in the dark so that their bodies are almost invisible. When Joe enters, at first, he keeps Harper sitting in the dark and instead of turning on the light, he tells his wife to do so, as if he was unable to actually face her. This way, he refuses to acknowledge her presence. Not only does he reject seeing her, but he strongly refuses to touch her, which confirms Drew Leder's notion that "[w]hen the body is rendered opaque through loss of function, we become aware of it as alien presence" (82). In a play that so consistently juxtaposes notions of perception and representation, darkness carries meaning (much like in *Equus*, as will be seen in the next chapter). As the production gallery of the 2017 National Theatre's revival production of *Angels* indicates, the dark and sparse stage used rather than providing somewhere to hide, put visual emphasis on the actors' bodies and the few props present (National Theatre). On the one hand, the sharp focus highlighted the play's naturalist elements and socio-political concerns, such as the hospital scenes or the lesions on Prior's body. On the other hand, it rendered the scenes of hystericised realism with Harper even more surreal.

In addition to Harper's psychological condition, Kushner also gives her an undesirable body and an obvious 'alien presence' in the scene. As much as she claims that the rejection is reciprocal, Joe's dismissal alters her perception of her body: "HARPER. You think you're the only one who hates sex; I do; I hate it with you; I do. I dream that you batter away at me till all my joints come apart, like wax, and I fall into pieces. It's like a punishment. It was wrong of me to marry you" (*Angels* 43). This outbreak finds an echo in Leder stating that "[a]s long as perception presents no problem my body disappears. But in situations of questionable or blocked perception, I am called to reflect back upon bodily states" (85). Perception in the scene, as well as in the play as a whole, is indeed questionable, and Harper's reference to her joints coming apart like wax hints at a disappearing body alongside a disintegrating mind. In retaliation to Harper's rant, Joe launches an attack on the visible, her body, which is repulsive to him, rather than the invisible, her troubled mind, notwithstanding the fact that the state of the latter influences the former and vice versa: "I can always tell when you've taken pills because it makes you red-faced and sweaty and frankly that's very often why I don't want to

[…] Well, you aren't pretty. Not like this" (*Angels* 43).[30] The theme of rejection in *Angels* is in line with Harper's double-othering because it is her female body *as well as* her distressed mind that is rejected. Thereby, this constitutes a classic case of intersectionality because both factors equally discriminate Harper. The aspect of rejection is picked up with regard to the possibility of Joe and Harper having a baby. Even if, as a delaying element, it might provide temporary respite, the baby literally never materialises and thus ultimately corroborates the dysfunctional nature of the couple's relationship.

Similar to *WiM*, the bedroom scene with Joe and Harper in *Perestroika* connects the characters' sexual relationship with notions of female hysteria as a result of 'abnormal' female desire: Harper confronts Joe about closing his eyes when they have sex and she demands that he acknowledge her. Here, rejection turns into negation:

> HARPER. Look at me. *Look at me.* (*Loud*) HERE! LOOK HERE AT …
>
> JOE. *(Looking at her) What?*
>
> HARPER. What do you see?
>
> Joe. What do I …?
>
> HARPER. What do you see?
>
> JOE. *Nothing*, I … *(Little pause.)*
>
> HARPER. Thank you.
>
> JOE. For what?
>
> HARPER. Finally. The truth. (*Angels* 238-39; italics in original)

This is Joe ultimately negating not only Harper's body but also her entire existence. Like Susan asking the characters on stage (as well as the audience) to remember her, Harper wants to be seen and recognised, which Joe denies her. The scene marks a turning point in their relationship because afterwards, Harper will truly be absent. In the penultimate scene of *Perestroika*, she finally leaves the story world with his credit card and by boarding a plane. Tellingly, and as a confirmation of her not belonging, *Perestroika* ends with an epilogue in which she is yet again markedly absent.

The Thalia Theater production once more digressed from the text by showing Harper to be more empowered and assertive. Added to that, the production end-

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[30]   The exchange is reminiscent of Tennessee Williams' *A Streetcar Named Desire* and aligns Harper with Blanche DuBois whose first husband shot himself after Blanche's cruelty over his homosexuality even if, admittedly, *Angels* is less drastic. But there is a crucial reversal in that it is Joe who tells Harper he finds her repulsive. In *Streetcar*, Blanche intimates that she told her husband that he repulsed her: "It was because – on the dance-floor – unable to stop myself – I'd suddenly said – 'I know! I know! You disgust me.'" (Williams 184)

ed the play with Harper's monologue rather than the epilogue set around the Bethesda Fountain with which Kushner's script finishes (*Engel* performance). This alteration changes the tone of the play significantly because it locates Harper far more at the centre and subverts Kushner's 'men's world.' More importantly, it highlights Harper's transformation that Kushner's text yields but never fully develops beyond sending her away on a plane. Savran argues that almost in reconciliation of the play's ambivalences, Harper's departure "signal[s] her repossession of her life and her progress from imaginary to real travel" (215). While it is true that by boarding the plane, Harper gains the agency she formerly lacked, it is still Prior who ends the epilogue in Kushner's script. Ultimately, the fact that the physically ill man has the last word, not an unstable woman, underlines the notion that "*Angels* seems to replicate many of the structures that historically have produced female subjectivity as Other" (215).

In her final scene with Joe, the stage directions indicate that "*Harper digs in the sofa. She removes her Valium stash. She shakes out two pills, goes to Joe, takes his hand and puts the Valium in his open palm*" (*Angels* 273; italics in original). This is a highly symbolic act in which she figuratively hands over her mental health problems to Joe. One way of looking at the handing over of the pills is as an act of returning them to Joe, which would suggest that he is to blame for her condition. After the handover, she boards a plane and leaves, allowing the conclusion that there is no place for her in the homonormative stage world, neither as a woman nor as a madwoman, rather than that she has actually undergone credible changes. The Thalia Theater production undermined the play's gender conceptions and seemed to correct some of the othering that Harper is exposed to in the script and in productions that are more truthful to the text. Confirming that there appears to be a recent trend in correcting Kushner's ambiguous gender policy, Angels' revival production at the National Theatre in 2017 made the female protagonist "angrier and harsher than your average Harper," as Paul Taylor put it in his review in The Independent: "you almost cheer when she finally sends this spouse on his way with a slap, a handful of valium and an injunction to explore." Foregrounding Harper's anger removes some of the stigmatising notions regarding her condition and vehemently opposes the pathologisation of female subjectivity.

All in all, however, *Angels* remains ambivalent regarding Harper's potential for change and empowerment as originally conceptualised by Kushner because she is sent off to a place outside the stage world, suggesting that she cannot exist there after all. This ultimate othering of the female madwoman echoes the blue ambulance lights that take Susan off stage even if Harper's destination is at least not a hospital. Productions that move away from Kushner's text make a powerful statement against such gendered madness by suggesting that pathologising women is a matter of interpretation. What is more, such productions more openly gesture towards *Angels*' qualities as a multi-layered mental health play that brings to the fore 'hystories' of characters experiencing mental distress in the face of chaotic

and uncertain times. Lastly, despite its ambivalent gender politics, it raises epistemological questions regarding the nature of knowledge, which are corroborated by employing epic elements that reveal strangeness in the everyday.

3.3 Chapter Conclusion

Ayckbourn's and Kushner's plays remind us that madness is not only to be located within the individual but has to be considered as a systemic phenomenon that emerges within a wider network. The two plays problematise in innovative and powerful ways how mental distress can be a response to family conflict and that the notion of power/knowledge is not only actualised in the clinic. At the same time, the plays' subversive potential remains ambiguous particularly because both playwrights fall back on stereotypical notions of gendered female madness, while not always exposing them as such.

   In both plays, the audience gaze is not at all authoritative but directed towards looking *with* madness, i.e. the audience share Susan's and Harper's perspective because the plays employ hystericised realism and epic elements, respectively. This perspective-taking has subversive qualities because it enables the audience to experience, at least partly, the sense of alienation that is often attached to mental distress. When joining the female characters' hallucinations, the audience can be said to be temporarily mad, too, because they can see what is not 'really' there.

   Ayckbourn's dramaturgy, particularly the employment of a heterotopic in the round-stage, corroborates the challenge of the audience gaze further as it adds yet another perspectival dimension in performance. By making visible not just the actors on stage but also other spectators, auditorium and stage enter into a (silent) dialogue that oscillates between and thematises what is 'real' and what is 'imagined.' Simultaneously, the audience can see what is happening on stage *and* in the auditorium. On the one hand, this can delay immersion, but on the other, the spatial structure can generate an atmosphere in which self-reflexivity yields metacognitive knowledge due to the constant foregrounding of acts of gazing and renegotiations of what is 'real' and credible. In the challenging atmosphere of spectators having to navigate complex narratives and perceptual levels, they might begin to wonder about categorisations of normalcy and pathology and how and by whom these are justified even if there is no clinical or psychiatric context depicted that they could directly relate such thoughts to.

   Both plays function as mental health plays precisely because they still invite such considerations outside of this context. Yet, as the analyses demonstrated, Kushner's use of epic elements, while by definition inviting critical reflection on Harper (as much as on the other characters), also complicates notions of subversion and othering when the audience share her perspective. Harper, like Susan, is repeatedly fashioned as a hysteric and this gendered portrayal of madness diminishes the play's counter-discursive qualities.

Ultimately, it is the plays' theatricalities and recent productions more than the plots (and texts) that reveal their subversive and epistemological potential. Put differently, the plays are mental health plays not so much because of what is told about madness but rather how this knowledge is rendered problematic in performance. However, the highly gendered portrayals of female characters as hysterics on the page counteract this notion, resulting in an ambivalent evaluation of their subversive stances. The following chapter offers analyses of mental health plays that also operate with stereotypical notions of madness while explicitly criticising psychiatry and its authority by exposing and challenging power/knowledge structures in the clinical contexts where Foucault located them.

4 On the Battlefields of the Mind: Exploring Mental Distress in the Institution

While the plays discussed in the previous chapter situate mental distress in the domestic context, the plays analysed in the following, Peter Shaffer's *Equus*, Joe Penhall's *Blue/Orange*, and Lucy Prebble's *The Effect*, lay bare the clinical, administrative, and psychopharmacological sides of mental distress and particularly scrutinise the psychiatric profession in dramatic ways. In no other plays discussed here is the interplay between real world-mental health discourses and madness on stage more visible and more important. Whereas in the preceding chapter, power relations in Foucault's sense were analysed within the institution of the family and with regard to the plays' staging, here. the gaze comes under scrutiny in the space where most people would expect it, the clinic. The clinic, in Foucault's understanding, forms a "heterotopia of deviation" because this is where "individuals whose behavior is deviant in relation to the required mean or norm are placed" ("Other" 25). Such an undoubtedly questionable, spatial contextualisation, when transferred to modern day mental hospitals, promises insights into the relationship between power/knowledge and psychiatric authority as they manifest themselves in the gaze.

In keeping with its interest in institutional power, this chapter also illuminates the plays' approaches to the sociocultural and -political contexts and medical reali-

ties in which they were written and produced in order to corroborate the hypothesis that mental health drama has a significant ethical dimension when it comes to challenging institutional hegemony. In this context, it is important to recall that to Foucault, "[p]ower is a general matrix of force relations at a given time, in a given society" and that "[a]lthough power is imminent to institutions, power and institutions are not identical," as Hubert Dreyfus and Paul Rabinow explain (185-86). In the plays I analyse, power is also not a uni-directional phenomenon but it is a complex operation that involves patients as well as therapists and doctors. The therapy in Shaffer's *Equus*, for example, is firmly rooted in psychoanalytical practices juxtaposed with references to anti-psychiatry and R. D. Laing's work – both prevalent concerns of 1970s psychiatry. Emphasising broader cultural contexts, Madeleine K. MacMurraugh-Kavanagh points out that *Equus* expresses "the prevailing *zeitgeist* of the early 1970s, a period when, following the confused excesses of the 1960s, society seemed to turn inwards on itself and embrace psychological exploration of the human condition" (8). In line with this cultural orientation, Ariel Watson coined the term 'psychotherapy play' for plays that "emerge out of a distinctly British historical moment, expressing a profound distrust of the National Health Service" (189). The historical moment she refers to is post-Thatcher Britain with its reduced NHS provision, hospital bed shortage, and contested Care in the Community.

Similar concerns can be found in the other two plays analysed here. Penhall, who already problematised the UK's Care in the Community-policy in *Some Voices* in 1994, continues his critical explorations in *Blue/Orange* with a focus on institutional racism and the repercussions of NHS funding cuts and deinstitutionalising mental health care.[31] Prebble's *The Effect* with its clinical trial setting critically uncovers the damaging hierarchical order doctors are exposed to while it also immersively introduces the audience to cutting-edge debates on psychopharmacology and the two interpretative models of mental illness.

Another key point explored in this chapter is the interplay of the mental health plays' form, content, and staging. As all three plays are grounded in dramatic naturalism with theatrical strategies that invite the audience to look *at* madness, in Anna Harpin's sense, they can be closely aligned with the genre of the 'science play,' a term coined by Kirsten Shepherd-Barr.[32] The most important reference point to science plays lies in the fact that form and content should be considered together because this is essential for calibrating the plays' ethical dimensions (Shepherd-Barr, *Science* 10). Audiences look at how the closed walls of mental

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[31]   Harpin sees parallels to plays such as Wayne Buchanan's *Under Their Influence* (2002) and Zindika's *Leonora's Dance* (1999), which are similarly "self-consciously preoccupied with the potential neo-colonial politics of psychiatric care in Britain" (*Madness* 61).

[32]   Harpin refers to *Blue/Orange* and *The Effect* as prime examples of plays that sustain a dramatic tradition of looking *at* mental distress (see "Dislocated" 212). See also Shepherd-Barr, *Science;* Johnson *Quantum Theatre;* Carpenter, *Dramatists*.

institutions (and related establishments) constitute a "means of social invisibility" and how psychiatry is depicted in mental health plays as contributing to this (C. Gordon 276). I argue that such depictions successfully counteract the very notion of invisibility. The fact that multiple productions of the plays employed in the round-stages brings to bear questions on Foucault's concepts of gaze and heterotopia both on the textual level with regard to the analysis of the plays' doctor-patient and doctor-doctor relationships, and on the level of production and reception. Although the plays do not express, in Harpin's words, a "methodological 'withness'" with madness because they favour an audience position of looking *at* madness (*Madness* 12), their dramaturgies problematise notions of commonality on heterotopic stages in the round resulting in profoundly subversive and insightful moments. What is more, audiences are forced to engage with their own gazes. Robert J. Topinka's notion of "intensification of knowledge" (55) that he considers fundamental of heterotopic spaces because in them "epistemes collide and overlap" (55), resonates with how the plays challenge audiences into questioning the foundations of diagnoses and trust in psychiatric expertise.

Key figures in the process of defining madness and sustaining hegemonic power are doctors and therapists. It bears keeping in mind that such characters have populated stages across periods – one might think of the doctors in Molière's and Shakespeare's plays as well as in Henrik Ibsen's and Anton Chekhov's work – and have also featured in more recent dramatic genres such as film and television.[33] The past three decades have seen an increasing critical interest in the role of medicine in early modern society and culture, particularly in configurations of illness and health on Elizabethan and Jacobean stages, where illness was often juxtaposed with the theatrical, as Stanton B. Garner has shown (317-18; see also Shepherd-Barr, *Science* 155). Furthermore, Garner points to the presence of doctors in the naturalist theatre of Ibsen, Strindberg, Chekhov, Maeterlinck, Hauptmann, Shaw, Wedekind, and O'Neill, and argues that this "presence […] underscores how centrally the idea of medicine functions in the emergence of modern drama in Europe" (317-18).

Another reason for the popularity of doctors and medicine on stage, which can also account for the rise of mental health plays, is that "such plays have a relevance for many audience members for whom doctor-patient interaction is often their only direct, personal encounter with science" (Shepherd-Barr, *Science* 155). According to Garner, in medical drama of the early twentieth century, "[a]s diagnosticians trained in an increasingly scientific body of knowledge for examining, interpreting, and treating the body, doctors occupy a privileged position in the observational field within which the embodied subject is apprehended onstage" (321). This suggests that in the late twentieth and early twenty-first century with

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[33]   Television drama set in hospitals has been popular since the 1960s and includes such series as *E. R.*, *Grey's Anatomy*, *Scrubs*, and *General Hospital* in the US as well as British dramas like *Holby City*, *Doctor Foster*, and *Doctors*. See also Surawicz and Jacobson.

the ever-increasing visibility of the somatic body, the role of doctors has become even more important. The following case studies seek to show how the juxtaposition of the personal dimension Shepherd-Barr mentions and Garner's claim of the "privileged position in the observational field" is negotiated in mental health plays that voice criticism of psychiatric practices. Moreover, I will elucidate how the theatrical stage is a site on which multiple gazes (doctors', patients', audiences') are brought into play.

Numerous dramatic and fictional works paint negative portrayals of the medical profession, and the three plays under consideration are no exception. Other examples include Ibsen's plays in which "doctors are expert diagnosticians but inept curers" (Shepherd-Barr, *Science* 157).[34] Shaw's biting satire *The Doctor's Dilemma* (1906) in which the doctors operate according to a questionable ethical framework, the distant and objectifying doctor in Büchner's *Woyzeck* (1836), the offstage quack doctor in O'Neill's *Long Day's Journey into Night* (1956), Dale Wasserman's stage version of Ken Kesey's 1962 novel *One Flew Over the Cuckoo's Nest* (1963) with its tyrannical Nurse Ratched, and more recently, Margret Edson's *Wit* (1995), with two doctors who "come across as cold, tough, and inhumane" (Shepherd-Barr, *Science* 168; see also Garner 322-24). Mental health plays do not portray doctors and therapists as outright villains but as subjects who also operate under systemic constraints.

Negative dramatic portrayals of doctors and mental institutions often extend to wide-ranging system criticism and thus provide an important context for the mental health plays analysed here because of their focus on systemic concerns.[35] Peter Nichols' satire *The National Health* (stage 1969, film 1973), Stella Feehily's farce *This May Hurt a Bit* (2014), and Michael Wynne's *Who Cares* (2015) criticise the NHS and its representatives. The play and film adaptation of *One Flew Over the Cuckoo's Nest* (first staged on Broadway in 1963, film 1975) and Peter Weiss' *Marat/Sade* (1962) are sceptical of what confinement does to human beings and thematise asylum life as creating a community of "an oppressed underclass of semi-vagrants" (C. Gordon 276). In Tennessee Williams' *Suddenly Last Summer* (1948) widely used treatment forms such as lobotomy to eradicate traumatic memories and in Harold Pinter's unnamed institution in *The Hothouse* (1958, first performed 1980) electroshocks for treating unspecified conditions, come under critical scrutiny. All examples have in common a pervasive sense of negativity and criticism of psychiatry (and medicine) that reveal a profound and long-standing distrust of institutionalised care. Why such a critique in mental health plays has ethical potential and how it adds to theatre's objection to the epistemic injustice of psychiatry's dominance of the mental health discourse will be explored next.

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[34] For a close analysis of Ibsen's "impotent doctors," see Shepherd-Barr, *Science* 156-60.
[35] For theatre's critical comments on asylum life, see, for instance, Harpin, "Puzzle Factory" 50.

4.1 "You see, I'm lost": The Therapist on the Edge in Peter Shaffer's *Equus* (1973)

When *Equus* was written and first staged at the Old Vic Theatre in London and became part of the National Theatre repertory in 1973, Peter Shaffer had already made his dramatic mark with *The Royal Hunt of the Sun* (1964/65) – a play that explored the topic of worship and the binary of reason/instinct, both of which were to recur in *Equus* and *Amadeus* (1979) (MacMurraugh-Kavanagh 3; see also Gianakaris, *Shaffer* 91). Known for dramatic innovations, Shaffer is one of the most commercially successful yet criticised contemporary British playwrights whose work is characterised by the ability to "forc[e] the audience into involvement with his dramas through detective-story suspense, human identification, and the presentation of complex conflicts" (MacMurraugh-Kavanagh 2). *Equus* similarly follows a trajectory searching for truth, although more in 'whydunnit'- than 'whodunnit'-fashion, while engaging the audience in an ambiguous web of pathological mental distress, professional responsibility, and moral failure.[36] The following analysis problematises the play's epistemological potential as mental health play with references to how it represents and subverts the audience's gaze. It will further address Doyle W. Walls' claim that the play forces spectators "to see what may be our own madness, a modern malady which has become so commonplace that we may fail to recognize it" (314). Not only does Walls' comment anticipate Madsen's concept of a 'therapeutic culture' that we all participate in nowadays but it also touches upon the question how mental health drama addresses and potentially reconfigures notions of normativity.

Loosely based on an undocumented story that Shaffer was told by a friend who worked at the BBC, *Equus* deals with child psychiatrist Martin Dysart who has to treat teenager Alan Strang at a psychiatric hospital because he blinded six horses with a metal spike at the stable where he worked (*Equus* 9; see also Gianakaris, *Shaffer* 90). The story is told in not strictly linear episodes but still follows a clearly identifiable plot in two distinct acts. Following Gay McAuley's "taxonomy of spatial function," the play's "fictional place" is fictive Rokesby Psychiatric Hospital, a southern England mental institution for children and teenagers providing the play with a naturalistic setting, at least on the page, in the play's "textual space," because the suggested staging does not demand the hospital to be visible as "onstage fictional space" (24-35). Throughout the play, Dr Dysart serves as a narrative filter and a homodiegetic narrator who, making use of epic elements, turns to the audience from time to time to allow glimpses into the invisible workings of Alan's mind. The play combines epic and naturalistic elements: apart from

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[36] Even though in the early stages of his career Shaffer wrote three detective novels, C. J. Gianakaris points out that there are no indications of any links to his later work so "[t]he temptation to see the suspense novels as foreshadowing characteristics of Peter Shaffer's plays must not be over-indulged" (*Shaffer* 13).

the realistic setting in Rokesby Hospital, the therapy loosely resembles psychoanalytical practice to the extent that audiences would recognise it as such. This interplay is equally important for the following discussion because it illuminates the play's critical engagement with the 1970s psychiatric *zeitgeist*.

4.1.1 Ambiguity as Truth: The Psychiatrist as Unreliable Narrator

Shaffer's play sustains a highly ambiguous atmosphere throughout and thus displays one of the aspects that have already been touched upon as characteristic of mental health plays. Ambiguities are established by the repeated use of "ruptures" (Pavis 246). To recall, whenever a rupture occurs in a play, this demands 'emancipated spectators,' in Jacques Rancière's sense, i.e. audiences are forced to make meaning themselves, thereby joining the creative process of performance and contributing actively, if silently and individually, to a performance (272). This, of course, is true for all drama but I argue that ruptures in mental health plays in particular carry the weight of their ethical criticism because it is in these gaps that a productive metacognitive stance can be facilitated in spectators.

That spectators will be confronted with an ambiguous conundrum is not apparent from the outset. Rather than opening with the narrator's direct audience address in the tradition of epic theatre, the play begins as a tableau in which Alan is on stage embracing Nugget, the horse he will have violated with a hoof pike; only the audience does not know this at this point.[37] The fact that the scene favours gaze over language echoes a system of observation and the establishment of knowledge and truth that Foucault recognises as a defining feature of the nineteenth-century clinic (*Birth* 107-08), one which also permeates *Equus*. As the audience watches the silent, non-verbal exposition, the first truth that is established is that Alan and the horse have a tender relationship. However, this is never verbalised, so unlike a direct audience address that would discourage emotional engagement, the tableau potentially has the opposite effect. And then the play's first rupture ensues and, retrospectively, the scene evokes a strong sense of ambiguity because the audience learns about Alan's violent attack next. Furthermore, in retrospect, the scene calls to mind seventeenth-century imagery of madness as animality, foregrounding a domination of passions that result in delirium as well as "a fundamental blindness that cuts the mad off from the light of reason" (Gutting 73). Building on such imagery and employing the notion of blindness in the play's plot and theatricality, Shaffer traces how, in Foucault's sense, Alan will be returned to the realm of the human with all related consequences (Gutting 73).

Ambiguity also prevails in Dysart's audience address, which follows the tableau scene, when he introduces himself as "an overworked psychiatrist in a provincial

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[37]   See the stage directions: "ALAN's pose represents a contour of great tenderness: his head is pressed against the shoulder of the horse, his hands stretching up to fondle its head. The horse in turn nuzzles his neck." (*Equus* 17)

hospital" beset with doubts regarding his profession (*Equus* 18). The play's conflicted psychiatrist who bears traces of Ibsen's Doctor Stockmann in *An Enemy of the People* with his desire for truth but disdain for people, and of the morally flawed doctors in Shaw's *The Doctors' Dilemma*, simultaneously and paradoxically functions as an authority figure and unreliable narrator.[38] Rather than guiding the audience and commenting on the action, Dysart's self-reflexive musings take up substantial ground, which gives the impression that the play is much more about him than Alan and that he is indeed an autodiegetic narrator (Gianakaris, "Theatre" 38). This in itself is telling because it shows the unequal weighting of a doctor's and a patient's expertise when it comes to managing mental distress also thematised in a number of other mental health plays, including *Blue/Orange* and *4.48 Psychosis*. In addition, the fact that Dysart is an unreliable narrator constantly calls into question his supposed role as an "instrument of social values" (Gutting 74). Furthermore, in a self-introductory confession, which potentially serves as a rupture because it might break with spectators' expectations, Dysart tells the audience straightaway: "You see, I'm lost" (*Equus* 18). That the play's ethical criticism is indeed expressed in this confession becomes increasingly clear. The play's most recent revival production at the Gielgud in 2007 put special emphasis on the statement and even dressed actor Richard Griffiths in a costume that problematised Dysart's conflicted nature. Coupled with the dim lighting of John Napier's set and as a visual marker against stereotypical all-white doctors' garment, Griffiths wore black clothes and in some parts of the play almost conflated with the background ironically highlighting his professional crisis and serving as a warning for the audience not to trust him and his perspective (*Equus* video recording). Unlike the instances of perspective-taking discussed in the preceding chapter, Shaffer does not utilise hystericised realism, as the spectators do not share the mad character's perspective. And yet, since Dysart serves as a filter, the perspective on madness provided to audiences is no less subjective.

Dysart's perspectival filter also influences how Alan's family situation is depicted. Foucault's assumption that "[t]he watchful family eye bec[omes] a psychiatric gaze, or, at any rate, a psycho-pathological, a psychological gaze" (*Psychiatric Power* 124) is enacted in the play in the sense that in the Strang household a *über*-religious mother and a suppressed socialist and atheist father try to inculcate their respective dogma into their son. In short, Shaffer relies on a stereotypical family situation as a means to contextualise Alan's mental distress. Alan's mother is suggestively named Dora, whereby Shaffer recreates psychoanalytic stereotypes because a mother called Dora hints at Freud's case-work with the 'hysteric' patient Dora (Ida Bauer) (Showalter, *Hystories* 42). The name evokes a renewed sense of ambiguity with regard to the reasons for Alan's crime. Still, Dora voices her frus-

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[38]   For a discussion of the ambivalent character of Doctor Stockmann, see Shepherd-Barr, *Science* 156-57, as well as the in-depth character analysis in chapter 3 of Shepherd-Barr, *Theatre* 63-91, especially 78, 88-89.

tration at being blamed for his crime and thus sarcastically echoes R. D. Laing's now notorious comment that parents cause their children's mental distress.[39] She laments: "It's *our* fault. Whatever happens, *we* did it. Alan's just a little victim. He's really done nothing at all! [*Savagely.*] What do you have to do in this world to get any sympathy – blind animals?" (*Equus* 77; italics in original). Dysart further substantiates the sense of ambiguity that Dora's name induces when he states:

> Think about him. He can hardly read. He knows no physics or engineering to make the world real for him. No paintings show him how others have enjoyed it. No music except television jingles. No history except tales from a desperate mother. No friends. No one kid to give him a joke, or make him know himself moderately. He's a modern citizen for whom society doesn't exist. He lives *one hour* every three weeks – howling in a mist. And after the service kneels to a slave who stands over him obviously and unthrowably his master. With my body I thee worship! … Many men have less vital [sic] with their wives. (81, italics in original)

When Dysart voices the anti-psychiatric idea that Alan's madness is a response to living in isolation from a society that he is unable to belong to, on the one hand, he echoes the ancient Greek concept of madness as non-participation in *logos*, that is, shared values and language (Thiher 13). On the other hand, Dysart's curative faculties come under scrutiny because, to an extent, he seems to justify Alan's madness. What is more, the response appears to be the result of Dysart's off-stage troubled, sexless marriage, which not only corroborates his unreliability as a narrator but also has repercussions on his professional conduct when it comes to evaluating Alan's passionate worship of Equus, the horse god, as not altogether negative.

According to Foucault referencing French psychiatrist Phillipe Pinel (1745-1826), in order to cure the 'lunatic,' the one who exercises medical power has to be equipped with "physical and moral qualities that enable him to exercise an influence that can have no limit, an irresistible influence" (*Psychiatric Power* 8). In Dysart's case, while he is equipped with the ability to influence his patient, his moral qualities are questionable especially after he reveals his envy of Alan's passion for Equus:

> Look … to go through life and call it yours – *your life* – you first have to get your own pain. Pain that's unique to you. He can't just dip into the common bin and say 'That's enough!'… He's done that. All right, he's sick. He's full of misery and fear. He was dangerous, and could be again, though I doubt it. But that boy has known a passion more ferocious than I have

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[39]   Laing in later life denied to have said that parents made children mad in his autobiography *Wisdom, Madness and Folly: The Making of a Psychiatrist 1927-1957* (1985) (Kotowicz 6).

> felt in any second of my life. And let me tell you something: I envy it. (*Equus* 82; italics in original)

With this statement, Shaffer offers a radical challenge to the rational language of psychiatry, which has provoked critical responses since the play's first production (Spencer "Radcliffe"). It is the aforementioned return to ancient Greek conceptions of madness which suggests that Dysart does not treat Alan with professional distance. According to Dysart, Alan possesses something that he himself does not have: passion and energy. Passion to the supposedly rational therapist is connoted positively, although, historically the passion of madmen and madwomen was feared, as Foucault explains: "The savage danger of madness is related to the danger of the passions and to their fatal concatenation" (*Madness* 85).

Taking up both the play's psychoanalytical thread and the references to ancient Greek concepts that Shaffer builds on, Ronald J. Lee provides a psychoanalytical reading of *Equus* based on C. G. Jung's theory of archetypes and concludes that it is the archetypal Dionysian that the Apollonian Dysart craves.[40] That is why Dysart's gaze, unlike the medical gaze Foucault described, is not objective but highly subjective and both dramatic and dramatising:

> The condition of the medical gaze (*regard médicale*), of its neutrality, and the possibility of it gaining access to the object, in short, the effective condition of possibility of the relationship of objectivity, which is constitutive of medical knowledge and the criterion of its validity, is a relationship of order, a distribution of time, space, and individuals. (*Psychiatric Power* 2-3)

Although, due to his assigned role as narrator, Dysart has power because he is in charge of ordering time, space, and the individual characters on stage, his neutrality is constantly called into question, not only based on the direct comments on his doubts but also with regard to how Shaffer positions him between audience and stage world. Dysart's in-between state is thus essential for negotiating observation, power, and knowledge not just on stage but extending into the auditorium because it raises doubts about his agenda and reliability. From the perspective of the contemporary mental health discourse with its concern for destigmatisation, Shaffer's narrator and the use of archaic imagery of madness might be problematic. Charles Spencer, for example, criticises "the play's absurd and dangerous psychobabble, inspired by that most dodgy of 60s gurus R. D. Laing, in which we are asked to believe that the mentally ill are vouched an insight, and a passion, denied to the boringly sane" ("Radcliffe"). What Spencer does not mention, however, is that neither Dysart nor Alan are fashioned as inspirational gurus but as deeply conflicted characters. In essence, Dysart embodies an ethical conundrum that therapists might actually face. According to some real-world psychologists, the overstepping of boundaries can be the result of intense therapy and is thus not

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[40]   For a close analysis of Shaffer's use of Jungian archetypes in the play, see Lee 10-21.

altogether uncommon. American psychologist Leslie H. Farber, for instance, has observed this in his practising years when treating schizophrenia patients:

> [T]he therapist might see in the schizophrenic a sort of oracle, with whom he sits each day – a truly ragged oracle, *untutored*, *unverbal* and naturally unappreciated, who has the rare power to cut through the usual hypocrisies and pretensions of ordinary life, thereby arriving at some purely human meaning. His illness now appears as an appropriate response to the impurities in the therapist's heart, even to the deceits and contradictions of the world in which he lives. (39; my emphasis)

Alan, who works as a stable boy and at first only communicates in commercial jingles with Dysart, can be said to be "untutored" and "unverbal." This conspicuous kind of verbal communication is a marker of Alan's madness going back to ancient Greek theatre (such as *Oresteia*) in which a break from traditional verse pattern indicated mental pain and a non-participation in *logos* (Fenwick 4), as also seen in Susan's gibberish and Harper's prophetic musings. In defence of Shaffer's play, critics have pointed out that it has often been overlooked that Dysart's questionable nature serves Shaffer's aim "to create a mental world in which the deed could be made comprehensible" (*Equus* 9).[41] It is easy to see why one might take issue with an approach that seeks to justify a violent crime as madness and employs theatricality that relies on stigmatisation for effect. While such criticism was raised in the 1970s when the play was first performed and anti-psychiatry was highly controversial, arguably, in our current therapeutic society with its increased mental health awareness, a performance of *Equus* that solely builds on making a spectacle out of Alan's mental distress will also be and has been met with criticism.

4.1.2 Implications of Fashioning Mental Distress as a Spectacle

For conceptualising the play's spectacle and its potential epistemological dimension, it is important to consider questions of dramatic form and theatrical staging as well as the problematics of *mise-en-scène* versus *mise-en-page*. I will show in the following analysis that Shaffer constantly juxtaposes entertaining aspects with references to knowledge production. Such a strategy transfers the ambivalence present on the textual level into the auditorium, resulting in a highly ambiguous atmosphere that requires emancipated spectators.

On the textual level, the repeated references to Alan's stare and the excessive use of references to eyes and seeing, first and foremost, serve as markers of his madness.[42] In performances of the play, however, this emphasis on perception has

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[41] For a positive evaluation of *Equus* based on a reading grounded in Félix Guattari's and Gilles Deleuze's work, see Woodward.

[42] On the symbolic connotations of eyes, see Klein 115-16.

another crucial function: the references constantly remind audiences that the gaze is conflicted and never serves to satisfy any scopophilic desire. This is corroborated by the fact that, as the play progresses, the allusions to vision and the gaze become increasingly uncomfortable.

At first, Dysart only mentions that Alan "has the strangest stare I ever met" and that one of his therapy aims is to find out what this stare is all about (*Equus* 26). Rather than questioning why Alan stares, Dysart reveals his self-centered preoccupation and overstepping of professional boundaries yet again when he tells Hesther: "Don't you see? That's the Accusation! That's what his stare has been saying to me all the time. 'At least I galloped! When did you?' … […] I'm jealous, Hesther. Jealous of Alan Strang" (82). Dysart admits that his patient's mental disorder expressed by his powerful piercing gaze reminds him of his own inadequacies and paradoxical powerlessness. In other words, in a reversal of the power relation between doctor and patient, Alan's gaze rather than Dysart's medical gaze is able to "establish the individual" (Foucault, *Birth* xiv), in this case Dysart not Alan. Because Dysart thus denies himself this privilege of establishing the individual, which, according to Foucault, is usually granted the medical gaze, Shaffer counteracts the power of the psychiatric gaze. What is more, due to the fact that audiences rely on and share Dysart's perspective, by extension, the audience position of looking *at* madness rather than *with* it also becomes more problematic. Anna Harpin assumes that the external perspective (looking *at*) fosters the analysis of behaviours rather than experiences ("Dislocated" 212), but in the case of *Equus*, since the audience gaze is determined by the conflicted psychiatrist, the differentiation is much less clear.

It turns out that, tragically, it is not Alan's perceptual power but the power of the horse eyes that dominates the play, for instance, when Dora and Dysart discuss the horse poster in Alan's rooms as being "all eyes" and "staring straight at you" (*Equus* 45-46). Alan's madness makes him succumb to the penetrating silent gaze of his god Equus, and he has entered into a submissive relationship fashioning himself as the object of Equus' power. Paradoxically, Alan's giving in to his god reminds Dysart that he himself is unable to create and worship even though Dysart has a deep sense of yearning and strongly believes that "Life is only comprehensible through a thousand local Gods" (62). Walls cogently states that even the name 'Dysart' "reveals that the one quality needed to remedy his existential problem is art; however, he finds that he lacks the spiritual power of art, that power which generates creation" (320). The pervasive sense of a lack is further substantiated by Dysart's inability to have children and by his admission: "Without worship you shrink, it's as brutal as that … I shrank my *own* life" (*Equus* 82; italics in original). Such thoughts are triggered by Alan's worship for Equus so it can be argued that Dysart is not only established as an individual by Alan's gaze but rather by Equus', even if it is a figment of Alan's imagination. Thus, the very presence of the mentally distressed Alan justifies Dysart's existence, which again re-

verses the notions of epistemic injustice and power/knowledge. By extension, the scene encourages audiences to reflect on their own understanding of worship and it might even make spectators question in what ways their own spiritual or creative life is active.

The play's perceptual framework is further complicated by the fact that the human/horse relationship and Alan's worship of Equus is highly sexual, especially the nightly riding of Nugget on the "Field of Ha Ha." The medical gaze is thus underpinned by Laura Mulvey's notion of the 'male gaze,' which introduced a decidedly sexual connotation to the gaze (even if, since its emergence in her essay "Visual Pleasure and Narrative Cinema" in 1975, numerous scholars have criticised and modified the concept (for example, Bannerji; Král)). While Mulvey refers to the binary of male/female and related unequal power distributions, Shaffer's play operates with a human/animal dichotomy coupled with aspects of religiousness as markers of Alan's mental illness. Significantly, Mulvey's unidirectional gaze is broken because Alan's religious gaze projects Equus' gaze onto himself so, ultimately, the power distribution is either self-made or an expression of his condition (Walls 315) but not external in Mulvey's sense (17). While some critics would argue that it is an expression of Alan's madness, in the pseudo-religious setup, it makes perfect sense because it provides Alan with a spiritual bonding experience with his idol and constitutes an act of liberation from the confines of his limited everyday life that is merely coloured by his parents' incongruent dogmata.

Alan's sexualised worship is complicated when he meets Jill Mason at the stable and then tells Dysart about Nugget in the same way as he describes Jill, thereby confusing the binaries mentioned above: "His eyes shine. They can see in the dark … *Eyes*!" (*Equus* 71; italics in original). When Alan's desire is transferred to Jill, he also notices her eyes and, significantly, words fail him again: "*She's* the one with eyes! … I keep looking at them, because I really want –" (97; italics in original). The sexual dimension of the gaze is emphasised further the more Alan wants Jill, juxtaposing Alan's worship of Equus with his adoration for Jill. The perceptual framework of the staging corroborates the power of Equus' gaze because as Alan is telling Dysart about the encounter and enacting his memory at the same time, both Dysart and the audience turn into powerless observers.

ALAN. […] She was always *looking*.

DYSART. At you?

ALAN. […] Saying stupid things. […]

JILL. You've got *super eyes*. […] There was an article in the paper last week saying what points about boys fascinate girls. They said Number One is bottoms. I think it's *eyes* every time … They fascinate you too, don't they?

ALAN. Me?

> JILL. […] Or is it only *horses' eyes*?
>
> ALAN. […] What d'you mean?
>
> JILL. I saw you *staring* into Nugget's *eyes* yesterday for ages. I *spied* on you through the door! (89-90; my emphasis)

While Alan's fascination with Nugget's eyes is expressed by his incessant gazing at the horse, he, too, has become the object of Jill's external, sexualised gaze. On the one hand, he is turned into a desirable sexual object reversing Mulvey's gendered notion, on the other, he is now also under Jill's uncomfortable scrutiny and has become the object of her voyeurism. As Equus' and Jill's gazes have sexual connotations, the pressure on Alan rises and leads to his violent stabbing of the horses' eyes. The scene suggests that the power of the gaze is uncomfortable to endure on the textual as well as the performance level. This is crucial because it means that audiences simultaneously contribute to the pressured situation and find themselves somehow subjected to Equus.

This raises the question how Shaffer achieves this complex juxtaposition. I argue that it is not only the narrator's aforementioned in-between state but also Shaffer's spatial politics that confirm the notion that theatre's heterotopias reveal but also problematise structures of power and knowledge (Tompkins 1). Despite the fact that the play is set in a mental hospital, Shaffer's suggested *mise-en-scène* is not supposed to be naturalistic and show this; rather, in line with the aesthetics of epic theatre, the stage is bare with movable blocks and benches allowing the actors to change the setting (*Equus* 13). In addition, the actors are on stage for the entirety of the play, as is also often the case in epic theatre. The stark contrast between the bare stage and the naturalistic therapy scenario highlights the difference between what Pavis terms "dramatic space" and "stage space" (153). While it is true for *Equus* that the dramatic space "creates interference between the iconicity of a concrete space and the symbolism of language," Pavis' assertion that "[t]he spectator-listener is no longer in a position to distinguish between what she sees with her eyes and what she perceives 'in the mind's eye,' to borrow Hamlet's phrase," does not apply (153). Shaffer's heterotopic quasi in the round-staging which is conceived with a raised gallery where some of the spectators are seated, deliberately evokes operation theatres and lecture halls that turn the audience members together with the actors on stage into "witnesses, assistants – and especially a Chorus" (*Equus* 13), strongly resembling Charcot's lectures in the Salpêtrière. In Elin Diamond's sense, such staging is ideologically charged because while it suggests openness and visibility, it "may […] be understood as a symptomatic cultural site that ruthlessly maps out normative spectatorial positions by occluding its own means of production" (iii).

Hence, Shaffer exploits the stage's historical connotations as a means of eliciting certain responses from audiences. Because the upper gallery on stage is in the "fashion of a dissecting theatre," as Shaffer describes it, this implies that Alan is a

specimen under Dysart's and the audience's scrutiny (*Equus* 13). Or, as Emily Shaowen Su puts it:

> Alan Strang is the object to be carved, observed, and operated upon. The doctor is like the professor of a medical school, lecturing on and demonstrating the entire operation before the students, who include not only the inactive, motionless characters on stage but also the audience, all surrounding the circle listening and learning. (158)

The historical references to anatomy complicate the idea of observation and bring to the fore questions of knowledge production also raised by Brechtian epic drama (Gianakaris, "Theatre" 39). After the publication of Andreas Vesalius' *De humani corporis fabrica* in 1543, the practice of anatomy became increasingly popular (Garner 312). Dissections had two functions then, an educational one, "to disseminate knowledge of the human body," as well as an entertaining one (312).[43] In *Equus*, dissection has a third, revelatory function, which yet again tells audiences more about the therapist than the patient. In a confessional scene, Dysart reveals that he is haunted by a ritualistic nightmare in which he carves up children as part of a sacrifice ceremony, again admitting to his scepticism of the psychiatric profession. More precisely, he perceives himself as a "Priest" of the "God of Health" when he states: "[m]y tools are very delicate. My compassion is honest. I have honestly assisted children in this room. I have talked away terrors and relieved many agonies. But also – beyond question – I have cut from them parts of individuality repugnant to this God, in both his aspects" (*Equus* 65). The nightmare is telling and raises a number of ethical questions because it shows that the therapist is doubtful of the idea of a cure to mental distress. By comparing psychiatry to a God, Dysart confirms Foucault's notion that psychiatry is a power system that everyone involved in, not just patients, can fall victim to. In other words, power, and by extension, psychiatry, is not a binary system but it is relational and should be considered as "a complex 'mesh' of power" (Revel 377). Due to the play's audience placement and perceptual politics, then, the spectators also participate in and contribute to this complex mesh. Most importantly, Dysart suggests that a return to what is perceived as 'normal' or 'healthy' inevitably comes at the cost of losing one's individuality.[44] This is yet again a dubious assumption audiences are encouraged to ponder.

Shaffer's spatial politics raise the question if Alan's dissection – figuratively, not literally – is supposed to have any educational purpose, that is, if it is meant to disseminate knowledge of the human mind. In analogy to Charcot's presentation

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[43] On contemporary adaptations and adoptions of the operating theatre in performances, see Bleeker's study *Anatomy Live*.

[44] Klein sees an interesting parallel to Anthony Burgess' *A Clockwork Orange* (book 1962, film 1971), which also "questions the right of the society to cure patients by removing from their personalities the antisocial traits that make them unique" (112).

of hysterical women, Mark S. Micale concludes: "It is a familiar historical image – a legendary medical showman, a hysterical woman rather luridly placed on public display in the name of high science" (*Hysterical* 2). Yet in *Equus*, it is the struggling physician Dysart and the patient Alan who are both on public display in the name of entertainment. The ideological dimension is further complicated by the stage's allusion to a reversed *panopticon* whereby an all-seeing audience that surrounds the stage holds a seemingly superior position. Along the same lines, Ryan Claycomb argues that "it is difficult to avoid the historically loaded image of surveillance as a means of establishing and containing difference" (106). Both stage and narrator are responsible for the emphasis on Alan's state of being other. On the one hand, this is self-evident because the narrator as psychiatric/psychoanalytic authority has to perceive the patient as other in order to return him to the community. On the other hand, paradoxically, Dysart envies Alan's otherness and even perceives it as positive. Because these diametrically opposed notions are never reconciled, as demonstrated above, they result in the play's skewed picture of mental distress.

Another important factor which limits the ways *Equus* offers an alternative portrayal of madness and can destigmatise mental distress is the visual interpretation of Alan's distress as spectacle. Part and parcel of creating the spectacle during the abreaction scene, which sees Alan relive the traumatic stabbing of the horses' eyes, is a turn towards Alan's memories via Dysart, that is, a shift to what can be interpreted as filtered "internal space, […] a fantasy, a dream or waking dream evoked by the mise-en-scène" (Pavis 155). In order to realise the play's theatricality, many productions of *Equus* have followed Peter Shaffer and John Napier's idea of evocative and surreal horse costumes in the tradition of Japanese Noh and Kabuki theatre and Bunraku puppetry (Claycomb 100). The expressive costumes had a lasting impact on the staging of animals, as later productions such as *The Lion King* on Broadway and, more recently, the National Theatre's adaptation of *War Horse* illustrate (Galtney). In several productions of *Equus*, the horse heads were made of metal wires and the actors wore brown full body suits and cothurni as hooves, which added to their height, and thus made their appearance even more impressive.[45] One reviewer of the play's first production in the US in 1974 commented that "the impact on the audience is one of palpable terror" (Gruen), while a critic of the revival production that moved from the West End to New York in 2008 remarked on the horses that "[w]hile they're wonderfully theatrical, they're distracting. The buff boys pose mechanically, hitting marks like runway models. It doesn't help that their eyes glow, sci-fi-style" (Dziemianowicz). Michael Billington especially mentioned the costumes in his review of the Gielgud's production in 2007, but concluded that the horses "were even more stampingly fretful in the original production" (Review *Equus*). The diverging evaluations testify to the significance of theatrical spectacle and show that the rendering of the horses

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[45]   The productions at the Old Vic Theatre London in 1973, at the Gielgud Theatre London in 2007, and at The Guild Theatre East Hampton New York in 2010 are cases in point.

can go in two directions, either fostering or hindering the audience's empathic engagement.

Criticism of Sidney Lumet's realistic filmic adaptation (1977) indicates how crucial the non-realistic depiction of the horses is for the overall impact. Although the film was received positively by some critics, and was even nominated for a number of Oscars, one of the main points of criticism was the film's realistic mode of representation.[46] *New York Times* reviewer Vincent Canby disapproved of the resulting lack of the play's theatricality by stating that, "[w]hat once was poetic and mysterious becomes, when seen in this literal detail, banal, anticlimactic" (n.p.). The negative remark on the horses' glowing eyes as an obvious technical marker of their non-naturalism also points to the fact that an experiential engagement with the spectacle of madness, namely the opposite of what epic elements are supposed to generate, is intentional in the abreaction scene. The "faint humming and drumming" of the horses at the beginning of the scene is further productive for the creation of the ritual that the spectators now no longer witness but take part in experientially (*Equus* 104). Moreover, Alan's fear expressed in accelerated speech and short exchanges between him and Dysart combined with the rising noise of the horses leave little time for the spectators to think about the action. The ensuing spectacle is uncomfortable to watch when it becomes clear that the highest order gaze is that of Equus. It forces Alan into his crime because his self-created moral framework marks his feelings for Jill as betrayal that deserves punishment.

> ALAN. [*to* DYSART: *whispering*] 'Mine! … You're mine! … I am yours and you are mine!'… Then I see his eyes. They are rolling! […]
>
> I see you. I see you. Always! Everywhere! Forever! […]
>
> You will see ME – and you will FAIL! […]
>
> DYSART. The Lord thy God is a Jealous God. He sees you. He sees you forever and ever, Alan. He sees you! … *He sees you!*
>
> ALAN. [in terror] Eyes! … White eyes – never closed! Eyes like flames – coming – coming! … God seest! God seest! … NO! … […]
>
> Equus … Noble Equus … Faithful and True … Godslave … Thou – God – Seest – NOTHING! [*He stabs out* NUGGET'*s eyes*. […]]. (105; italics in original)

Inevitably, following the logic of his religious worship, Alan has to blind the horses as they represent the all-seeing entity that holds infinite power over him.

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46   Animal rights activists and filmgoers did not agree with Lumet's realistic depiction of Alan's crime. Shaffer also took issue with Lumet's interpretation as being "too literal to sustain the more abstract scenes" (Gianakaris, *Shaffer* 91).

Inspired by Dora's overzealous religiousness, the act of blinding is a tragic attempt at ridding himself of "guilt and shame concerning his sexuality and its relation to an ultimate concept like God" (Walls 321). Ironically, it is also a response to one of Dora's catch phrases: "What the eye does not see, the heart does not grieve over" (*Equus* 31). Considered in reverse, the phrase echoes *Equus*'s ending because it implies that the audience, like Dysart, will be haunted by Equus/*Equus*, by the god Alan created on stage and, on a metatheatrical level, by the performance. Confirming this notion, Thea Sharrock's 2007/2008-production ended "with an image of Dysart crowned by six floating horse heads that gleam in David Hersey's pure white light. It's haunting and powerful and, finally, free of mist and blazing orbs" (Dziemianowicz). This final image can be read as a memorable reminder to the audience that they have both witnessed and taken part in Alan's painful memories, and will not be able to evade their own responses.

After the unsettling spectacle and the apparent curing of Alan through the process of abreaction, Dysart presents a sobering and, once again, ambiguous outlook regarding Alan's reintegration into society. In the fashion of a ponderous "modern day Hamlet […]" (Gianakaris, "Theatre" 33-34), he has lived through his time with Alan in the clinic as a heterotopia of deviation which enabled Dysart, not Alan, to better understand himself and his actions, yet it is doubtful in what ways he has achieved this.[47] Walls concludes that "[a]t the very least, [Dysart] is more knowledgeable by the end of the play" (322). Furthermore, in a reading that is not in line with what the play's pessimistic ending suggests, he states:

> And the struggle which he has begun could well be the catalyst for creation. When one considers the cultural criticisms which Shaffer makes, and the difficulty with which Dysart struggles between the tension of his modern, Socratic mind and his new-found Dionysian wisdom, one can find some joy in the fact that Shaffer, like Nietzsche, is engaging his public, so that it will realize that both science and art are necessary in our world. (322)

This evaluation of the potential for change appears somewhat optimistic since the play does not give any indication that Dysart might have changed in any way. Or, as Ashley Woodward argues, "[w]hile Dysart goes a long way to open his mind to what takes place between Alan and Equus he ultimately fails to understand" (242). In other words, while in the Foucauldian sense, Dysart has in parts managed to submit Alan to his doctor's gaze, he does not succeed in gaining any more knowledge, neither about his patient, nor about himself.

The various critical comments return the discussion to the question of the epistemological dimension of *Equus* and its potential as mental health play. I argue that there is not as much wisdom in Dysart as Walls suggests, but rather resignation and, paradoxically, the only apparent certainty he has is his professional

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[47]   For the idea that Dysart is a tragic hero, see Klein 119.

doubts. Audiences share Dysart's perspective until the denouement and potential-ly mirror his emotions up to this point. The emotional knowledge based on the experience in performance and the emotional engagement with the spectacle might leave audiences with similar conflicting feelings. Although the psychiatrist's task is finally completed, *Equus* remains ambiguous because while Alan will be cured, Dysart is still not satisfied with having returned him to normalcy (*Equus* 107). Furthermore, he questions if "the Normal world where animals are treated properly: made extinct, or put into servitude, or tethered all their lives in dim light, just to feed them – blinking our nights away in a non-stop drench of cathode-ray over our shrivelling heads!" is a desirable place to be in after all (108). In this sense, Shaffer lets Dysart echo the anti-psychiatric stance later adopted by philos-ophers Gilles Deleuze and Félix Guattari who argue that mental distress is an appropriate and inevitable response to a mad world (see Woodward's interpreta-tion). Thus, ultimately, *Equus* offers a counter-discourse to psychiatry because Alan's 'normalisation' is not celebrated as a success of reason dominating over madness. The fact that the play's particular character conception – most im-portantly, the doubting psychiatrist – and its conclusion incited criticism and elic-ited divided opinions probably reveals more about theatre critics' attitudes toward psychiatry and mental illness than the quality of the play itself. Furthermore, the reception can be read as a reflection of real-world psy-discourses being battle-grounds, not only in the 1970s when anti-psychiatry had established itself as a counter-project to classic psychiatry, but to this day, when the competing strands within psychiatry and psychology are still battling out who defines and treats best what we now call mental illness, when the etiology of most mental conditions is still unclear, and when the very concept of mental illness is attacked. It appears that in this regard, *Equus* has undergone a similar conceptual transformation to *WiM*, although a focus on making an entertaining spectacle of mental distress potentially hinders the play's negotiations of ethical questions on psychoanalytical practice and psychiatric treatment.

4.2 The Mental Hospital as Battlefield in Joe Penhall's *Blue/Orange* (2000)

Blue/Orange, even more explicitly than the plays analysed so far, is what Rachel Clements calls an "'issue-conscious' play, [with] its themes and concerns resonat-ing potently with a wider set of political and social debates" (xiii). In the decades between the first productions of *Equus* in 1973 and *Blue/Orange* in 2000, signifi-cant changes in mental health care and the policies revolving around it took place, particularly the closing of many British asylums and the move towards deinstitu-tionalisation, which also informed Penhall's play. In his first issue-conscious play, *Some Voices* (1994), Penhall already engaged critically with Care in the Community

at a time when it was gaining public momentum. This was due to the fact that, as a reporter, the job he had before turning to playwriting, Penhall had not reached a large enough readership with his coverage of the situation of mentally ill citizens in West London at the time, so he "used the theatre to highlight the mental illnesses so visibly present in the London streets" (Boles 20). *Blue/Orange* even more explicitly and more politically than his other plays resonates with the psychiatric *zeitgeist* of the 1990s and early 2000s, particularly with its criticism of institutionalisation and the Care in the Community-policy as well as with thematising institutional racism.

Blue/Orange, much like *Equus*, initially seems to deal with diagnosing a state of mental disorder and taking the necessary steps towards the wellbeing of the patient. Christopher is a young Black Londoner, whose 28-day assessment period in a NHS-psychiatric hospital, another modern-day heterotopia of deviation in Foucault's sense, has come to an end. Only, while Alan Strang arrives at the hospital as a patient because of the deeds he committed, Christopher is sectioned temporarily for 'odd' behaviour he exhibited before the play sets in. So, to a certain extent, the reason for the sectioning echoes R. D. Laing's idea that "some people come to behave and to experience themselves and others in ways that are strange and incomprehensible to most people, including themselves" (*Politics* 86). Apparently, Christopher's behaviour was strange and incomprehensible before he was sectioned, and the question of diagnosing the significance and severity of these ways – is he schizophrenic, neurotic, or does he have borderline personality disorder? – lies at the heart of the play and triggers the power struggle between the two consultants involved. *Blue/Orange* asks if, as an audience, we can trust what we see but rather than utilising hystericised realism, Penhall tells the audience about Christopher's behavioural oddities. Unlike Susan and Harper, Christopher does not experience hallucinations but he is delusional and his perception is distorted. Moreover, audiences never share his perspective. As a result, the external spectatorial position with all its implications is much more clearly defined than in *Equus*. Christopher shares with Susan and Harper the experience of intersectional discrimination, i.e. he is doubly othered by his mental distress and ethnicity. Thus, Penhall is concerned both with the disadvantages that come with mental illness and with institutionalised racism.

Structurally, Penhall involves the audience in an intellectual Darwinian battle between the two consultants Robert and Bruce who have to make a decision regarding the course of action for Christopher. The audience surrounds Penhall's heterotopic boxing ring stage, yet whereas the battle merely serves as a metaphor in some of the other plays examined in this study, it is actualised in *Blue/Orange*, even if the weapon of choice is the word rather than fists. Penhall applies a dialectic structure with Bruce, a young speciality registrar, and Robert, a senior consultant, fighting over who knows best (Clements xxx). Because of their antagonistic

behaviour, both embody perfectly Foucault's notion that "what is organized in the asylum is actually a battlefield" (*Psychiatric Power* 6).

The setting and stage put further emphasis on the idea of a fight. It is a battle that does not leave the patient as weak or voiceless as the patients that Foucault describes in the clinics of the eighteenth and nineteenth centuries as "a silent body" (*Birth* xv). Rather, Christopher, like Alan Strang, is an active player. Or, as Watson puts it, "[t]he patient holds a central place of power because [he] is the locus of the narrative that justifies the encounter, the only authority (whether subconsciously or consciously) for what facts or truth there are to be uncovered, explained, or analysed" (190). However, while Christopher's assessment can be said to motivate the play, Christopher's power is limited insofar as he is ultimately at the mercy of the two consultants because they decide his fate.

Juxtapositions of authority and uncertainty constitute a key element of mental health plays, as the preceding analyses have already shown, and they also permeate *Blue/Orange*. The strictly hierarchical setup of the mental hospital suggests that the Foucauldian gaze is at work. The placing of the audience around the stage seemingly underlines this. However, the all-seeing position of the gazing audience in performance by no means mirrors the process of diagnosis on the plot level as the consultants are far from silently observing their patient but argue heatedly in front of him.[48] In addition, the speed of the delivery alongside the pervasive sense that language and meaning are slippery concepts coupled with the extensive use of divergent registers highlights the fact that the process of meaning-making is a thorny one not only for the characters but also the audience, particularly when the speed of the fight accelerates and the arguments escalate (Clements xlii-xliii). Thus, although the spectators might be able to see everything, they might still not be able to follow or understand. Added to that, Clements points out that "the play explores a set of anxieties about the ways in which language relates to reality. This is partially reflected in Penhall's use of the psychiatric profession, where diagnoses are based on observation and the interpretation of behaviour in relation to a set of diagnostic criteria" (xliii). The anxieties that Clements refers to are also expressed in the controversies around each new and ever-extending edition of the *Diagnostic and Statistical Manual of Mental Disorder*, as explored earlier in my study. In *Blue/Orange*, then, authority and anxiety go hand-in-hand and create an ambiguous atmosphere in which Penhall's ethical criticism can fully develop.

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[48] "The observing gaze refrains from intervening: it is silent and gestureless. Observation leaves things as they are; there is nothing hidden to it in what is given. The correlative of observation is never the invisible, but always the immediately visible, once one has removed the obstacles erected to reason by theories and to the senses by the imagination. In the clinician's catalogue, the purity of the gaze is bound up with a certain silence that enables him to listen." (Foucault, *Birth* 107)

4.2.1 "I am the Authority": System Failure in the Mental Hospital

Part and parcel of problematising aspects of language and power in psychiatric practice is Penhall's choice of a quasi-realistic/naturalistic dramatic mode in the traditional two-acter with its linear plot reminiscent of other political pieces, for instance, by David Edgar and Peter Nichols (Clements xv). It is important to point out that the mode is expressed in the hospital discourse but that it does not transfer to the stage design and costume. The play's first production at the National Theatre's Cottesloe in London in the year 2000 had, as envisaged by Penhall, an almost bare stage design, "well beyond the purview of the Blair-era NHS," that did not hint at its mental hospital setting (Wolf), much like some productions of *Equus*. The two doctors played by acclaimed actors Bill Nighy and Andrew Lincoln did not wear white but regular clothes. In fact, unlike Ibsen who was accused of turning the entire theatre into a hospital when he thematised hereditary syphilis in *Ghosts*, Penhall condenses the mental hospital discourse to the interactions between the doctors and the patient (Garner 319). By focusing on the outside perspective and foregrounding the spoken discourse rather than any visual markers of potential madness, Penhall particularly circumvents the challenge of the formal representation of mental distress that Alan Ayckbourn, Sarah Kane, and Anthony Neilson highlight (Clements xxxiv-xxxvii). At the same time, the dramatic mode is essential for voicing socio-political critique not just of the NHS (although the hospital is not explicitly a NHS-institution) but also of mental health care. This is corroborated by the heterotopic in the round-stage as a means to "reconfigure space in performance in a way that may be meaningful to remaking spatial structures beyond a performance" (Tompkins 179). In the case of *Blue/Orange*, form, content, and stage, expressed in two heterotopias, the psychiatric hospital as heterotopia of deviation and the in the round-stage, thus challenge the audience into rethinking the power of psychiatry as it is exerted in the spaces of mental hospitals and related institutions.

Language and power are inextricably linked in the play's psychiatric hospital. The use of medical jargon and the instability of language as central features contribute to the alienation and confusion of the audience but also add a touch of deliberate "poetic realism" to the play (Penhall, "Award-Winning"). The doctor's fight for labelling Christopher's condition particularly resonates with the introduction of Anthony Jorm's term 'mental health literacy' in the late 1990s (Jorm et al. 182-86). To recall, Jorm believes that increasing mental health literacy will lead to the dissemination of mental health knowledge and will have a positive impact on treating and living with mental disorder (182-86). Robert provides a negatively reversed interpretation of Jorm's idea, which echoes the Foucauldian concept of power/knowledge when he tells his younger colleague: "my semantics are better than yours so I win" (*Blue/Orange* 28). With this, Robert confirms Foucault's notion that perception and language form the basis of authority and power in the clinical context (*Birth* 112) and as the more experienced superior, he claims linguis-

tic dominance. Bruce, on the other hand, as a young doctor in the early stages of his career, is keen to do everything by the book and addresses political correctness and medical labelling when he tells Christopher off for using words such as "crazy" and "nuts" before launching into a short lecture on medical terminology:

> People with – well – we don't actually use the term 'crazy' … […]

> OK, look … there are things we … there are terms we use which people used to use all the time, terms which used to be inoffensive but things are a bit different now. Certain words. […]

> For example, people used to say 'schizophrenic' all the time. 'Such-and-such is schizophrenic.' Because it's two things at once. OK. Used to denote a divided agenda, a dual identity, the analogy of a split personality. Except we know now that schizophrenia doesn't mean that at all. Split personality? Meaningless. OK? So it's an unhelpful term. It's inaccurate. What we call a 'misnomer'. And this is a sensitive subject. We must think carefully, be specific. Because it's too … you know … it's too serious.

> *Pause.*

> You were diagnosed with 'Borderline Personality Disorder'. What does that mean? (*Blue/Orange* 12-13)

Bruce makes the important point here that medical terminology undergoes changes because scientific advances and epistemic alterations shape the psychiatric landscape, as the disappearance of hysteria as officially recognised illness or the renaming of shell shock as post-traumatic stress disorder exemplify. However, Christopher is the wrong addressee because he is the one under assessment and will be judged precisely with this jargon. So rather than asking Christopher what "borderline personality disorder" is, one would expect Bruce to provide a comprehensible explanation for his patient. Both instances reveal that in *Blue/Orange*'s mental health-related language is primarily used as a weapon to exert power. This power not only affirms the doctors' authority over the patient but it is also utilised to maintain a strict hierarchy in the clinic.

 Since language is used to augment the power relations between the doctors, Robert throws rhetorical darts at the younger colleague on various occasions, not only to strengthen his position but also to provoke Bruce. One way of being provocative is referencing R. D. Laing and anti-psychiatric positions. On the surface, Robert raises radical epistemological doubts by forthrightly challenging what is commonly perceived as 'normal':

> We spend our lives asking whether or not this or that person is to be judged normal, a 'normal' person, a 'human', and we blithely assume that we know what 'normal' is. What 'human' is. Maybe he's [Christopher's]

more 'human' than us. Maybe *we're* the sick ones. (*Blue/Orange* 32; italics in original)

While the flippant statement resonates with Laing's understanding of madness, its epistemological dimension is not affirmed but rather serves the purpose of provocation. This notion is confirmed when Laing receives another mention in the following exchange between Bruce and Robert:

ROBERT. The human species is the only species which is innately insane. 'Sanity is a conditional response to environmental …

BRUCE. I don't believe you're saying this …

ROBERT. … stimulae.' Maybe – just maybe it's true.

BRUCE. Maybe it's *utter horseshit*. (*Beat*.) I'm sorry. Doctor Smith. But. Which, which existential novelist said that? I mean, um, you'll be quoting R. D. Laing next.

ROBERT. That was R. D. Laing.

BRUCE. R. D. Laing was a *madman*. They don't come any fruitier. (33; italics in original)

This is a comic yet confusing scene because there is very little logic in Robert's position that humans' natural state is insanity. The longer the discussions continue and the faster the pendulum swings back and forth between the consultants, the harder it gets to resist the impression that all three characters on stage are mad in some way and that Christopher is not at the most extreme end of this after all. Added to that, increasingly, the position of power of the defenders of normalcy – the doctors – fades because of the instability and inconsistency of their arguments.

Most of the tension between the doctors derives from the hierarchical system they are part of and which Robert enjoys pointing towards on every possible occasion in order to put pressure on his younger colleague. Based on his experience as a doctor, Solomon Posen points out that in real-world hospitals such power structures often cause damage, particularly to junior doctors:

The great strength of hospitals – their hierarchical structure – also constitutes a significant source of friction. The chiefs and the senior staff exercise such a decisive influence over the future careers of the younger doctors, that the juniors are at their mercy to an even greater extent than the patients. This power-structure may lead to bad-mannered, capricious or dogmatic behaviour on the part of the seniors. (84)

The hierarchy in *Blue/Orange* at times resembles a father/son relationship highlighting the parallels between the disciplinary systems of family and clinic Foucault draws on (*Psychiatric Power* 26, 79). This comes to the fore, for instance, when Rob-

ert takes on a paternal tone and offers Bruce patronising career support, which is more of a disguised threat:

> Take my advice, if you keep your nose clean and you enjoy psychiatry you'll almost certainly become a consultant. Nevertheless, you don't want to be a consultant forever. Sooner or later you'll want to become a Senior. You too may one day seek a professorship. […] Follow the Path of Least Resistance. (*Blue/Orange* 24)

It becomes clear that "the Path of Least Resistance," in meaningful capital letters, would equal agreeing with his senior colleague, which Bruce refuses. Penhall exposes the system's flaws in this scene and emphasises systemic power on the page by using capital letters. According to Robert, climbing the career ladder requires complete acceptance of the system.

The fast-developing struggle between Robert and Bruce executes what Posen finds to be true for many literary representations of doctor colleagues:

> There is a widespread, deeply entrenched (and to a large extent false) perception that interpersonal relationships within the medical profession are uneasy if not hostile, and that infighting is endemic both inside and outside hospitals. The male doctor is portrayed not only as a friendless individual, but also as incapable of relating to his colleagues and subordinates. Instead of cooperating with each other in the interests of their patients, doctors are continually fighting among themselves over status, money and personal prejudices. These tensions and quarrels become particularly unpleasant when two physicians share the management of a patient. (61)

Indeed, Robert does not tire of telling Bruce how much he is at his mercy and the more hot-headed the debate becomes, the more threatening Robert's authoritarian pressure becomes. He argues with the backing of the system the two find themselves in:

> That's the procedure. I can't allow you to be alone with him. It's a question of Seniority as much as anything else. Perhaps if you'd show some respect to Seniority in the first place; if you'd listened to Somebody Who Knew, we wouldn't be in this mess. (*Blue/Orange* 88)

Robert accuses his colleague of being incompetent and disrespectful, which in turn leads Bruce to fight his superior by attacking his methods as well as his research and latent racism. At other times, Robert changes his tone and falls back on his manipulative tactics by reverting to a paternal adviser role:

> Look. I'm not the big bad wolf. I'm not trying to undermine your decision and I certainly don't want to release Christopher if he isn't ready. I *care*. And I know you care. All I'm saying is sometimes you can care *too much*. One can have too much Empathy – Understanding – an *overweening* Compassion.

> You try to be all things to all men: Doctor, Friend. A *reasonable* man. We all want to be reasonable men. Eh? Please. Now. Am I not your friend? (54; italics in original)

These changes come quickly and make it challenging for the audience to follow. In the end, Bruce has to admit defeat. This is another common feature of fictional accounts of the colleague relationship between doctors, as Posen states: "More recent fictional consultants continue to humiliate, disparage and patronize their primary care colleagues who, if present, regress to the role of medical students cowering before their teachers" (64). After the long battle, Bruce finally, too, has to give in because he has to face the fact that Robert has the upper hand. The Cottesloe production in 2000 showed that, indeed, the doctors fought a battle: actor Andrew Lincoln was drenched in sweat and looked utterly exhausted. Bill Nighy's Robert, despite his "inflated sense of self" (Clements xlii) did not manage to keep his cool until then either but he did not look as defeated as Lincoln (*Blue/Orange* video recording).

The use of language in the play has another effect that goes beyond the plot level. Since audiences are confronted with a plethora of powerful medical terms and few explanations, hesitations and unfinished sentences, this creates a pervasive sense of uncertainty. This is set against the assumption that the mental hospital is the place where meaning will be made and where doctors have the power to treat illnesses. Especially the mention of "schizophrenia" and "split personality" comes with pop-cultural connotations evoking someone with a Jekyll-and-Hyde personality, as summed up by Robert's dramatic explication:

> Schizophrenia is the worst pariah.
>
> One of the last great taboos.
>
> People don't understand it.
>
> They don't want to understand it.
>
> It scares them.
>
> It depresses them.
>
> It is not treatable with glamorous and intriguing wonderdrugs like Prozac or Viagra.
>
> It isn't newsworthy.
>
> It isn't curable.
>
> It isn't heroin or Ecstasy.
>
> It is not the preserve of rock stars and supermodels and hip young authors.
>
> It is not a topic of dinner-party conversation.

Organised crime gets better press.

They make movies about junkies and alcoholics and gangsters and men who drink too much, fall over and beat their woman until bubbles come out of her nose, but schizophrenia, my friend, is just not in the phone book. (*Blue/Orange* 53)

A number of points addressed in the statement find support in critical literature on schizophrenia. Christopher Frith and Eve Johnstone, for instance, confirm that schizophrenia in particular has received a lot of bad press because of a lack of knowledge and damaging media coverage (1-2; see also Read et al. 157-77). Robert only focuses on the negatives, as words like "pariah" and "taboo," or the comparison with heroin addiction show, in order to corroborate his position that Christopher should not be diagnosed as schizophrenic but is 'merely' neurotic.

Penhall's play offers an account of how the hierarchical structures of mental health care induce individual suffering, not only on the side of the service users but also on the staff side. His dramatic strategy makes this a visceral experience for the audience. Due to the way Penhall has written Robert and Bruce and due to the sheer speed of the delivery of the dialogue when performed, the audience struggles to follow the doctors' discursive battle, as Michael Billington observed in his review of the National Theatre's Cottesloe production: "Part of Penhall's success lies in keeping one's sympathies shifting. One moment you think Bruce has a protective idealism; the next that Robert has a paternalistic common sense" ("Review *Blue/Orange*"). The speed in performance also creates a hierarchical relationship between stage and audience. Not being able to comprehend everything that is said on stage can lead to a feeling that one has not understood enough – especially when the action on stage continues relentlessly. In scenes where the doctors discuss Christopher's condition in medical terms the sense of frustration is particularly heightened and thus mirrors the real patient experience. Aligning the audience with the patient in this way can foster an understanding of the incomprehensibility of clinical proceedings. In other words, the aspect of experientiality in *Blue/Orange* does not relate to the experience of mental distress but of having to submit to systemic power, of which psychiatry is one example. One cannot help but think that not only the superior doctor Robert "seems to be not just inadequate but also worrying hubristic," as Clements has it (xlii), but both doctors are in their own ways presumptuous. The fact that Penhall puts so much emphasis on the power play between the two reveals a profound distrust in the mental health care system because he exposes vanity and hunger for authority as vested interests. It also shows how much subjectivity is involved in the process of assessment, which confirms the conclusion drawn in chapter 2 that objective knowledge, in spite of what the existence of the 1000-page strong *DSM* suggests, is a critical notion.

4.2.2 The Earth is Blue Like an Orange: Seeing as Truth

With placing the audience around the stage and thus evoking operation theatres and medical lecture halls, Penhall's dramaturgy highlights aspects of observation and emphasises complete visibility, although, of course, this is an illusion, as discussed in chapter 2 (see also Watson 202; Clements xxxvi). Set against the in the round-stage is the play's concern for aspects of invisibility on the textual level, which provides an interesting complication of Foucault's idea that diagnostic processes in the clinic are traditionally supposed to establish a visible truth (*Birth* 114). That this process is much more complex when it comes to the invisible workings of the mind, has already been established in this study. In *Blue/Orange*, it is precisely Penhall's approach to the aspect of the invisible that can facilitate a metacognitive stance in spectators because it provides both a rupture that carries some of the weight of the play's ethical criticism and it serves as a repeated reminder to question psychiatry's authority which seems to rest on matters of interpretation and "semantics," as Robert states (*Blue/Orange* 28).

A crucial feature of making a meaningful connection between madness and invisibility, which might otherwise not be readily apparent, is the programme of the Cottesloe production. It presents an amalgamation of both literary and real-world madness discourses as the context in which the play was written and conceptualised. This way, the programme constitutes a 'paratext' in Genette's sense because it mediates between performance and audience (Genette; Fodstad), and indicates the various discourses that have shaped the play and informed the production. Significantly, it opens with a quote from Ralph Ellison's novel *Invisible Man* (1952) which encapsulates Penhall's notion that "[i]f you are ill or bereaved or disadvantaged or unemployed, then you are invisible […]" (qtd. in Boles 47). In addition, it points toward the double-othering Christopher experiences in the play: "I am an invisible man … – and I might even be said to possess a mind … Before that I lived in the darkness into which I was chased, but now I see. I've illuminated the blackness of my invisibility – and vice versa" (*Blue/Orange* Programme). In a similar fashion to Harper and Susan being othered in two ways with regard to their gender and madness, Christopher's state of double-other relates to his ethnicity and madness and thus presents another prime example of intersectionality.[49]

Apart from madness, ethnicity is the second social stratification that Christopher's state of double-other rests upon and that the Ellison quotation anticipates. Penhall makes it clear that racism is just as institutionalised as madness when he has Robert refer to a set of statistics provided by the National Schizophrenia Fellowship in 2000, also quoted in the programme. The statistics reveals that out of the group analysed "African-Caribbean males are up to 12 times more likely to receive a schizophrenia diagnosis than white males" and "88% of black respond-

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[49]   Françoise Král shows that social scientists take a cue from Ellison's novel for exploring invisibility in relation to social decline (2).

ents had been detained under a section of the Mental Health Act compared with 43% of white respondents" (*Blue/Orange* Programme). If anything, presenting the facts might make audiences wonder why this is the case. Because of Robert's incessant use of racist notions, the play provides an answer to the question. What is more, Robert is keen to make Christopher a case for his research on "black psychosis," a term that, on the one hand, speaks of the disparity based on ethnicity in mental illness diagnoses that Robert unquestioningly adopts (*Blue/Orange* 48). On the other hand, it lays bare that the seemingly objective language of psychiatry enables psychiatrists to come to completely subjective evaluations.

Put simply, Christopher's case corroborates the notion that the visible signs of his ethnic origin are used as an explanation for the invisible workings of his distressed mind. In essence, to Robert, Christopher must be mad because he is black and what does not fit this equation is simply not considered, or, as he puts it bluntly: "It's a matter of 'opinion'" (28). Thus, through Robert's subjective position, Penhall radically challenges psychiatry's normative categorisations and power to act on these. Following the play's dialectic trajectory, Bruce is less certain about Christopher's behaviour, as the following exchange shows:

BRUCE. Because he is black? […]

ROBERT. (*icily*) I'm saying where he comes from it is almost certainly not an unrealistic notion. Where we come from, it evidently is. Get it?

BRUCE. But he comes from Shepherd's Bush.

ROBERT. He sees himself as African. And we don't say 'black' any more –

BRUCE. Yes we do –

ROBERT. We say 'Afro-Caribbean.' […] I'm not going to squabble. His 'origins' are in Africa. (*Blue/Orange* 50; italics in original)

Robert operates with a questionable racist us/them-vocabulary in order to buttress his stance. Set against this is Bruce's constant doubting of Robert's authoritative evaluations. Thus, if we accept that in the clinical context, seeing equals knowing, then invisibility as a metaphor for uncertainty also extends to the diagnosis, and although Penhall clearly states that Christopher is indeed schizophrenic, suspense is created until the moment of revelation. In turn, the suspense is intensified by the doctors' fluid positions: "[t]he story keeps you guessing about each of the characters' true intentions," as Jason O'Neale Roach has observed (1216).

It is not only the characters' true intentions but also the diagnosis of Christopher's condition that is at stake. In performance, the guesswork that the play invites thus becomes a powerful statement on the arbitrariness of the clinical gaze and psychiatry's resultant objective knowledge. Placed around the stage, like Charcot's disciples, the spectators are in a quasi lecture-hall, a place of learning, in which they observe the goings-on, gather evidence, and come to conclusions,

which puts them in a position to diagnose Christopher. The audience becomes part of a Foucauldian surveillance and power-machinery in which deviance is marked as 'mad.' To Foucault, psychiatry's pervasiveness results in a problematic omnipresence in which "many people go to psychiatrists and psychotherapists, and even those who do not […] visit psychiatric experts will engage in a popularized form of psychologizing themselves and others" (C. Taylor 405). This mirroring of and embodied response to the process of diagnosis viscerally corroborates Penhall's critique of psychiatric practices. Simultaneously, this way, Penhall attacks the very foundations of psychiatric knowledge, which aligns the play with Foucault's concern to "cut and shatter what we consider knowledge," as Chloë Taylor has it (404).

Penhall's challenge to how psychiatric knowledge is created and sustained is also brought to bear in Christopher's behaviour, appearance, and statements that might be called 'mad.' In other words, Penhall tests the spectators' mental health literacy, i.e. "knowledge and beliefs about mental disorders which aid their recognition, management or prevention" (Jorm et al. 182), throughout the play. When the play opens, Christopher is othered in the sense that his assessment period after having been sectioned under the Mental Health Act for 28 days comes to an end (The National Archives). The sectioning as an extreme measure of keeping someone under observation (and potentially under strong medication) in a mental hospital against their will, suggests that Christopher was indeed invisible in the community until his odd behaviour made everyone recognise his mental distress because he externalised it. In short, the fact that no one in his community had mental health literacy skills resulted in a forcible removal from said community. In performance, audiences, by virtue of surrounding the stage and thus forming a community, might also wonder what is odd about Christopher's behaviour and if they might be able to spot someone's mental distress in a real-world scenario where this person might have been left to be cared for in the community.

Among the most obvious, stereotypical markers of Christopher's mental distress, if not a specific condition, are his dislike of being looked at – highly reminiscent of the notion of staring as threatening in *Equus* – as well as the delusions about his potential fathers, Idi Amin and Muhammad Ali. While Watson points out that "[o]ver the course of *blue/orange* [sic], Christopher's emerging schizophrenia reveals itself through a terrible fear that he is thinking other people's thought, specifically those planted by the doctors" (201), it is doubtful if, without knowledge of Penhall's character conception of Christopher as schizophrenic, such behaviour would in itself be considered pathological. This echoes the point Rachel Cooper makes about the arbitrariness of pathologising certain behaviours and including them in the *DSM* (37-38).

In a revelatory scene which reverses the notion that observation establishes truths, Christopher's perceptual faculties are under revision and tested using a bowl of the title-giving oranges. To Christopher, the oranges are blue and thus

they constitute the ultimate 'proof' of his mental disorder. Robert's racist attitude dominates again when he claims:

> For some reason he wants to see blue instead of orange. Neurotics do it all the time. They see what they want to see, not what they really see. Maybe he knows the poem. […] There's a lot of French speakers in Central Africa. His mother could have read it to him as a child. It planted an image in his mind. When he's not a hundred per cent that image presents itself. (*Blue/Orange* 45)

As stated above, Robert now makes use of the blue oranges as proof of Christopher's mild mental illness because it fits his equation. Paradoxically, Robert's racist bias serves to explain Christopher's behaviour as comprehensible, rendering him yet again as a dubious psychiatrist. The apparently well-read Robert makes an intertextual connection to Paul Éluard's poem "La terre est bleu comme une orange" in order to argue that the simile of the blue oranges is not as indicative of the severity of Christopher's condition, as Bruce suggests, but to him, it proves that Christopher is merely neurotic.[50] What it more, Robert claims to know more about Christopher than Christopher himself when he states that neurotics "see what they want to see, not what they really see" (*Blue/Orange* 45). All this shows that "the language of psychiatry [as Robert uses it] is a 'monologue' in which, even if the patient is heard, they are not listened to" (C. Taylor 408). At the same time, this kind of othering is a prime example of Miranda Fricker's concept of 'testimonial injustice' because "prejudice on the hearer's part causes him to give the speaker less credibility than he would otherwise have given" (4).

As questionable as the psychiatrist's interpretation of the blue oranges is, the scene marks a rupture and the oranges are a *punctum*, in Roland Barthes' sense, an element calling attention to itself and meant to challenge spectators' attitudes (26-27). Patrick Duggan has appropriated the Barthesian concept for his analysis of performances of trauma and calls such instances "mimetic shimmering" in order to account for the audience's pausing over the aspect that provides the *punctum* (9). In the play so far, the audience has only been *told* about Christopher's delusions but when their gaze is directed towards the oranges, a moment of "mimetic shimmering" occurs and they do not see what Christopher sees, namely blue oranges but orange oranges. Seeing thus and once only in the play is the highest order sense because it conveys truth. If until then, it has not become clear that Christopher is mentally ill, the audience will now come to the conclusion that he actually perceives the world differently. At this point, we are back in Foucault's clinic where "all truth is sensible truth" (*Birth* 120). After all the conversations around Christopher's potential condition, it is the sense of seeing that finally tells the audience that Christopher is mad, whereby power is returned to the gaze. The

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[50]   The poem was published in Éluard's collection *L'Amour la poésie* (1929). It is misquoted as "le monde" in the play.

devastating twist to this is, however, that the truth established is not based on Christopher's subjective perception, i.e. that the oranges are actually blue, but the truth that demarcates normalcy from pathology is that the blue oranges show Christopher's mental disorder.

It can be argued that the blue oranges, much like Robert's Laingian explications on common notions of normalcy, when taken seriously, raise radical epistemological concerns. After all, who decides that oranges have to be orange? Both the blue oranges and the intertextual references to Ellison's *Invisible Man* point towards a sense of arbitrariness that lies behind ascriptions of colours and their meanings. In Ellison's novel the nameless protagonist is socially invisible because of his blackness. In Robert's opinion, Christopher's blackness renders him mentally ill and he sees this as a 'normal' response to living in a white society, so in this way both Ellison's protagonist and Penhall's character are fashioned as other. What is more, by letting the psychiatrist revert to the old, lazy equation of blackness and madness, so expertly traced by Gilman in *Difference and Pathology*, Penhall "create[s] an abyss between [himself] and the sufferer" (149). In other words, declaring Christopher to be mad because he is black is the ultimate othering while, at the same time, it confirms Gilman's notion that even in the context of the mental hospital, practitioners fall back on "mythologizing […] both the black and the mad" (148). As the play leads up to the blue oranges-scene, the arbitrariness of this notion becomes increasingly and devastatingly apparent (Wolf). Penhall asks the audience to consider the possibility that madness and normalcy are not stable or universally agreed upon categories. As this would imply that the audience is potentially mad, too, this radical notion cannot be realised in performance.

Penhall chooses the visual marker as the ultimate sign of truth because he intended for Christopher to be schizophrenic all along and did not mean to keep the audience in doubt until the end of the play (Clements xvi). The reception of the 2000 production shows, however, that audiences and critics were divided about Christopher's madness, as Clements recalls:

> Penhall's understanding of the character that he has created is that he is, indeed, schizophrenic, and various factors (such as Christopher's delusions, and occasional references to auditory hallucinations) point towards this reading. However, it's worth recalling that in the play's initial reception there was less consensus around Christopher's diagnosis and Penhall has pointed out that, when the play is performed, it is *most effective when the audience are kept unsure of Christopher's mental health as long as possible.* (xxxii; my emphasis)

In a metatheatrical twist, the discord in the reception echoes the doctors' uncertainty in diagnosing Christopher and taking the appropriate measures outlined above. At the end of the play, it has become clear that Christopher is not well at all and yet, ironically, he is allowed to leave the hospital because the superior con-

sultant wants to free up a hospital bed, thereby exercising his authority in a bold demonstration of power at the expense of Christopher's wellbeing.

All in all, Penhall addresses pressing mental health care issues and has a clear critical stance towards the National Health Service's mental health care policies. He exposes the therapists as power-hungry and thus deconstructs their authority as flawed because it is based on vested interests in a system that generates hierarchies and sustains itself by forcing its participants to adhere to them. In Bruce's case, this means a desire for climbing the career ladder and in Robert's, a questionable combination of serving the system that allows him to maintain a position of authority and also a craving for yet more power (he wants to be a professor). The pressing issues in mental health care at the time of writing and when the play was first performed in 2000, such as NHS funding cuts and hospital bed shortage, are still in the public eye nowadays. It is no surprise that when the play was revived at the Young Vic in London in 2016 it was announced as both "a state-of-nation-play" and "as timely now as it ever was" echoing that destigmatisation has gradually become a key concern in the arts as well as in mental health care (The Young Vic). The play's relevance can also be related to an argument for a complete re-evaluation of medical labelling, put forward, for instance, by clinical psychologists Peter Kinderman (*New Laws*) and Anne Cooke ("Problems"). Above all, although these are never explored to full extent, the play draws on fundamental epistemological notions of normalcy and aberration that lie at the heart of all mental health care and that, by extension, uncover how (Western) societies are organised by arbitrary systems of language and power.

4.3 Dissecting the Biomedical Model: Lucy Prebble's *The Effect* (2012)

The third play analysed in this chapter, Lucy Prebble's *The Effect*, strongly reflects the medical and dramatic *zeitgeist* of the early twenty-first century with its interest in neuroscience, the limitations of psychopharmacology, and the science behind depression (and emotions more generally). Prebble already demonstrated a concern for pressing current issues in her play *ENRON*, which dealt with the financial crisis, and premiered in 2009 to critical acclaim. The following analysis adds to the debate a perspective on how uncertainty and ambivalence do not only pervade today's psychiatric practices but also the science of mental disorders. In this respect, the play is as issue-conscious as *Blue/Orange* and sets out to explore a number of doubts also raised in Shaffer's and Penhall's plays from the perspective of the science of mental illness.

Fundamental questions in *Equus* and *Blue/Orange* regarding what it means to be human and 'normal,' in *The Effect* also encompass a romance plot that thematises emotion and affect, yet another current scientific concern. The play's trial

scenario at the centre of the science plot toys with notions of certainty in medical research and allows Prebble to explore freely the arbitrariness of psychopharmacology and the biomedical model of mental illness.

In *The Effect*, during a medical trial for a new antidepressant, trial volunteer and psychology student Connie falls in love with fellow trialist Tristan but they are uncertain if their feelings are genuine or merely the result of taking the trial drug. Meanwhile, the doctors, Lorna James, who has a history of mental illness, and Toby Sealey, who represents the pharmaceutical company running the trial, express opposing views regarding the efficacy of antidepressants. To complicate matters, they also had an affair in the past. As the play progresses, it turns out that some of the trialists take a placebo for control purposes. Further complication arises when Tristan has a seizure because of an undiagnosed heart condition and suffers from transient global amnesia at the end of the play. This in turn triggers a bout of depression in Lorna James. Although Tristan leaves the trial facility together with Connie, and Lorna decides to take medication, both crises are not entirely resolved at the end.

4.3.1 Dramatising the Science of Mental Illness

When *The Effect* was first staged at the National Theatre's Cottesloe in London in 2012, the same place that Joe Penhall's *Blue/Orange* had premiered at twelve years previously, Lucy Prebble put the science of mental health centre stage following a recent trend in theatre and performance.[51] As stated above, Shepherd-Barr termed this dramatic phenomenon 'science plays' in *Science on Stage*, and the late chemist and writer Carl Djerassi recognised a wider trend both on stage ('Science-in-Theatre') and in narrative fiction ('Science-in-Fiction'), which he outlined, for instance, in the Dennis Rosen Memorial Lecture (n.p). While there is no consensus among scholars regarding the poetics of the science play, it is largely agreed on that the genre encompasses plays dealing with dramatic explorations of science, scientists, and mathematics on stage, and that science plays have a centuries-old history. Oft-cited examples include Christopher Marlowe's *Doctor Faustus* (1592), Bertolt Brecht's *Life of Galileo* (1943), and Michael Frayn's *Copenhagen* (1998), and, more recently, Tom Morton-Smith's *Oppenheimer* (2015), and Tom Stoppard's *The Hard Problem* (2015).[52] Over the years, increasingly sophisticated and innovative dramatic renderings of scientific topics and phenomena have been put on stage but while medical doctors frequently feature in science plays (Shaw's *Doctor's Dilemma*, for instance), hardly any of the existing science plays have thematised mental disorder. Arguably, this is because the scientific knowledge behind mental ill-

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[51]   The play will be referred to as *Effect* in quotations from here.
[52]   Among numerous others, examples also include Friedrich Dürrenmatt, *The Physicists* (*Die Physiker*, 1961); Tom Stoppard, *Arcadia* (1993); Carl Djerassi, *An Immaculate Misconception* (2000); Richard Bean, *The Heretic* (2011); Lucy Kirkwood, *Mosquitoes* (2017).

ness is still limited and constantly evolves as more people are diagnosed with and treated for mental disorder each year (see, for example, Read and Dillon). Against this backdrop, *The Effect* makes a significant contribution to the body of mental health plays analysed in my study because it is the first play to illuminate the scientific side of the current mental health discourse.

The playwright's interest in controversies around cutting-edge psychopharmacological research and practices has been substantiated by a production blog on the social networking website Tumblr, which was published during the play's first production period and can still be accessed ("The Effect"). In many ways, this paratextual device, in Genette's and Fodstad's sense, which is in essence a virtual noticeboard, can be compared to *Blue/Orange*'s first production programme mentioned above, but it is even more elaborate with its expert and cast/creative team interviews (YouTube videos), rehearsal diary, photographs, and links to relevant scientific and popular scientific publications. Most importantly, the noticeboard with its dialectical structure negotiates highly politicised current mental health debates, for instance, by juxtaposing Deepak Chopra's article "You Are Not Your Brain" with neuroscientist Thomas Zoëga Ramsøy's response "You Are Your Brain." These two articles express diametrically opposed views on the question if brain activity determines identity formation. Interestingly, the blog, like the play, does not side with any position. This way, it mirrors Prebble's dramatic strategy of presenting opinions rather than providing answers (Spencer, Review *The Effect*). Adhering to Genette's notion of the paratext's "functional aspect," it contextualises the play's far-reaching inspirations and concerns, and provides the audience with a reference tool to consult for information before attending a performance and/or as a resource for further study afterwards (Fodstad 159).

To start with, the play's two doctors are the main calibrators for madness and normalcy and, on the surface, it appears that, like in *Blue/Orange*, the main question that arises out of their dialectically opposing arguments is "Who wins?". However, Prebble also provides the doctors with shared and individual backstories that add complexity to the characters, similar to Shaffer's character conception of Martin Dysart. Like in Dysart's case, the doctors' attitudes towards the efficacy of antidepressants is inextricably linked with their personal stories, whereby their professionalism comes under scrutiny.

Science in the form of neuroscience and as represented by the psychopharmacological industry, is not an invisible external entity exerting power over the characters, as, for instance, the unknown authority in Harold Pinter's *Hothouse* (1958/80) or the relentless power apparatuses in Franz Kafka's *Penal Colony* (1919), but through the doctors, science becomes both internalised and humanised. Put differently, science is not just the provider of facts, knowledge, and the correct course of action, which would suggest a linear relationship between science and the problem (in the form of the clinical trial) but through the doctors in the play, science is part of the action. Thus, crucially, because the doctors almost

literally embody scientific positions, Prebble puts up for discussion an uncritical belief in science.[53]

Prebble raises one of the most fundamental questions of the current mental health discourse, namely, if medication can be a means of reinstalling a state of 'normalcy,' when Lorna states: "Who are the vast majority being medicated! We're not deluded, we've just lost a delusion that makes us 'normal!' Millions of people believe they have a disease of the brain that can be cured. And no one's allowed to say different" (*Effect* 81). It might come as a surprise that Lorna as the doctor carrying out the trial has a very critical view of medication and the biomedical model most psychiatrists apply to mental disorder nowadays. During an argument with Toby, she even claims: "Every study, every test shows that so-called 'depressed' people have a more accurate view of the world, a more realistic view of themselves and the future" (80). As the term suggests, the biomedical model explains mental illness as grounded in biological factors, thereby justifying the use of psychopharmacological medication to treat it. In opposition, Georg Engel in 1980 developed a biopsychosocial model of mental disorder "as emerging from a human system that has both physical elements (a biological nervous system) and psychosocial elements (relationships, family, community, and the wider society)" (Kinderman, "Psychological Model" 207). While psychiatrists favour the biomedical model, psychologists tend to support the biopsychosocial model. As Lorna's superior and the pharmaceutical company representative, Toby counters her arguments with a biomedical position: "Don't hide behind this fashionable trashing of it all. Every time you have an episode, every time, the brain is altered and makes the next one longer and deeper. The sooner you start to medicate, the more you protect yourself" (*Effect* 79-80).

As the play moves forward, it becomes clear that when Toby says "you" he does not refer to people in general but he talks directly to Lorna because, as is revealed, she herself goes through bouts of depression and refuses to take medication. The ensuing war of words between the two doctors, in which Lorna supports the notion that "[t]here's no real evidence for the efficacy of antidepressants, there has never been. Everyone who knows, knows this has been the biggest disaster in the history of medicine" (79), is reminiscent of the professional struggles between the doctors in *Blue/Orange*. But Prebble adds the personal dimension to complicate the debate. After all, Lorna is under attack not only as a doctor but also as a service user who, ironically, does not use the service provided, suggesting that her personal views, like Martin Dysart's, compromise her professionalism.

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[53] For a critical evaluation of scientific knowledge, see Bruno Latour's work, especially *Science in Action: How to Follow Scientists and Engineers Through Society*; *We Have Never Been*; and *Pandora's Hope: Essays on the Reality of Science Studies*.

Within the laboratory atmosphere of the trial, at first, Lorna still makes an attempt at balancing out Toby's position by arguing in favour of the biopsychosocial model of mental illness without directly referring to her personal story:

> DR JAMES. Oh for god's sake Toby, you ask someone about their history of depression they don't say I felt tired one day. They say, I lost my job, I lost my wife, there are external events they respond to.
>
> TOBY. Everybody loses their job, everybody loses their wife!
>
> DR JAMES. No they don't, Toby! It's about an interaction with the world. It doesn't just appear. I know this depression as disease thing is good for business but –
>
> TOBY. Don't. Don't say that in front of me.
>
> DR JAMES. Don't say that in front of *me*! I was a clinical psychiatrist at Barts for ten years while you were greasing your way up the ladder. (47, italics in original)

Later on, in a confessional monologue Lorna tells that she firmly believes in the biopsychosocial model even if in her professional position, she would have to advocate and act according to the biomedical model:

> I was having a tough time, quite a few years ago. I'd broken up from a long relationship I'd been in forever and that was a big decision and I'd lost a parent after a long … time. And I was supposed to be going away for work, a conference, but I didn't know if I could, I'm afraid of flying and I nearly didn't make it. But I did, and that week turned out to be one of the best weeks of my life. (61)

She goes on to tell how she had an affair with a colleague at the conference, who turns out to be Toby, and how he was a notorious heartbreaker who had a devastating effect on her health: "As we flew back I sort of felt something dissolve, in the jet stream, like something got eroded down. And by the time I got back it was dark" (62). Put simply, based on Lorna's experience of how overwhelming life events lead to her depression, she does not believe in medication because she sees no neurological link. Her experience of how Toby's career developed faster than hers because he supports psychopharmacology in all respects substantiates this belief. Although the biomedical and biopsychosocial models are by no means mutually exclusive, as clinical psychologist Peter Kinderman explains ("Psychological Model" 206), it appears that, to Lorna, they are separate ways of approaching her own condition.

Prebble complicates the dialectic narrative by introducing the idea that one of the trialists might be taking a placebo, which is part of a plot twist revealing that the trial is also testing practitioner bias. This examination of practitioner bias re-

configures the hierarchical power structures of Foucault's clinic because it sets Toby as the representative of the trial's sponsor above Lorna who is tested. The placebo also carries additional meaning as it represents the challenge *par excellence* to scientific certainty.

4.3.2 Psychiatry as the "Cinderella" of Medicine

Psychiatry and attitudes towards its objective knowledge are further discussed when Toby speaks at a pharmaceutical industry event reminiscent of a TED-talk in which he thematises his career path. Prebble uses the scene to present a filtered critical perspective of psychiatry as a discipline and field of research which might question psychiatry's legitimisation altogether.

Toby explains that his father, a heart surgeon, called psychiatry "the *Cinderella* of medicine," highlighting his father's scepticism towards the profession (*Effect* 28; italics in original). Moreover, his father had mixed stereotypical notions of mental illness because he "thought psychiatry was nonsense about Freud and everything being motivated by your parents" (79). Even if this background story can be read as clichéd, it is nevertheless telling that Prebble decides to give Toby such a background against which his attitude towards medication for depression, and his understanding of psychiatry is developed. Behind Toby's seemingly innocent introduction to his talk, lies a profound hierarchical understanding of medical practises. This relates to the fact that the doctor of the body (the surgeon) mocks the doctor of the mind (the psychiatrist) by belittling psychiatry as the stuff that fairy-tales are made of. Even if it is only mentioned in passing, the fairy-tale metaphor is highly significant because it provides a possible explanation for Toby's insistence on the physical side of mental illness. What is more, it accounts for his advocacy of a neuroscientific approach to mental distress and the endorsement of psychopharmacological treatment. It appears that by emphasising the physical (i.e. neuroscientific) aspects of mental illness, it is easier for Toby to legitimise his career choice. There is irony in the fact that Toby's father condemned Freudian notions of family influence when, as suggested by the backstory, this is exactly what motivated Toby to become a psychiatrist.

Epistemological questions on aspects of uncertainty and invisibility in the current mental health discourse, which were addressed in the analyses above, also feature in *The Effect* with regard to the cutting-edge topic of neuroscience. As an advocate of the biomedical model, Toby is stylised as a character with a desire to probe boundaries and to travel to the unknown, as an explorer who 'advertises' mental illness as entirely physical and thus as something to be located in the brain (*Effect* 29). Since the workings of the brain have not been uncovered and deci-

phered completely, it requires courageous explorers to go there.[54] Roslynn D. Haynes has analysed six stereotypical representations of scientists from the Middle Ages to the late twentieth century in her seminal study *From Faust to Strangelove* (1994). One of these stereotypes is "[t]he heroic adventurer in the physical or the intellectual world. Towering like a superman over his contemporaries, exploring new territories, or engaging with new concepts, his character emerges at periods of scientific optimism" (R. Haynes 3). Since neuroscience is a rapidly advancing field, it might be possible to consider the current situation as optimistic. Toby fashions himself as courageous and mystical when he states in opposition to his father's stance: "I didn't want to be a *plumber* of the body. I wanted to be an explorer" (*Effect* 29; italics in original). The statement might sound like a rejection of the physical aspects of illness but since Toby supports the biomedical model of mental illness, it rather refers to the aspect of visibility and, by extension, to knowledge.

As a visual aid and as an enhancement of the fact that he believes mental disorder to have a physical, neuroscientific explanation, Toby presents one of the play's few props. His monologue comes with an added surprise effect: he enters the stage with a bucket and the audience cannot guess that he carries a human brain. What makes the effect even more striking is the fact that to most of us, the brain is an invisible entity, locked away carefully in our skull. The brain presented thus becomes a *punctum* that focuses the spectators' attention. In addition, as a visual marker, it constitutes a bold but simplistic image of one of the underlying key concerns of Prebble's play, the aspect of ethics in current neuroscientific research, termed 'neuroethics' or 'brainethics' (Ramsøy).

As a representative of a pharmaceutical company, Toby regards medication with the utmost optimism in line with the optimism suggested by Haynes' explorer type when he asserts that "[w]e need to consider mental health the same way we do the bodily kind, because it is the bodily kind. (*Referring to brain*.) Here's our body. And sometimes it requires medication. Those who suffer mental illness are not weak" (*Effect* 29; italics in original). In essence, Toby calls for an integration of mental illness into 'normal' life as an everyday occurrence. To recall, in the UK one in four people will experience a mental health problem at some point in life (Mind).

> And how about we start by *expanding* that idea of 'normal' anyway to *include* mental illness. We are many of us going to experience a mental health condition in our lives. Why are we still tied to the notion of the sane and the insane? Why not call ourselves the insane and the 'not insane at the moment'? We are facing an everyday epidemic. Depression is fast becoming

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[54]   Exploration as a spatial metaphor for probing physical boundaries was also prominent in nineteenth-century medical discourse when surgeons such as Thomas Chevalier compared surgery to travelling and the notion of discovery (Sedlmayr, Introduction 7-8).

the biggest cause of disability in the world. This is why medical intervention is so important. (*Effect* 30; italics in original)

Prebble implicitly draws on Jorm's aforementioned concept of 'mental health literacy' which is meant to increase the awareness of early signs of developing mental health problems and which advocates community care in order to normalise the conditions (231-43). Viewed from a positive angle, Toby wants mental health problems to be normalised but the conclusion that medical intervention is the only means of achieving this, is debatable. Along the same lines, critics consider the term 'mental health literacy' to be problematic and potentially even contributing to the stigmata attached to mental distress because it suggests that all it takes to alleviate mental distress is a sophisticated and informed response (Read et al. 165). For instance, psychologists John Read, Nick Haslam, and Lorenza Magliano argue:

> While the approach to depict mental disorders as an 'illness like any other' and to emphasize its biological correlates seems useful to enhance the acceptance of professional medical treatment for mental disorders, it is not suitable to improve social tolerance. Dissemination of biological knowledge is not a solution to discrimination and stigmatization. (165)

By presenting arguments for both models of mental health Prebble's play does not stigmatise or take sides. Toby praises the Care in the Community-policy as more useful than mental institutions. Ultimately, he creates a link between medication and the potential to destigmatise and with this pulls emotional strings in his audience:

> It's love that means we treat people so they can live at home, in the community, rather than locked away. And it's love and it's trust that means that people don't lose their jobs or their children when they have a bout of depression. The psychopharmacological revolution is the most important occurrence in medicine in my lifetime. (*Effect* 30)

In keeping with the play's dialectical structure, Toby in his optimistic talk is just as convincing as Lorna describing what led to her depression. However, Prebble later makes a decisive statement regarding the trustworthiness of psychopharmacology when Tristan has a seizure. It seems to echo British physician Ben Goldacre's critical book *Bad Pharma* (2008), also mentioned in the Tumblr blog, that the trial is stopped when Tristan's life-threatening seizure causes transient global amnesia, the temporary loss of short-term memory. Goldacre describes "how vital important information from clinical trials is still being withheld from doctors and patients [...] and that patients experience avoidable suffering and death as a consequence" ("The ABPI"). Even though it turns out that there is a physical explanation for Tristan's seizure, an undiscovered heart condition causing the extreme physical reaction to the trial drug, overall, Prebble expresses considerable doubt

about the practices of the psychopharmacology industry, and invites the audience to critically reflect on rather than accept Toby's enthusiastic explications. After all, the fact that Tristan was not sufficiently examined before his acceptance to the trial, questions the safety of drug trials. It suggests that pharmaceutical companies might neglect their duty of care not only for patients but also in the early stages of developing new medication.

4.3.3 Trial and Error: Staging Uncertain Knowledge

Negotiations of neuroethics not only take place on the textual level but Lucy Prebble and director Rupert Goold also utilised the theatre space accordingly by placing the audience around the stage for the play's first production at the National Theatre's Cottesloe. Due to the Cottesloe's arena-style auditorium, the spectators surrounded the rectangular stage on four sides and up three levels. Thereby, epistemological questions that arose in performances of *Equus* and *Blue/Orange* coupled with this particular theatrical mode of thematising aspects of observation in performance also emerged during performances of *Effect*. Due to the fact that the staging served the distinct purpose of turning the audience into silent participants in the clinical trial, the stage can be considered heterotopic because it engaged audiences actively, fostered the production of mental health knowledge in performance, and thus bridged the gap between the stage and the auditorium, as outlined in detail in chapter 2 of this study.

The heterotopic stage in the round coupled with the use of special visual technology such as large screens above the stage suggested the complete permeability of body and mind. What is more, it evoked the metaphor of 'gläserner Mensch' (literally, transparent human) now used to describe methods of mass surveillance and data protection issues related to the World Wide Web but just as apt for capturing neuroscientific imaging. The first production's stage and the trial environment itself can be called heterotopic in that both refer to "actual or imagined spaces/places […] in dialogue with 'real' locations" since audiences were directly implicated in the trial (Tompkins 26). In an earlier draft version of the play, one idea was for audience members to receive a wristband before entering the theatre and actually taking a sweet in the shape of a pill to increase the 'physical dialogue' with the 'real;' yet the idea was dropped because it was too difficult to carry out, as Prebble and Goold explained in an interview with Dan Rebellato (Prebble and Goold).

In Miriam Buether's design at the Cottesloe, two large screens above the stage served as visual devices that made the otherwise invisible inside of the characters' bodies visible (*The Effect* performance). The screen enabled the spectators to share Lorna's perspective because it was linked to the electronic tablet that she used to monitor the trialists. The staging in the round substantiated the impression of complete surveillance, as pointed out above. Especially audience members in the circles looked down on the stage, calling to mind Charcot's medical demonstra-

tions. So, not only were Connie and Tristan observed inside out, but every finding was also being recorded in real time. With this, the trialists became transparent and were exposed to complete surveillance in a hyper-technological environment, or as Tristan put it, "now everyone comes in with laptops and headphones, it's a bit more (*gesture*) … used to be like Big Brother" (*Effect* 10).

The authority Lorna holds over Connie and Tristan is thus also handed to the audience during the performance because it provides superior knowledge. When the trialists have to do the Stroop Test, an exercise in which words appear in different colours and one has to name the word rather than the colour, the spectators potentially double up as trialists because as the words appear on the screen, it is possible to mentally carry out the test, too. The position of the spectators shifts from having a superior understanding of the trial scenario to potentially turning into active trialists. This shift in positioning is mirrored in Lorna, who carries out the trial *and* suffers bouts of depression. Put simply, audiences are in as complex a position as Lorna. Considering different layers of power distribution between stage and audience, it has to be pointed out that actually doing the Stroop Test as it happens on stage is perhaps only possible for spectators who are familiar with it, who are able to react very quickly, and who are willing to engage in this way. The stage directions explain how the test works but this piece of information is not available to audiences. Still, such an indirect breaking of the fourth wall speaks of Prebble's dramatic strategy of engaging audiences both intellectually and experientially.

The soundscape realised in the Cottesloe production corroborated the pervasive sense of observation. The audience had access to the trialists' heartbeat through the audible noises of the ECG attached to them. Thus, the spectators were able to ascertain more about Connie and Tristan, and in a hyper-modern version of dramatic irony, knew about their feelings for each other even before them. The beginning of the Stroop Test, which was marked by the word "LOVE," visually enhanced this (*Effect* 16-17). The spectators were part of the heterotopic hyper-modern laboratory in which they participated as observers and, by extension, as creators of knowledge gathered for the trial and beyond.

Prebble probes the boundaries of objective knowledge further when the trialists begin to doubt the efficacy of the trial drug und ponder the potential use of placebo. Connie and Tristan have questions such as 'What is real?' that inevitably emerge in cases of mental distress, as for instance discussed in chapter 3 with regard to Susan's and Harper's hallucinations, but also in the pressure cooker environment of the clinical trial. Prebble juxtaposes a staple of drama, the idea that love is like madness, known for instance from *Hamlet*, with the question of how to know what it real. Connie and Tristan discuss their potentially deceptive emotions as a result of the confines of the trial space:

TRISTAN. It's horrible to feel you can't trust your senses.

CONNIE. I love you. You can feel that (?)

TRISTAN. I don't know what it means now.

CONNIE. (*desperate*) Yes you do. I wish I could show you inside my brain. Let's get the doctors to shrink me down like in that film and they can inject me into you and I'll wander round then curl up in your heart and I won't be any trouble. I'll just live there and spend your life with you and if you need me that's where I'll be. (*Effect* 86, italics in original)

Connie's wanting to show Tristan her brain as proof of her emotions reveals the brain-centred worldview endorsing the biomedical model of mental illness also propagated by Toby. Crucially, by referring to the Cartesian mind-body problem, Prebble brings in the 'philosophical side' that neuroscientist and clinical psychologist Vaughan Bell considers an integral part of all psychiatric definitions (n.p.). In short, the mind-body problem "says that even though the mind clearly arises from the brain, it doesn't necessarily follow that the concepts we use to describe the mind can be cleanly mapped onto neurological processes" (n.p.). Put differently, Prebble subverts Toby's notion of science's superior knowledge by ending the play not on a eulogy about science and progress but on a pessimistic note, which is not only expressed by Connie's futile longing and the devastating repercussions of Tristan's transient global amnesia (Connie and Tristan keep repeating the same conversation day in and day out in short snapshot scenes), but also by Lorna's breakdown. The final scene's soundscape of an EEG (brain wave patterns) and an underlying ECG (heartbeat) on the one hand evokes the play's scientific setup (*Effect* 101); on the other hand, it once again reminds audiences of the mind-body problem, thereby reiterating on the supposed binary Prebble has drawn on throughout the play.

Ultimately Lorna, like Tristan, represents the drawbacks of modern science's claim for certainty and the resultant medicalisation of mental distress, echoing Goldacre's notion of *Bad Pharma* (or bad pharma). Consequently, similar to *Equus*, epistemology in Prebble's play paradoxically relates to the acknowledgement of uncertainty. Lorna's finally taking antidepressants further substantiates this claim. As a representative of the medical profession, we would expect from her certainty regarding the treatment of mental disorder. Yet similar to Dr Dysart in *Equus* and the consultants in *Blue/Orange*, there is a pervasive sense of uncertainty and doubt regarding the promises of the biomedical model of mental illness and the psycho-pharmacological industry. In the context of current mental health debates, Prebble's play touches upon a number of controversially discussed issues including Jorm's concept of 'mental health literacy.' Read, Haslam, and Magliano take a critical stance vis-à-vis Jorm's notion of the 'readability' of mental disorder and the related assumption that mental illness only has biological causes (159). To recall,

Jorm assumes that the early signs of mental illness can be detected and that educating people in this respect will increase mental health overall (231-32). Along the same line, the more than 1000 pages of the *DSM-V* make it seem like there is increasing certainty regarding mental illness. While it is true that such a classification system of mental disorders is useful and necessary, as, for example, Bell points out, it would be wrong to conclude that what follows from the sheer quantity of possible diagnoses is more certainty regarding the etiology of mental illnesses or improving the life conditions of service users (n.p.). By virtue of not staging mental distress, such as the plays analysed in the following chapter, but by focusing on the medical trial, Prebble circumnavigates the potential stigmatisation of mental disorder and rather engages with pressing mental health care concerns.

4.4 Chapter Conclusion

All three plays analysed in this chapter express vocal criticism of psychiatric power/knowledge structures. Their counter-discursive dimension largely rests on heterotopic in the round-stages as these corroborate the critique of contemporary mental health care by problematising notions of perception, knowledge, and power in the psychiatric hospital and the clinical trial facility, respectively. The arena-style stages in the round deliberately evoke teaching and learning scenarios but although audiences surround stages and spectators look *at* madness not *with* it, the analogy to the total visibility of control systems such as the *panopticon* is reversed and serves to undermine the therapists'/doctors' authority in the plays. Knowledge is a contested notion that audiences are encouraged to question in the community of the theatre.

    As a counterpoint to the alleged objectivity of psychiatry, a strong sense of uncertainty pervades all three plays. This uncertainty not only relates to treating and diagnosing Alan and Christopher in *Equus* and *Blue/Orange*, but it also extends to the depictions of the therapists/doctors as flawed human beings. The plays echo notions held by some philosophers of science who maintain that "in psychiatry, 'truth' is dependent on perspective" (Kinderman, "Psychological Model" 211). Rather than allowing audiences to empathise with the doctor characters, because the troubled personal conflicts impact their professional performance and judgment, a certain distance is created between audiences and characters that is rarely bridged. Thereby all three plays ask spectators to consider their own attitudes towards normative thinking coupled with a reliance on powerful hierarchical systems that ultimately sustain themselves by human beings adhering to self-imposed, questionable rules.

    Significantly, in contrast to the two plays analysed in the preceding chapter in which audiences share the mad characters' perspective, the three plays examined in this chapter are much more focused on the doctors than the patients/trialists: Dysart narrates Alan's story, Bruce and Robert talk (fight) more *over* Christopher

than with him, Lorna (herself a service-user) controls Connie and Tristan and is controlled by Toby. This is noteworthy insofar as it reveals the same neglect of the patient perspective that can often be detected in real-world psychiatry. In keeping with the medical lecture halls that are alluded to through in the round-stages, characters are metaphorically being dissected on stage but it is the psychiatric professionals, not the patients. While this does not dilute the plays' system critique and is in a way necessary for the criticism to gain momentum, the patient perspective is strangely absent. The analyses in the following chapter introduce two mental health plays which seek to capture the patient perspective by combining experientiality of mental distress at the theatre with criticism of psychiatry in formally innovative ways.

5 What It's Like to Live with Mental Disorder: Theatrical Solutions to the "Hard Problem" of Consciousness

Chapter 3 introduced two plays that let audiences look *with* madness, i.e. in parts of the plays, spectators share the madwomen's perspectives, including their hallucinations, by operating with what Wald calls hystericised realism (49). The two plays examined in this chapter, Sarah Kane's *4.48 Psychosis* and Anthony Neilson's *The Wonderful World of Dissocia*, probe the boundaries between madness and what is commonly referred to as normalcy even further.[55] Both take their audiences to "the darkest and most unforgiving internal landscapes" (Greig ix) of mental illness in formally innovative ways and, at the same time, offer critical perspectives on mental health care.

In what follows, I will demonstrate to what extent the plays' forms and interpretations on stage are responsible for the experiential effect they produce in performance. Although it goes without saying that the audience experience at the theatre can never recreate the real-life experience of severe mental distress, the plays at hand make madness visible in order to make experienceable what it might be like to live with mental illness (Clements xxxv). Both plays thus face a common

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[55] The play will be referred to as *Dissocia* from here.

conundrum that in the philosophy of mind is called *qualia* to describe the problem of what it is like for a person to have a particular experience (Levin 693). David J. Chalmers aptly calls this "the hard problem" of consciousness (Chalmers; see also Davies 191). In the two plays, the "hard problem" has two facets: first, the question what it is like to live with mental disorder. Secondly, there is the ethical problem of how to represent the disordered mind without othering the character. The solution to these problems lies in the plays' fragmented (*4.48 Psychosis*) and dissociated (*Dissocia*) forms, respectively, which mirror their content and create a sense of unease in the audience. They hold the potential for raising awareness of the difficulties of perceiving the world through the lens of mental disorder in visceral ways that speak of Kane's and Neilson's association with experiential 1990s in-yer-face drama (Sierz). The plays confront readers and audiences alike with ruptures in Patrice Pavis' sense: in Kane's play, it is countless ruptures, in Neilson's, it is one large rupture between Act I and II that audiences have to fill meaningfully (Pavis 246).

To recall, the process of making mental distress visible on stage in mental health drama often involves the Foucauldian gaze either by thematising it on the level of content or by incorporating it in dramatic form and structure. In Neilson's and Kane's plays, perception, power, and knowledge are fluid categories. Due to the fact that in the two plays form and content go hand-in-hand, fractured minds create fractured narratives. Thus, the workings of the gaze are complex because making visible mental distress in a visceral way, while at the same time thematising it on the content level, leads to an overlap of various 'frames,' which in cognitive theory refers to the concepts that specific knowledge representation systems use (Nebel 324). As a result, the Foucauldian triad of perception-knowledge-power is complicated because of what Trish Reid aptly calls "deformities of the frame," which "draw[…] attention to the theatre's own representational forms and to how they are perceived" ("Deformities" 496). Such deformities, coupled with ruptures, cause particular challenges for creative teams and audiences alike when it comes to making meaning. At the same time, they provide moments in which the mental health plays' ethical criticism can emerge.

Making the inside of the mind (not just the distressed mind) visible has long fascinated theatre-makers, writers, painters, and scientists alike. The surge of studies on consciousness and the cognitive sciences, advancements in neuroscience, as well as multiple intersections and collaborations of the arts and sciences have confirmed this fascination in the past four decades (see, for example, McConachie's studies *Theatre and Mind* and *Engaging Audiences*). With their concern for challenging knowledge about mental illness in theatrically innovative ways and literally enacting their content, the two plays analysed here show parallels to what Kirsten Shepherd-Barr calls 'alternative science plays.' Such plays digress from mainstream realist and naturalist drama towards theatre in which the "experience of the audience becomes much more about imbibing, sensing, or 'dreaming' the science

through its enactment than about listening to explanations of it from characters and following their story" (Shepherd-Barr, *Science* 201). Examples such as Peter Brook and Marie-Hélène Estienne's *The Man Who: A Theatrical Research* (1993) and Mick Gordon and Paul Broks' *On Ego* (2006) resonate with alternative science plays due to their particular interest in dramatically investigating, or, in fact, "researching," as Brook and Estienne suggest, the science of the mind and brain.[56] Kane's and Neilson's plays are also formally innovative because they forgo linear plots and convey a brokenness in narrative and form. A slight alteration lies in the way that the two plays concentrate on the *experience* (the sensing) of mental distress rather than the *science* of mental illness, and thus yield different responses based on aspects of immediacy and the experientiality they foster.

Numerous playwrights have attempted to visualise the distressed mind on stage; examples include such varied plays as Arthur Miller's *Death of a Salesman* (1949), Samuel Beckett's 15-minute dramatic monologue *Not I* (1962), John Osborne's *Inadmissible Evidence* (1964), Tom Stoppard's *Travesties* (1974), Caryl Churchill's *The Skriker* (1994), and David Auburn's *Proof* (2000).[57] All examples engage with the aforementioned notion of *qualia* and share the urgency to engage creatively with one of humanity's last great mysteries, the invisible mind in distress. The sense of urgency is often expressed in formally innovative ways. *Death of a Salesman*, for instance, "is a double drama of the interior, of the house and of the mind – the fluid space of the home, which dissolves into Willy's flashback scenarios, backed by the high-rise apartment blocks of the city looming beyond," as Nicholas Grene explains (8). This comment on how stage realism can converge with other dramatic forms, such as expressionism, in order to depict inner states resonates with *4.48 Psychosis* and *Dissocia*, particularly with regard to how formally innovative pieces can yield alienating effects. Due to their complex formal nature and their weaving together of the above-mentioned strands, all examples literally embody the complexities of mental distress that they express on the page.

In no other chapter of the present study is the differentiation between text and performance more important because so many of the plays' effects depend on negotiations of the materiality of the textual with the ephemerality of the performative. The two plays analysed here thus raise a question that William B. Worthen makes central in his informative study on *Print and Poetics of Modern Drama*: "To what extent can the rhetorical, alienating means of the mise-en-page find an adequately alienating mode of production in the mise-en-scène?" (138). I argue that the fragmented and dissociated texts and alienating performances of Kane's

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[56] Brook and Estienne's play is based on neurologist Oliver Sacks' book *The Man Who Mistook His Wife for a Hat* (1985). Gordon's co-writer Paul Broks is a neuropsychologist.

[57] Films that feature the inside perspective of mental distress include *A Beautiful Mind* (2001) and the adaptation of David Auburn's *Proof* (2005). References to modernist fiction with its innovative use of stream of consciousness suggest themselves as much as 1950s beat poetry such as Allen Ginsberg's *Howl* (1956).

and Neilson's plays have to be considered separately yet side-by-side; particularly because the fragmented, poetic nature of the "textual space" (McAuley 25) of Kane's script allows for a plethora of interpretations on stage, whereas the secondary text of Neilson's play with its elaborate stage directions and notes shows a concern for keeping control over productions (even if these do not have to be implemented). In both instances, the *mise-en-page* challenges the *mise-en-scène* and only in conjunction can the two possibly "conflicting sensibilities between the experiential and textual" develop their full potential (Saunders, "Just" 101).

Alongside their formal intricacies, one of the two plays' most important contribution to the body of mental health plays in the present study is giving a voice to the patient/service user experience. Asked about his inspiration and research for this perspective, Neilson explains: "I didn't do any research in the conventional sense. I'd had extensive experiences with people who had mental health problems throughout my life, including close family members, friends and several long-term partners" (Interview). Like Neilson, most playwrights considered in my study quote personal involvement with mental distress as inspiration (for example Ayckbourn; Penhall; Prebble), some also express an interest in destigmatising madness with their work (for example Ridiculusmus; Macmillan). Sarah Kane stands out in this respect because her biography provides a tragic backdrop to her play: she suffered from severe depression and killed herself on 19 February 1999.

In the dramatic tradition of Beckettian and 1990s in-yer-face drama, both plays analysed in this chapter overturn notions of perception, power, and knowledge. By embodying madness in their very structures, the plays' self-reflexivity holds the potential to *forcefully* challenge audiences into addressing their assumptions about what it means to be mad. Rather than being invited to lean back and enjoy the experience, audiences are pushed into succumbing to the confusion, despair, and inexplicability of mental disorder when the pieces are performed in ways that mirror and embody their radical epistemological visions. By presenting completely subjective and idiosyncratic stances towards madness on page and stage, Kane and Neilson seek to radically redefine normativity in the theatre and beyond.

5.1 Mental Disorder Between Textual Lyricism and "Explosive Theatricality" in Sarah Kane's *4.48 Psychosis* (2000)

Sarah Kane's *4.48 Psychosis* was first produced posthumously at the Royal Court Jerwood Theatre Upstairs in London in June 2000.[58] Given that Kane had killed herself in 1999 after a long struggle with depression, it is tempting to read a biographical subtext into her work. Nevertheless, playwright David Greig suggests

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[58]   The play will be referred to as *Psychosis* in quotations from here.

that it would be wrong "if, in attending to the mythology of the author, we were to miss the explosive theatricality, the lyricism, the emotional power, and the bleak humour that is contained within the plays themselves" (ix). The "explosive theatricality" of her work can be cited as one reason why Kane was and still is considered an *enfant terrible* of British theatre.[59] Most importantly, Greig brings to the debate the two aspects that are most relevant for the following analysis, theatricality and lyricism, namely the performative and the textual side of Kane's work. As Graham Saunders explains in a conversation with playwright Jeremy Weller (whose play *Mad* Kane praised): "one part of her wanted to break down that demarcation between 'the real' and 'the performed', while her writerly instincts always wanted to impose strict formal controls over the plays – and those two desires were never reconciled" (Saunders, *About* 120). Weller and Saunders discuss Kane's work as torn between creating text-based drama and allowing the uncertainty of experientiality in performance that ruptures in the narrative produce.

The "explosive theatricality" Greig mentions (ix), runs through Kane's entire *oeuvre* and yields powerful effects in performances. Her first piece *Blasted* (1995) set the tone for the confrontational and experiential in-yer-face drama of late 1990s Britain. This kind of theatre "grabs the audience by the scruff of the neck and shakes it until it gets the message;" it borrowed from Antonin Artaud's concept of 'Theatre of Cruelty,' which Kane cited as inspiration for her own work (Sierz 4). Artaud believed in the transformative nature of theatre as the following statement shows:

> Just as it is not impossible that the unconsumed despair of a lunatic screaming in an asylum can cause the plague, so by a kind of reversibility of feelings and imagery, natural disasters, revolutionary order and wartime chaos, when they occur on a theatre level, are released into the audience's sensitivity with the strength of an epidemic. (17)

With his sustained interest in the experience and experientiality of madness in his theoretical and creative writings, Artaud is an early literary proponent of antipsychiatry *avant la lettre* because he believed in a positive creative dimension inherent in the experience of madness (Miller 28). His notion of madness being able to spread like an epidemic in the space of the theatre anticipates the effect that Kane's work has had on audiences ever since *Blasted* premiered. References to Artaud's aesthetics substantiate the analysis of Kane's powerful critique of psychi-

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[59]   Kane's work is still very much alive: the year 2001 saw a Sarah Kane-season at the Royal Court Theatre, many European theatres have successfully staged her plays, the Schaubühne Berlin had Thomas Ostermeier's version of *Crave* (*Gier*) in repertoire for more than fifteen years. In the UK, Kane's work has become part of the curriculum for the Theatre and Drama Studies A-level as well as at universities. In 2015, Sheffield Theatre produced a Sarah Kane-season and in 2016, the first production of *Cleansed* was staged at the National Theatre in London, directed by Katie Mitchell (Dickson).

atry's hegemony in the *mise-en-page* juxtaposed with the experientiality and viscerali-
ty of the *mise-en-scène*.

Apart from having found inspiration in Artaud's work, Kane quoted the
postmodernist fragmentary nature of Martin Crimp's *Attempts on her Life* (1997)
with its multitude of voices as having influenced her to experiment with form
(Saunders, *About* 49). The pieces also share a deep sense of distrust of the idea of
coherence when it comes to one's self and identity. In this regard, Ken Urban's
useful parallel to the concept of montage taken from the visual arts resonates with
Kane's play because

> it takes different types of language, monologues, scenes and brings them
> together under the 'constructive principle' of articulating the experience of
> a psychotic breakdown. […] Yet, as with a visual montage, the different
> registers of language in Kane's play are never fully integrated into a seam-
> less whole since their differences remain. ("Kane" 317)

The image of a "seamless whole" that *4.48 Psychosis* cannot form simultaneously
captures how the play mirrors a sense of fragmentation often accompanying men-
tal distress as well as the potential challenges of meaning-making for the audience
confronted with a deconstructed self on stage.

Kane's rejection of conventional narratives of self and identity also extends to
the aspect of gender. Contrary to what some casting choices or over-
interpretations of the biographical might suggest, *4.48 Psychosis* does not present
madness as gendered. In fact, Kane's notoriously difficult relationship with the
label 'woman writer' and with feminism more generally contradicts any attempt at
primarily reading her work within traditional British feminist theatre (Urban,
"Kane" 316). The play's production history shows that it is open to castings rang-
ing from two women and one man in James Macdonald's first production in 2000
and at Sheffield Theatre during the Sarah Kane-season in 2015 (directed by Char-
lotte Gwinner), to one woman in a version with Isabelle Huppert at the Brooklyn
Academy of Music in 2005, to as many as 21 women in Fourth Monkey's produc-
tion at the Edinburgh Festival Fringe in 2012. As this chapter shows, however,
madness in *4.48 Psychosis* is not a female malady in Showalter's sense; it is a univer-
sal phenomenon.

5.1.1 The Fragmented Mind as "Alternative Space"

Stylistically speaking, Kane's work has followed a reductionist trajectory of con-
ventional dramatic elements: *Blasted* had three distinct characters, stage directions,
and an episodic plot, and *Phaedra's Love* (1996) had a discernible narrative bor-
rowed from Greek myth. *Cleansed* (1998) was inspired by Roland Barthes' *A Lov-
er's Discourse* (1977), a book divided into eighty fragments outlining certain behav-
ioural types, while in *Crave* (1998) the characters were only marked by letters
(Saunders, *About* 74-76). In *4.48 Psychosis* all the elements of traditional theatre

realism and of Aristotelian unity are absent (Greig xvi; see also Saunders, "Just" 105). There are no characters, acts, stage directions, or a distinct plot. Yet, the play clearly traces the suffering of a mentally distressed character or characters in intense monologues and quasi-dialogues, in hospital scenes and nightmarish scenarios evoking the apocalypse, in snippets of painful conversations with loved ones, and random numbers on a page. On this reductionist trajectory, according to Saunders, Kane's last two plays "are more like metaphorical openings that allow the spectator/reader glimpses into fractured mindscapes rather than the familiarity of the everyday" (*About* 1).

Building on Saunders' spatial metaphor of "fractured mindscapes," I argue that *4.48 Psychosis* can be regarded as heterotopic. To start with, the play in its entirety is a heterotopia not so much in a physical sense as in an abstract one because it conceptualises the distressed mind as "an alternative space" (Tompkins 24-25). The word "alternative" refers to the idea that a heterotopia is simultaneously anchored in reality but then exists completely separate from it. On the textual level, by entering the alternative space of the disordered mind, readers follow the thoughts of a mind that "is the subject of […] bewildered fragments" (*Psychosis* 210), but if this is also true on the performance level, depends on productions, particularly with regard to visual interpretations of Kane's lyrical prose and to assigning actors to the play's multiple voices.

Before exploring the notion of the mind as an alternative space in more detail, it is essential to consider what the play's fractured mindscapes are on the page and how they have been interpreted in performances. Above all, the play is complex, multi-layered, and in parts almost inaccessible. "While images were central to her previous plays, the[] final pieces [*Crave* and *4.48 Psychosis*] contain the images within the language of the plays, and she [Kane] does this through the creation of a distinctly poetic style" (Urban, "Ethics" 43). This poetic style both on page and stage is established from the start, as the play literally opens *in medias res*: a very long silence is followed by a sentence starting with the adversative conjunction "but" suggesting that the spectators have missed parts of the conversation. Questions which add to the overall impression that essential information is missing, follow this deliberately open beginning. More silence ensues before a free verse-style collage of dark thoughts speaks of despair (Innes, *Twentieth* 534).

> a consolidated consciousness resides in a darkened banqueting hall near the ceiling of a mind whose floor shifts as ten thousand cockroaches when a shaft of light enters as all thoughts unite in an instant of accord body no longer expellent as the cockroaches comprise a truth which no one ever utters
>
>> I had a night in which everything was revealed to me.
>
>> How can I speak again?

the broken hermaphrodite who trusted hermself alone finds the room in reality teeming and begs never to wake from the nightmare

> and they were all there
>
> every last one of them
>
> and they know my name
>
> as I scuttled like a beetle along the backs of their chairs. (*Psychosis* 205-06)

The complex, cryptic lines suggest a haunted mind, and the nightmarish scenario they evoke is reminiscent of the dark and disordered landscapes of Alan Ginsberg's *Howl* (1956) or Caryl Churchill's *The Skriker* (1994).[60] Particularly Ginsberg's evocations of "angelheaded hipsters burning for the ancient heavenly connection to the starry dynamo in the machinery of night" and "a lost battalion of platonic conversationalists jumping down the stoops off fire escapes off windowsills off Empire State out of the moon, / yacketayakking screaming vomiting whispering facts and memories and anecdotes and eyeball kicks and shocks of hospitals and jails and wars" (1-2) reverberate through *4.48 Psychosis'* first lines as much as the "Skriker's virtual double-talk, a Joycean cacophony of associational and literary puns, rhymes, and mid-line logic switching" (Diamond 99). Kane's dystopian lines speak of instability; the instability of the mind, represented by moving cockroaches, as well as an uncertainty of gender ("hermself") similar to the shape-shifting Skriker, which is one indication of why the play has been performed with so many different approaches to character. Moreover, the notion of "a consolidated consciousness" being trapped in the mind pre-empts the play's effect upon "the audience's sensitivity," in Artaud's words, because of the emotional chaos that is described (17).

In the first Royal Court production the first lines were preceded by "the longest (deliberate) pause […] ever witnessed on stage," giving way to a sense of disorientation and leaving time for uncomfortable feelings to arise and spread within the audience, almost like an epidemic, in Artaud's sense (Singer 159). During the Sheffield performance the words were accompanied by the relentless ticking of a clock. Both the Royal Court's silences and Sheffield's ticking clocks are rich with meaning. One might think of the notorious 'Pinter pause,' and the ticking clock that reminds the audience of lifetime running out. In Sheffield the clock was an uncomfortable thread running through the entire play; a clock running towards

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60   "Put my hand to the baby and scissors seizures seize you sizzle. Metal cross cross me out cross my heartburn sunburn sunbeam in my eyelash your back. Or garlic lickety split me in two with the stink bombastic. Or pin prick cockadoodle do you feel it? But if the baby has no name better nick a name, better Old Nick than no name, because then we can have the snap crackle poppet to bake and brew and broody more babies and leave them an impossible, a gobbling, a no." (Churchill 10)

4.48am "the happy hour when clarity visits" (*Psychosis* 242). Critic Lyn Gardner was reminded of "the beat of a failing heart," suggesting yet another biographical interpretation of the play by foregrounding the suicide link ("Painfully"). While Gardner made the obvious, somewhat reductive biographical reference, she concluded the review with attesting the play a certain universality that is undoubtedly part of it: "The clock ticks. The abstract blue scar that encircles the playing space tingles and convulses like an electric shock. Time runs out, as it does for all of us" (n.p.). What is more, the play builds on madness as a spatial phenomenon because it "is a report from a region of the mind that most of us hope never to visit but from which many people cannot escape" (Greig xvii). The spatial metaphor of entrapment extends to the identifiable hospital scenes, one of the facets of Kane's negotiation of the 'real.' Furthermore, this spatial interpretation in performance goes hand-in-hand with the notion that the mind in *4.48 Psychosis* is an alternative space.

A good example of how this alternative space is arranged on the page and stage are the scattered (and listed) numbers on an otherwise blank page that occur twice in the play (*Psychosis* 208, 232). Variously interpreted as evoking a thought-focusing exercise for depressed patients or as merely representing the scattered thoughts of the speaker, in the 2000 Royal Court production the three actors did not speak but wrote the numbers backwards on the table top for audiences to read in a large tilted mirror that hung at a 45-degree angle above the stage (Worthen 149). The act of writing materialised the numbers in the there-and-then of the performance (which I would interpret as analogous to reality in Foucault's heterotopia), while the perceptual distortion effected by the mirror actualised Foucault's notion of a virtual "placeless place" ("Other" 24). I will return to the mirror below when it comes to considering its influence on the gaze in performance.

The juxtaposition of these two acts, i.e. the simultaneous writing and distorting, underlines the play's heterotopic dimension because it underscores both the play's key concern of being torn between two poles that cannot be united and the paradox that "I need to become who I already am," as the play's distressed voice states (*Psychosis* 212). Reflections on Cartesian dualism and the split between body and mind, of a "[b]ody and soul [that] can never be married," which gesture towards a similar conundrum, also permeate the play (212). Descartes in his *Meditations* said that "the concept of body includes nothing at all which belongs to the mind, and the concept of the mind includes nothing at all which belongs to the body" (158). Kane already experimented with the notion of loss of self in *Cleansed*, which was inspired by her outrage at Roland Barthes' statement that unrequited love or the loss of a lover "is not unlike a situation of a prisoner in Dachau" (Saunders, *About* 76). After initially rejecting the notion, Kane came to the conclusion that "It's about a loss of self. And when you loose yourself where do you go? There's nowhere to go: it's actually a kind of madness" (76). Kane equals the loss of self with a feeling of displacement, a notion that Harpin fruitfully explores in

her essay "Dislocated: Metaphors of Madness in British Theatre," in which she juxtaposes madness with aspects of location and site, as already suggested by the title. The fragmented form of *4.48 Psychosis* suggests that madness, when it is defined as loss of self, has no distinct place. Thus, madness in Kane's play can be regarded as a heterotopia because it is a "placeless place" in Foucault's sense.

Reality is one of the defining features of heterotopia since it is instrumental for locating in which ways heterotopia can "offer[] a functional and reflective agency for change or commentary in contemporary society" (Tompkins 18). At the same time, it is a contested notion not only in theatre and literary studies (consider, for instance, the conflicting ideological intersections of nineteenth-century social reality and stage realism that Elin Diamond examines in *Unmaking Mimesis*) but also when it comes to discussing the experience of mental distress. 'What is real?' is a pivotal question for psychotic patients when they try to make sense of their experience.

Reality in Kane's play has two facets, one relating to the negotiations between text and performances touched upon above. The other 'real' facet more directly relates to Kane's negotiations of the experience of mental distress as a person and as a patient. The doctor/patient scenes discussed in the following exemplify Kane's concern for the real encounter in the clinical context and the use of mimesis as a basis for her powerful critique of contemporary mental health practices. Saunders supports this when he states that "the play is only ever partly introspective in its treatment of mental illness. For the most part it is an impassioned critique of the hospitalisation and treatment of those with mental illness, in which the individual is questioned, diagnosed and treated with powerful combinations of antidepressants and anxiolytics" ("Just" 105). This anchoring is crucial and adds to the play's heterotopic dimension because only the combination of such real elements with the "imagined space" of the distressed mind has "the capacity to influence an audience's understanding of the relationship between the theatre and the world outside its walls, such that theatre can continue – and extend – its function of both shaping and contesting its cultural context" (Tompkins 27). The biographical dimension of Kane's work does not so much initiate as corroborate the invitation to audiences to consider the world outside the theatre, especially their experience of or attitudes towards mental health care and mental illness.

The Royal Court production in 2000 put emphasis on Kane's focus on the imagined space of the disordered mind with the aforementioned large tilted mirror above the stage that distorted the impression of looking at one stage and played with notions of the representational. By now, the mirror has become iconic in the play's reception (Singer 159; see also Urban, "Ethics" 44). When designer Jeremy Herbert "suggested it, we [the creative team] saw that it would help to realise the mind/body divide which is at the centre of the text; and also it would solve the problem of how to talk to the audience without addressing them directly," as director James Macdonald remembers (Saunders, *Love* 124). In the context of

considering how to represent and discuss mental distress, the elusiveness that the mirror brought to the Royal Court stage reflects how pain can be communicated and why this is more problematic when expressing mental anguish as opposed to physical pain. Annabelle Singer points out in this regard that in the production "only a representation of 'pain' (pain as we have understood it to be, to feel like) is communicated. Pain ensures the instability of even the material world because it is both undeniable and intangible" (152). In other words, the mirror served as a means of conveying instability and uncertainty. In Foucault's terms, a mirror

> functions as a heterotopia […]: it makes this place that I occupy at the moment when I look at myself in the glass at once absolutely real, connect-ed with all the space that surrounds it, and absolutely unreal, since in order to be perceived it has to pass through this virtual point which is over there. ("Other" 24)

Transferred to the Royal Court production, the mirror as a material object juxta-posing visibility and intangibility complicated the audience gaze. Even if the mir-ror prohibited a purely pathologising audience gaze and was meant as a barrier to communicating directly with the audience, it is difficult to pinpoint if and/or when the audience in the Jerwood Studio looked *at* or *with* madness. This unde-cidedness of the gaze is a powerful visual and theatrical rendering of the instability and uncertainty that the *mise-en-page* anticipates. What is more, in the broken gaze lies the performance's epistemological moment. When audiences are confused by the strategy this can foster emotional knowledge regarding the sense of uncertain-ty that distorted perception might cause in mentally distressed people.

5.1.2 "Inscrutable doctors, sensible doctors, way-out doctors": Kane's Attack on Psychiatry's Authority

When it comes to Kane's attitude to mental health care, her work clearly contests "its cultural context" in Tompkins' sense (27), and indeed proves wrong 1980s critics who predicted the 1990s to become the "caring decade" after Thatcherism did substantial damage to the British National Health Service (Saunders, *About* 15). On the contrary, as the analyses of the plays in my study show, during the late twentieth and early twenty-first centuries, UK mental health care and national health services at large are still strained. Expressing such a pessimistic stance, Kane constructed an extensive, critical "hospital narrative" that had its starting point in *Cleansed* and continued in *4.48 Psychosis* (33).

The Foucauldian triad of seeing-power-knowledge is discernible in both plays (*Cleansed* and *4.48 Psychosis*), which suggests a concern for institutional structures that are designed to re-establish order by exerting their power. Kane's extreme depictions of such institutions as places of torture and suffering in *Cleansed* – char-acters are beaten up and executed, rats nibble at limbs, body parts are transplanted and sliced off – move towards the metaphorical and lyrical in *4.48 Psychosis*, but

the latter play is no less critical of institutional power (Sierz 112-13). Power-related aspects of institutional observation known from Harold Pinter's *The Hothouse* (1958/80), George Orwell's *1984* (1949) and conceptualised in Foucault's *Discipline and Punish: The Birth of the Prison* (1963) feature prominently in *Cleansed* and *4.48 Psychosis*. But *4.48 Psychosis*, with its resistance to straightforward theatricalisation of its content, takes her criticism of institutional power structures to the next level with her interrogations of "the status and staging of dramatic subjects" (Worthen 146). Thus, Kane makes a theatrical point about the possibility to present and describe, and by extension, to diagnose and cure mental disorder.

Regarding the representation of the patient experience, there is a paradoxical discrepancy between the text of *4.48 Psychosis* and its first stage production at the Royal Court Theatre in the year 2000 that reveals just how pervasive the notion of psychiatric power/knowledge even outside the clinical context is. Without limiting the play to its biographical references, undoubtedly, Kane brought her expert knowledge to *4.48 Psychosis*. Yet, while the interest in mental health issues was so prevalent for James Macdonald's production that he invited expert psychiatric advisers into the rehearsal room, the patient perspective was not considered at all in the process. Afterwards, Macdonald admitted that "[i]n retrospect I think we should have talked to more actual sufferers than we did, although it's an incredibly hard condition to describe from the inside – which is one of the things that makes the play so extraordinary" (Saunders, *Love* 124-25). The example of the rehearsal method reveals the creative team's interest in making meaningful statements about mental disorder. At the same time, it shows a surprising ignorance of the patient-perspective as expert knowledge. This is particularly noteworthy since the play abounds with hospital scenes.

The power/knowledge discourse in the play is mainly brought to bear in these mental hospital scenes. The patient experiences claustrophobia and subjection triggered by the confinement to both a hospital, which is no "curing machine" (Foucault, *Psychiatric Power* 102), and to her/his disordered mind. The scenes, like Penhall's *Blue/Orange*, reveal a "profound cynicism about psychotherapy's power dynamics and ability to change"(Watson 190) which goes hand-in-hand with Kane's more general critique of power structures and the biomedical model of mental health.

In a long monologue describing the patient's unease during the medical examinations and interviews, the scrutinising medical gaze of the observing doctors is perceived as a Foucauldian instrument of power:

> Dr This and Dr That and Dr Whatsit who's just passing and thought he'd pop in to take the piss as well. […] Dr This writes it down and Dr That attempts a sympathetic murmur. Watching me, judging me, smelling the crippling failure oozing from my skin, my desperation clawing and all-consuming panic drenching me as I gape in horror at the world and wonder

> why everyone is smiling and looking at me with secret knowledge of my
> aching shame. (*Psychosis* 209)

A strong sense of the anonymity of the doctor/patient encounter pervades these lines. The doctors have no names and they are many, highlighting that in Foucault's sense, mental health care is "a machinery that no one owns" (*Power/Knowledge* 156). Within this machinery, Kane fashions the patient as object under observation.

The aspect of perceptual power also comes into play when the patient recalls "[a] room of expressionless faces staring blankly at my pain" (*Psychosis* 209). S/he is an exhibit, an object to be scrutinised by a panel of anonymous experts who are interested in her/him as a specimen but not as a human being, reminiscent of Charcot's exposure of hysteric women for entertainment disguised as research and teaching. Moreover, like Foucault's medical gaze, the doctors "gain[] access to the object" ("looking at me with secret knowledge of my aching shame") (*Psychiatric Power* 2-3). However, in these lines, power and knowledge appear together, whereas Foucault notes that "medical authority, […] functions as power well before it functions as knowledge" (3), as seen, for instance, in the doctors' power battle in *Blue/Orange* in which the superior doctor takes decisions based on his superior position rather than expert knowledge, or in *Cleansed* where institutional power enables and justifies torture. By keeping their knowledge "secret," the doctors in *4.48 Psychosis* effectively establish a uni-directional power structure.

At the receiving end of institutional power/knowledge, the patient conveys a strong sense of passivity. Thus a lack of agency in the process of examination is hinted at in *4.48 Psychosis* ("Watching me, judging me," "everyone is smiling and looking at me with secret knowledge of my aching shame"). Kane provides insight into how difficult it is to put one's life into the hands of strangers and let them take crucial life decisions *en passant* ("Dr This and Dr That and Dr Whatsit who's just passing and thought he'd pop in to take the piss as well"). The patient's vulgar register is the only means of opposing "the secret knowledge" that s/he does not share although, paradoxically, s/he is the source of the "aching shame."

Kane's cultural work extends to challenging psychiatry's supposedly objective knowledge because she provides an *unfiltered* patient perspective, when the patient voices suspicion of the doctors' authority – a perspective missing, for instance, in *Equus* and *Blue/Orange*. To recall, in *Blue/Orange* the doctors appear increasingly less reliable but spectators potentially deduce this rather than Christopher saying it as explicitly as the patient in Kane's play. In *4.48 Psychosis*, a lack of trust in the doctors goes hand-in-hand with the patient questioning psychiatry's rational language:

> Inscrutable doctors, sensible doctors, way-out doctors, doctors you'd think
> were fucking patients if you weren't shown proof otherwise, ask the same
> questions, put words in my mouth, offer chemical cures for congenital an-

guish and cover each other's arses until I want to scream for you, the only doctor who ever touched me voluntarily, who looked me in the eye who laughed at my gallows humour spoken in the voice from a newly-dug grave, who took the piss when I shaved my head, lied and said it was nice to see me. Who lied. And said it was nice to see me. I trusted you, I loved you, and it's not losing you that hurts me, but your bare-faced fucking falsehoods that masquerade as medical notes. (*Psychosis* 209-10)

The voice aggressively questions the doctors' authority in this quasi-Foucauldian statement that suggests that power is often disguised as knowledge. The idea that doctors might just as well be patients in a different context "if you weren't shown proof otherwise," discursively arises in Penhall's *Blue/Orange*. As part of Kane's dramatic strategy of challenging normative thinking, the rebellious voice of *4.48 Psychosis* tells the audience directly and unflinchingly, thereby conveying a rawness and immediacy that might resonate with spectators.

Kane concludes her critical hospital narrative with a consultation scene towards the end of the play in which the enduring, stereotypical image of the doctor as a respectable pillar of society is challenged when the patient recalls: "I came to you hoping to be healed. You are my doctor, my saviour, my omnipotent judge, my priest, my god, the surgeon of my soul. I am your proselyte to sanity" (*Psychosis* 233). The almost god-like reverence of the doctor mocks the image of doctors as (demi-) gods in white coming to rescue their patients. The image of the "surgeon of the soul" echoes Martin Dysart's ritualistic nightmare of carving up children in *Equus* and is also adopted in *The Effect* by Toby, who draws up an opposition between psychiatry (his field) and surgery (his father's field). That the patient is failed is as undoubted at this point of the play as is the idea that doctors are by profession necessarily respectable and ethical.[61]

Charlotte Gwinner's Sheffield Theatre production formally created the observation scenario by performing on a "bald uninviting stage" in the Crucible Studio with spectators placed around the square stage (and close to the actors) on three sides and on the gallery from which the spectators looked down on the stage, bringing the discussion once again back to the Charcotian lecture hall with all its implications and dynamics (Sharp). Like a reversed *panopticon*, the stage turned audiences into observers of the anguish on stage and made them part of the machinery that was designed to objectify madness in order to create the secret knowledge the patient worries about. At the same time, in line with a strategy to have audiences look *at* madness rather than *with* it, the production favoured a pathologising audience gaze.

Depending on production choices, the critique of the medical profession can be enhanced or subdued, and many productions of *4.48 Psychosis* do not visually

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[61]   Dr Henry Jekyll in Robert Louis Stevenson's *Strange Case of Dr Jekyll and Mr Hyde* (1886) and Doctor Stockmann in Ibsen's *An Enemy of the People* (1882) are cases in point.

evoke a mental hospital in their *mise-en-scène*. While the productions at the Royal Court and in Sheffield did not suggest a mental institution or doctor character in setting or costume, Fourth Monkey's production at the Edinburgh Festival in 2012 explicitly set the play in a hospital with all actors wearing hospital gowns and the doctors "play[ing] a prominent role, whether they be understanding or evil, and are made up and physicalised to appear terrifying" (Aloess). Locating the doctors' representations in contemporary reality through costume and rendering them as terrifying is a powerful statement against the psychiatric profession. Due to the vocal patient, the doctor-patient scenes in themselves are a clear indication of Kane's scepticism of mental health care even if the psychiatric context is not realised visually on stage. Foregrounding the play's hospital narrative visually, however, might take away from the play's profound engagement with deep-rooted identity questions, particularly with questions of what it means to be, to treat, and to be treated human(ly).

Kane's criticism of mental health care extends to the question of treatment, especially to "the chemical cures for congenital anguish" (*Psychosis* 209). At the same time, gallows humour is derived from enumerating the failed attempts at finding the right medication for the patient, who renders them all pointless by stating: "There's not a drug on earth [that] can make life meaningful" (220). While the quasi-naturalistic litany of medication locates the play within medical practices of applying a biomedical model to mental illness, the enumerations of countless drugs are almost devoid of meaning and overpowering, especially for a layperson. This confirms that content (message: drugs do not make life meaningful) and response (the lists are meaningless) mirror each other. Not only is the patient fashioned as a specimen that is extensively observed but also the amount of medication that is tried in vain gives the impression that s/he is a guinea pig of psychiatrists who do not seek a holistic but a trial and error-approach to her/his condition. Yet, the scene in which most of the medication is mentioned does not lack black humour and some of the patient's reactions do not seem overtly out of the ordinary given what s/he is going through. One is tempted to say that a comment such as "Paranoid thoughts – believes hospital staff are attempting to poison her" (224) is not inaccurate because some of the side effects suggest similar reactions to poisoning, even if the hospital staff would not deliberately make the patient feel worse.

> Fluoxetine hydrochloride, trade name Prozac, 20mg, increased to 40mg. Insomnia, erratic appetite, (weight loss 14kgs,) severe anxiety, unable to reach orgasm, *homicidal thoughts towards several doctors and drug manufacturers*. Discontinued. (224; my emphasis)

Kane subversively turns against the psychopharmacological industry, particularly against the use of Prozac, the 'wonder drug' of the early days of SSRIs despite its potentially debilitating side-effects (Sharpe 871-73). The most demoralising con-

clusion of the 'medication scenes' is that the patient eventually refuses further treatment and tries to kill herself. Undeniably, Kane's suicide adds a tragic subtext to this critique.

As proof of the reciprocal relationship between theatre and mental health care, Kane's thematising of suicide resonates with and has caught the interest of mental health experts such as Ian Marsh, who, in his interdisciplinary book *Suicide: Foucault, History and Truth*, dedicates a chapter to the analysis of *4.48 Psychosis* as the "suicide note" Kane's agent Mel Kenyon and critic Michael Billington declared the play to be (Urban, "Ethics" 44; Billington, "Suicide Note"). By drawing on Foucault's explications on the constitution of self, Marsh, who is concerned with the discursive history of suicide, concludes that the play can be read as "a historically situated cultural product, constructed, in large part, from psychological and psychiatric discourse. From this perspective, the play can be interpreted as exemplary of contemporary representations of suicide – individual, private and pathological in nature" (Marsh 196).

Marsh's notion of a "historically situated cultural product" refers to the play's epistemological dimension. If the play is to an extent inspired by Kane's own experience of clinical depression, she clearly possessed expert knowledge about mental health care provision and its failings, and thus added an important subjective layer to the play. Reviewer Ian Shuttleworth goes as far as saying that *4.48 Psychosis'* "portrayal of acute clinical depression is the most unadulterated I know" (n.p.).

Arranging the various discourses in such a confusing manner that the order is essentially arbitrary, on the one hand, challenges psychiatry's claim to the existence of objective mental health knowledge. On the other hand, Kane's resistance to providing a linear narrative of mental disorder is the reason for what Shuttleworth rightly calls authenticity. After all, as the word 'disorder' suggests, mental distress is characterised by confusion and fragmentation. Set against this sense of confusion is the title-giving time of night. The patient repeatedly wakes up at 4.48am (*Psychosis* 207, 213, 223, 229, 242). However, s/he does not perceive waking up as negative, but calls it "the happy hour when clarity visits" (242). Moreover, s/he claims that "At 4.48 when sanity visits for one hour and twelve minutes I am in my right mind" (229). Ultimately, the hint at a normative concept of illness and health is rendered meaningless, however, because the patient is not able to sustain this sense of 'normality' and being 'right in one's mind' any longer than the 72 minutes mentioned. Depending on the performance, the 72 minutes mirror the time that the play takes, which again confirms how form/theatrical rendering and content are inextricably linked. Moreover, if performances take 72 minutes, this confirms the idea that *4.48 Psychosis* is heterotopic because when performed in real time, the levels of the real and the imagined merge.

Some critics saw the play's ending, particularly the way it was staged at the Royal Court in 2000, as indicative of the fact that the play was not as bleak as

others suggested (Saunders, "Just" 105). Firstly, some of the final words seem to betray Billington's "suicide note"-reading because the patient claims: "I have no desire for death/no suicide ever had" (*Psychosis* 244) which negates claims that the play is a mere 'suicide note.' The play's final line "please open the curtains" (245) was acted out at the Royal Court by opening a window in the theatre roof in order to allow the light back in, inspiring Saunders' following comment: "This sense of something passing is important, for with the entry of the outside world (and perhaps exacerbated by the knowledge that Kane committed suicide after *4.48 Psychosis* was written), it becomes an exorcism of sorts for the audience" ("Just" 102). The shift from catharsis, as the feeling classic tragedy was supposed to unleash, to exorcism is crucial because it points to the haunting nature of Kane's play. Even if this depends on the individual spectator and how they relate to the play, one might feel haunted at the end rather than relieved due to the subject matter and the theatrical interpretation. Depending on production decisions as well as on the available theatre space, the haunting effect can be exacerbated. It is easy to see how a small theatre space would enhance feelings of confinement and distress. Both the Royal Court's Jerwood Theatre and Sheffield's Crucible Studio are cases in point. Michael Billington, for instance, recalls the atmosphere in the small auditorium of the Jerwood Theatre accordingly: "the audience watches in near-silence: lovers clutch each other for comfort, someone quietly weeps" ("Suicide Note"). And yet there was a significant difference in the two productions. Unlike in London, in Sheffield there were no curtains that could have been opened. The not-opening of curtains suggested a much less hopeful ending even if the absence of curtains merely had practical reasons. There was neither street noise nor the soothing sense that outside life continued, which made the experience of watching much bleaker. Walking out into a dark and rainy March night enhanced the effect and made the darkness so often associated with mental distress more visceral (*Psychosis* performance).

Returning to the initial question of the epistemological aspects of *4.48 Psychosis* as a mental health play, it can be concluded that by employing the outlined strategies, Kane makes the lived experience of mental distress visible and painfully tangible. The play's fragmentary nature highlights the fact that it is for and about all of us, as creative teams and spectators have to fill in the blank spaces that the play leaves and may find that not every void can be filled. At the same time, it makes for an uncomfortable viewing experience because it confronts audiences with truths that one is rarely exposed to. Fragmentation, however, does not equal foregoing clarity. The play's most illuminating moments are to be found in Kane's frank addressing of the harrowing nature of mental distress and in forcing the audience to confront and live through, if only for the duration of the performance, the despair that is so often linked with mental disorder. In the next part of the chapter, colours, sounds, and excess bordering on mania but also an underlying threat, mark the madness that Anthony Neilson makes visible on stage before

breaking the illusion with a large rupture that reveals Neilson's formal experiment with mental disorder.

5.2 "It's Like the Sirens": Mania Versus Medication in Anthony Neilson's *The Wonderful World of Dissocia* (2004)

The second play analysed in this chapter follows a different dramatic strategy to that of Sarah Kane and yet Anthony Neilson shares the same interest in wanting to bring mental distress to the stage in an experiential and visceral fashion with a focus on form mirroring content. The Scottish playwright and director's radical work of the 1990s is marked by dramatic extremes, explorations of identity politics, and a sustained interest in experientiality, as labels like 'in-yer-face' and 'new brutalist' theatre (Nikcevic 255-72) that have been applied to his work (but firmly rejected by him) suggest (Bull, "Neilson" 359). Particularly Neilson's taboo-breaking plays *Normal* (1991), *Penetrator* (1993), *The Censor* (1997), and *Stitching* (2002) created a stir when first performed and are often grouped together, before his work took a turn towards more surreal dramatic realms (see, for instance, the table of contents of Reid's study *The Theatre of Anthony Neilson*).

The play at hand, *The Wonderful World of Dissocia*, premiered at the Tron Theatre Glasgow and opened at the Royal Lyceum Theatre as part of the 2004 Edinburgh International Festival.[62] It was revived by the National Theatre of Scotland in 2007 in collaboration with Drum Theatre Plymouth and toured the UK thereafter. Together with its companion pieces *Edward Gant's Amazing Feats of Loneliness!* (2002) and *Realism* (2006), it marks a move away from showing violent images on stage into more surreal and absurdist territories and towards formal experimentation (Reid, *Theatre* 67). Particularly with *Realism* (2004), as well as with *4.48 Psychosis*, it shares the exploration of "the darker side of the human psyche" (Sierz 68). All three plays are indicative of Neilson's challenges of theatrical conventions and normative categorisations, respectively. In addition, all three show "[h]is interest in the mechanics of storytelling in the theatre – or indeed storytelling *as* theatre" (Reid, *Theatre* 68). With the emphasis on story-telling, Neilson clearly takes a different route than Kane, who in *4.48 Psychosis* is not overtly interested in narrative and plot.

The focus on narrative should not distract from and is, in fact, intertwined with Neilson's implicit socio-political agenda. While Trish Reid in the first full-length study of Neilson's work takes his assertions to be apolitical seriously, she cogently argues that his plays can and should be considered "for their implicit political biases. These are as likely to manifest in formal experimentation as in

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[62] The play will be referred to as *Dissocia* from here.

choice of subject matter" (*Theatre* 7). The politics of *Dissocia* determine that the concept of 'normalcy' is scrutinised on both the form and content levels, or, as Anna Harpin puts it, the play is "engaged in a project of defamiliarising psychological normalcy in ways that have radical implications for the politics of mental health" ("Dirty" 173). Neilson, like Kane, is deeply invested in exploring the "problematics of dramatizing internal landscapes" not only in *Dissocia* but also in *Realism*, which points towards an underlying agenda that has gained socio-political momentum insofar as questions on the internal landscapes of the distressed mind have become increasingly politicised (Reid, *Theatre* 67).

By experimenting on the formal level with the idea of dissociation thematised on the content level, Neilson forces the audience into experiential engagement with the predicament of experiencing mental distress from the inside. In analogy to Urban's idea of *4.48 Psychosis* resembling a montage, the two distinct acts of *Dissocia* also present a montage in film theorist Sergei Eisenstein's sense that when two unrelated images are presented, "the human brain will make a connection and find a meaning" (M. Fisher, Review *Dissocia* 2004). In other words, the play's two distinct acts create a substantial rupture that requires audiences to fill in a large gap.

The two-acter's distressed protagonist Lisa Montgomery Jones has been going through a difficult period when the play sets in. She has a visitor, Victor Hesse, who bears a striking resemblance to Sigmund Freud, which adds an ironic twist to the character and visually locates the play within a mental health context; at least for spectators who make the connection. According to John Bull, the surreal Freud-like character allows the audience access to "two levels of consciousness: the world as magically conceived by Lisa in her disturbed and untreated state and the mundane realities of a material world that intersects and interacts with the world of Dissocia but never succeeds in denying its existence" ("Neilson" 355). This anchoring in the material world is essential for the play's heterotopic dimension and visceral effects. Hesse then gives Lisa a mundane reason for her state when he tells her that, on a recent trip to the United States, when crossing the Greenwich meridian, she lost an hour. The quest for finding the metaphorical lost hour in the land of Dissocia drives the first act but is interrupted before completion by an interval and followed by a vastly different second act. As the audience learns in the second act, the first act takes place entirely in Lisa's mind and is a journey to find reason.

Dissocia is a surreal place full of absurd characters and, not least due to its symbolism, reminiscent of Lewis Carroll's *Alice in Wonderland* stories (1865 and 1871), Frank Baum's *The Wonderful Wizard of Oz* (1900), particularly its iconic filmic adaptation of 1939, and Alfred Jarry's *Ubu Roi* (1896) (Bull, "Neilson" 356). These intertextual references are used throughout the play and serve two purposes: firstly, like the Freud character Victor Hesse, they are another indication of the two levels of consciousness present in the play because whenever a reference is

made and recognised by spectators, this serves as a reminder of the outside material world (356; see also Harpin, "Dislocated" 196). Secondly, they contribute to the play's theatricality in the first act. After the much longer first act full of colour, music, dance, but also menace and confusion, the second act takes place on a mental hospital ward where Lisa has to recover. Her boyfriend Vince and her sister Dot visit; doctors and nurses walk in and out to administer medication but there is hardly any action, creating the starkest possible contrast to the first act.

5.2.1 Implications of Form Mirroring Content

The notion of dissociation that the play's title *Dissocia* suggests, is analogous to the fragmentation in *4.48 Psychosis* and refers to the dissociative nature of the play's form with its two-part structure. The two contrasting acts, according to Neilson, constitute a meditation on the question "Why would a patient resist medication?" (Interview). Directed at experiential engagement with the question, Neilson's play largely subscribes to Artaud's notion that "[t]heatre, which is nothing, but uses all languages (gestures, words, sounds, fire and screams), is to be found precisely at the point where the mind needs a language to bring about its manifestations" (7). Neilson's play is a particular mixture of the dramatic languages Artaud declares to be constitutive of theatre in such a way that the relationship between audiences and stage is marked by a deliberately puzzling combination of double consciousness, theatricality, and experientiality. Both acts reflect Lisa's internal states but only in the first act audiences look *with* madness while in the second act a pathologising method of looking *at* madness is employed. This only becomes clear retrospectively when the spectators start looking *at* madness in the second act resulting in a delayed rupture, as the playwright explains:

> The aim was always to provide an 'experiential' understanding of Lisa's situation. The first act is deliberately too long and eventually quite irritating, so that the audience would be quite glad of an interval and pleasantly surprised by the change of scene. But the almost total withdrawal of stimulation in the second act leaves them craving a return to the "sugar-rush" over-stimulation of the first. (Neilson, Interview)

While it is true that the play's first colourful half might be considered more entertaining, the rupture might also lead spectators to critically evaluate the fun they had watching the first act. In fact, spectators of the play's revival at the National Theatre Scotland in 2007, when interviewed after the first act, called the performance "really funny" and commented that "I'm looking forward to the second half" (National Theatre of Scotland). At the end of the performance, other spectators pointed out that the play was like "two different plays," "poignant and sad and horrific," and many picked up on its mental illness context (National Theatre of Scotland).

The play's title, like Kane's *4.48 Psychosis*, suggests that it is about a particular mental health condition, a dissociative disorder, although the term is never mentioned in the play. Because of its two halves, critics have also compared it to the state of manic depression with Act I reflecting mania and Act II depression (M. Fisher, Review *Dissocia* 2007). Yet, I would argue that it does not matter which particular condition is depicted as this would only serve to underscore a sense of otherness or othering that Neilson wants to avoid (Neilson, Interview). Rather, it is crucial that the play places audiences "alongside its heroine rather than at an objective distance from her" (Reid, *Theatre* 78). Neilson's dramaturgy emphasises, then, the elation felt by Lisa in the first act, whereas in Act II, the "dramaturgy is so ponderous and subdued that it mimics Lisa's experience of being medicated" (78). Miriam Buether's stage design for the world premiere in 2004 and the revival in 2007 realised Neilson's ideas by achieving the split with a colourful wallpapered first act setting against an all-white setting in the second act that was further accentuated by costume and lighting (M. Fisher, Review *Dissocia* 2007). The hospital room was entirely contained in a box behind a front of clear perspex following Neilson's strategy to "achieve the maximum realism" against the stylised and fantastic set-up of the first act (*Dissocia* 74).

While Neilson in the second act uses the "fairly standard spatial metaphor of institutional enclosure – the psychiatric hospital" (Reid, *Theatre* 74) marking this difference explicitly is part of his strategy to highlight that "realism [is] imperfect in its capacity to capture *any* state of mind" (79). Reid thus extends Harpin's comment that "[r]ealism is limited in its ability to capture unusual states of mind" and that in realist dramatic depictions "dominant categories of normal and abnormal behaviours" are merely repeated because these normative categories help to establish in the play world who is mad and who is not ("Dislocated" 189).

Neilson's realism in the second act establishes Lisa as mentally ill but it is not a supposedly realist depiction of a mad state that allows the audience to draw the conclusion that Lisa is mad. Rather, it is the realist hospital setting that contextualises Lisa's state. This differentiation is crucial because it will make the audience reflect not only on beliefs they might hold regarding mental illness but also on the theatre as a medium for conveying these effects (Reid, *Theatre* 74). At the same time, despite the fact that the second act has realist traits, "*Dissocia* is far from being a didactic thesis play," that is, the second act does not constitute the antithesis to the first (82). Neilson explains:

> Dissocia was a breakthrough for me in that (I believe) I managed to achieve with form what I had previously only achieved with content, in that the entire structure of the play was designed to force the audience into at least analogous identification with the protagonist, Lisa. Hopefully, when she is asked in the second act why she doesn't take the medication that will suppress the symptoms of her mental illness, the audience – having been deprived of the spectacle of the first half and of any conclusion to its narra-

tive – *will understand on a visceral level why she is drawn to her condition.* (Foreword; my emphasis)

This statement shows that Neilson relates to a notion already touched upon in previous chapters, namely the idea that his play tries to communicate the seemingly compelling aspects of certain mental conditions. The notion emerges when Susan's imagined family provides a haven from her drab reality in *WiM*, when Harper in *Angels* prefers to spend time with Mr. Lies in Antarctica to find relief, and when Alan's worship of Equus seems more desirable than sanity – even to the psychiatrist. Yet, rather than suggesting that mental illness is a choice, Neilson's approach shows more nuance because he problematises "normative attitudes to sanity and madness" (Reid, *Theatre* 80), particularly the binary's black-and-white character. Most importantly, Neilson's special emphasis of the visceral level on which emotional engagement takes place in theatrical performance reveals his belief in the virtue of emotions that are not regulated by medication.

Neilson's criticism of psychopharmacology problematises a central question that arises in cases of mental illness, namely that of agency and of taking one's own decisions. Confirming that the emotional overload of the land of Dissocia might be preferable to the numbness of being medicated, Lisa confesses to Vince at the end of the play: "You know what it is: it's like the Sirens. […] They sit on the rocks and they sing to the sailors. And what they sing is so lovely it's like … they're hypnotized. They know if they sail to them their ship's going to get all smashed up. But they think it's worth it, you know – for the song" (*Dissocia* 88). Neilson uses the simile of the sirens to explain that taking a decision for or against medication is far from straightforward. Susan in *WiM* explains in similar terms but with a crucial difference: "I know … that somehow … like those genies that live in bottles, you know … If I can only keep them from getting out … I'll be all right. They mustn't get out … Whatever happens … " (*WiM* 67). The differing qualitative connotations of the sirens (as positive because they are enticing) and genies (as negative because they are a threat) are a significant marker of the politics of normalcy evoked in Ayckbourn's and Neilson's plays. As a matter of fact, Neilson's play has been criticised, for instance by Billington, for "the assumption […] that there is something life-denying about the curative treatment of mental disorder – a notion that strikes me as a late-1960s sentimental fallacy" (Review *Dissocia*). While on the surface it might seem like Neilson supports notions often simplistically attributed to anti-psychiatry, as Billington claims, i.e. that mad people have more insight into the human condition, Neilson balances out the idea that mental illness is compelling by the intense and potentially disturbing theatricality of the first act as well as by the politics of agency addressed in the second act.

To start with, the first act appears too long and might have an almost annoying effect on the audience, mirroring Lisa's inability to cope with her condition any longer. Furthermore, it is not all fun and games in Dissocia, as Lisa encounters menace and threat, for instance, when Goat attempts to rape her and when Disso-

cia's inhabitants deliberately boycott the search for the lost hour, much like Susan's imagined family trying to lure her away from her 'real' family. The cheerful character of Community Crime Initiative worker Jane, who is employed to endure all the crime committed in Dissocia, also embodies the contradictory nature of Dissocia and adds to the *dramatis personae*'s surreal elements. When she comes to Lisa's rescue from Goat, the scene turns into a nightmarish scenario that ends in Lisa screaming: "I hate this place, I hate it! I hate it and I want to go home! I want to go home! I want to go home!" (*Dissocia* 45). Apart from the double-consciousness reminder to the audience (Dorothy in *The Wonderful Wizard of Oz* famously wants to go home), the scene suggests that despite the fact that Lisa entered Dissocia at her own volition (hermeneutically speaking, this means she decided not to take medication), her agency over her state is limited. Dissocia is at war, too, the "Black Dog King," a pun on Winston Churchill calling his depressive episodes "visits by the black dog" (Bull, "Neilson" 356), fights against "Divine Queen Sarah Of the House of Tonin," a Lewis Carroll-like word play on serotonin, the mood-regulator in anti-depressants (M. Fisher, Review *Dissocia* 2007). Both are metaphors for Lisa's state and, by extension, represent her mental states in the two acts, as well as the agony of being torn between these two extreme states. Lisa's torment in both acts suggests that, ultimately, the extremity of the black (mental disorder) and the white (medication) of mental illness are equally undesirable.

The scene in which Lisa's sister Dot visits her in hospital in the second act adds to the discussion of agency the aspect of blame also touched upon in the analysis of *Equus*, when Dora Strang denies any responsibility over Alan's crime. With her quasi-monological rant, Dot represents the unfeeling relative and her accusatory tone disregards the fact that Lisa's agency is limited; instead, she blames her for the inability to take medication: "And all that because you can't manage to take a few pills twice a day. […] I mean, do you want everyone to think you're some sort of nut-case. I know you're not, but that's what people think and you can't blame them" (*Dissocia* 82). Following Dot's logic, one might ask that if it is true that people cannot be blamed for being unnecessarily judgmental, Lisa can then be blamed for her condition. It is a valid question Neilson leaves hanging in the balance.

Vince's response to Lisa's explanation of her state adds to Neilson's strategy of confronting the audience: "That thing you said. About the Sirens. *Pause.* I understand that. That's how it is for me, with you" (89). In essence, in contrast to Dot, Vince tells Lisa that he can relate to acting against what seems objectively right. The enduring comparison of love with madness, like, for instance, in Prebble's *Effect*, serves the purpose of challenging the audience's conception of normalcy because the intensity of being in love to the point of feeling like a different person (both in the positive and negative sense) is a sentiment potentially known to many.

5.2.2 Why *Dissocia* is a Mental Health Play

Returning to the play's title and Neilson's (supposedly implicit) socio-political agenda, it is justified to return to the point that *Dissocia* is a mental health play. Interestingly, when asked if his play was about mental illness, Neilson stated in an interview with playwright Mark Ravenhill: "That would be presumptuous. This is more like *The Wizard of Oz* or *Alice in Wonderland*, something that might be analogous to mental illness. In many ways, it's an experiment in form" (Ravenhill). Echoing the question, the critical spectrum of Neilson's play ranges from calling it "a subtle meditation on the nature of mental illness," as Mark Fisher has put it (Review *Dissocia* 2004), to Michael Billington explicitly calling the 2007 revival a "play about dissociative identity disorder" (Review *Dissocia*). Consultant child and adolescent psychiatrist Iain McClure, who reviewed the Edinburgh production in 2004, more tentatively judged that "[w]isely, Neilson has not fallen into the potential trap of staging madness from the medical perspective," and praised the "significant moments of moving lyricism and compassion for the human predicament" (690). Considering Neilson's comment alongside the discordant critical reception, it seems that the interconnectedness of the form and content of his experiential piece has different effects. As the analysis of Sarah Kane's play has shown, experimenting with form and writing a play about mental illness are not mutually exclusive tasks. It is precisely the fragmented form of *4.48 Psychosis* that reflects the fractured sense of self when experiencing psychosis.

Picking up on Billington's comment, it is worth asking if the two acts of *Dissocia* somehow represent the experience of dissociative disorder. According to the *DSM-IV*: "The essential feature of the Dissociative Disorders is a disruption in the usually integrated functions of consciousness, memory, identity, or perception of the environment" (American Psychiatric Association 477). So, first of all, there is no one dissociative disorder as Billington suggests but a range of disorders. The aspect of disruption features in the play: on the content level, Lisa's quest for finding her lost hour represents her search for an identity that also appears to be lost. Moreover, the distorted land of Dissocia with its insecurity guards, violent scapegoat, and singing polar bear stands for Lisa's disrupted perception of the world. What is more, on the level of form, the abrupt ending of the first act and the radically different second act disrupt the play's narrative.

Not only does this tie in with the notion of dissociation but also with the idea that narrative in postdramatic pieces is often disrupted, as Hans-Thies Lehmann states in his seminal study *Postdramatic Theatre* (16). While *Dissocia* is not a postdramatic piece in the purest sense, Reid argues cogently that "Neilson's postdramatic strategies can be read as deliberately drawing attention to, and problematizing the politics of representation itself" ("Deformities" 493). Neilson's critique of representation encompasses showing mental distress as a multi-faceted phenomenon in two distinct acts, whereby he pursues the argument that thinking in binaries is a reductive undertaking and neigh on impossible when mental health is concerned.

Hence, it is crucial that the play does not represent dissociative disorders as such and that it is not about dissociative identity disorder, as Billington claims. Rather, Neilson formally experiments with the notion of dissociation that often accompanies mental distress and combines it with stereotypical ideas about mental disorder as well as with comments on the mental health care situation in the early 2000s.

Ultimately, the monotonous second act neither necessarily outweighs the overstimulation of the first act nor does it deconstruct it. Neilson achieves balance because the extremity of the first act is compromised by the inertia of the second one. As a result, despite his comments on the effects on audiences, the play is not prescriptive but leaves it to the spectators to decide which of the acts, and by extension, which of the states (the manic versus the medicated one) is more compelling. Most importantly, Neilson's formal experiment generates experiential knowledge of the ups-and-downs of mental distress rather than a factual understanding of a particular mental health condition. Returning to the idea of the play as a montage, only in connecting the two acts, meaning will be made.

5.3 Chapter Conclusion

In the two plays analysed in this chapter, mental distress is a certainty that does not need to be established. While the plays' titles imply engaging with two particular conditions, psychosis and dissociative disorders, the focus is not on depicting these (accurately) as mental illnesses but on conveying a sense of the experience of mental distress to audiences. Thereby, the playwrights seek to respond to the conundrum of *qualia* and the question what it is like to have someone else's experience without othering the mentally ill characters.

In answer to the conundrum, making the invisible landscapes of the disordered mind visible has unsettling effects in both plays. In order to achieve these, form mirrors content in both cases but by adopting differing strategies. For considering the implications of Sarah Kane's fragmented play, it is essential to differentiate between the textual and performance levels because fragmentation is much more obvious on the page but relies on performance decisions when it comes to making it visible on stage. Neilson's *Dissocia* with its two radically different acts much more straightforwardly embodies and acts out a sense of dissociation, as suggested by its title.

Challenging the audience gaze is not a question of positioning the spectators around the stage, as in previous case studies, but in performances of *4.48 Psychosis* other strategies, such as a tilted mirror and breaking the fourth wall, were implemented to achieve a particular brokenness of the gaze. With its different structure and regardless of staging, *Dissocia*'s two distinct acts formally juxtapose looking *with* and *at* madness and thus break the gaze. The broken gaze can make audiences feel powerless, confused, and deeply afflicted. As a result, emotional knowledge

can be generated in performances. Audiences learn about mental distress that it singles out human beings and makes them feel misunderstood and alone.

Criticism of mental health care is intrinsic to Kane's and Neilson's theatrical strategies but only as part of the overall project of externalising mental distress on page and stage. Both plays, while building on haunting depictions of mental distress, do not present psychopharmacology as palliative or even curative. As a means of counteracting psychiatry's objective knowledge, the playwrights do not claim to have any answers to the question how best to live with mental disorders – Sarah Kane's suicide brings a tragic response. As mental health plays, both pieces have profound counter-discursive aspects that have the potential to radically challenge the current mental health discourse. With its focus on uniting auditorium and stage, the final chapter considers two recent mental health plays that seek to provide tentative answers by placing mental distress right at the heart of the community.

6 Democratising Madness: Socially Engaged Mental Health Plays

This chapter analyses two plays, Ridiculusmus' *The Eradication of Schizophrenia in Western Lapland* and Duncan Macmillan's *Every Brilliant Thing*, that are representative of contemporary plays and performances seeking to radically re-define how mental illness can be depicted and viewed. Both plays operate with the idea that it is possible to democratise mental illness in the sense that they actively strive to remove the stigma and taboo so often attached to disorders of the mind. The "hard problem" of consciousness (Chalmers) introduced in chapter 5 resurfaces in the following argument. However, Ridiculusmus and Macmillan approach the problem from an ethical standpoint in order to raise awareness of the moral responsibility to respect rather than outright condemn otherness. Building on Christopher Dingwall-Jones' and Matthew Ratcliffe's work, the two plays call for "radical empathy" towards mental illness (Dingwall-Jones 48-61, see also Ratcliffe 473-95).

As pointed out in the introduction to this study, mental health has increasingly received public attention over the past thirty years. Britain's first Minister for Loneliness was appointed in January 2018 to account for the fact that the challenges of modern life can lead to mental health problems, which can, by extension, become a public health concern (John). Efforts have been made by UK-

based organisations such as Time To Change, Mental Health UK, and Mind to foster a more open and democratic approach to mental illness. Other activist groups like Mad Pride and MindFreedom International, which originated in the US and now operate globally, alongside academics who focus on Mad Studies, have reclaimed the term 'madness' despite its negative connotations (Harpin, *Madness* 2-3). The strategies of large UK-funding bodies such the Wellcome Trust have supported impact-driven mental health awareness projects whereby the idea of a 'third culture,' in which the arts and sciences can develop and sustain productive and synergetic relationships, has also gained recognition (Wellcome Trust).

The two plays discussed here strive to democratise madness on the levels of plot and form, and foster an atmosphere in the auditorium that opens up a playing field on which audiences, too, can become active players rather than just active observers. This demands 'emancipation' in Jacques Rancière's sense as well as physical presence from audiences. In this sense, during performances the theatre space constitutes a heterotopia, "not of illusion, but of compensation" because it is "a space that is other, another real space […]" (Foucault, "Other" 27). Considering the idea of a democracy, this heterotopic space enables challenging notions of perception and psychiatric power/knowledge in order to create a dialogue between stage and audience that engages audiences cognitively as well as physically. The utopian aspect that constitutively accompanies the concept of heterotopia refers to the plays' negotiations of how madness is perceived and classified (24). Both plays evoke scenarios in which it is possible "to share experiences of meaning making and imagination that can describe or capture fleeting intimations of a better world," as Jill Dolan has it (2). A better world can be understood as a world in which the experience of mental illness is not automatically accompanied by exclusion and disadvantage but where dialogues and change are possible.

The metaphor of a dialogue was used by C. P. Snow in *The Two Cultures and the Scientific Revolution* (1959) and *The Two Cultures and a Second Look* (1984) in order "to articulate his vision of how to unify the sciences and the arts and humanities," as Kirsten Shepherd-Barr points out in *Science on Stage* (45).[63] Anna Harpin also draws on the notion of dialogue when she articulates her critique of contemporary psychiatric practices as solipsistic whereas art "invites a dialogue that is not closed but rather wilfully attends to depths and breadths of experience" (*Madness* 5). In keeping with the two definitions, both plays enter into a complex dialogue with current psychiatric practices as well as with audiences, and serve as a mediator between the two. In other words, 'the autopoietic feedback loop,' that is, the "bodily co-presence of audience and actors" in performance, in Erika Fischer-Lichte's terms, is built into the plays' textual fabrics with the aim to democratise madness (*Transformative Power* 38). In performances and afterwards it is actualised because audience members and actors are co-creators of meaning (38).

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[63]   Even if the 'third culture' is now a highly contested concept, links with debates around the term are by no means accidental. For a critical evaluation of the concept, see Brockman.

The notion that theatre can democratise madness rests on the assumption that "politics and performance have always been intertwined," advocated by theatre and performance scholars like Jill Dolan (3). The idea of democratisation through artistic expression arises in Henrik Ibsen's work (Durbach 124-38). Ibsen insisted on letting readers and theatre audiences participate in the creative process of meaning-making (Ewbank 14). Most importantly, Ibsen's radical dramaturgy aimed at uncovering what he perceived as social ills, giving his work a lasting political relevance which still substantiates "the status of drama as a medium of expression, and its status as an experimental laboratory for social thought and social change" (Esslin 72).

In the twentieth and twenty-first centuries, political theatre invested in social change has been represented by Bertolt Brecht's epic drama, *agitprop*, Augusto Boal's forum theatre, as well as by socially and politically engaged performance art, such as Richard Schechner and the Performance Group or experimental theatre company The Wooster Group. Fischer-Lichte, for instance, uses as examples strategies of role reversal and the disruption of frames in performance art by Schechner and the Performance Group in the 1960s and 1970s, as well as by Christoph Schlingensief in the 1990s, to make a case for how performances can renegotiate notions of democratisation (*Transformative Power* 40-51). Similarly, building on the assumption that the community in the theatre space fosters democratic engagement with the chosen politically or socially relevant topics, devising plays and performances in the context of applied theatre has become increasingly popular. Highlighting the importance of opening 'closed doors' – a metaphor for the stigma of mental illness – researchers Persephone Sextou and Paul Patterson describe their approach to devising inclusive mental health performances as follows:

> Similar to Ibsen's dramaturgy, we aimed to democratise mental illness on stage: using the dramatic conventions to bring onstage what is often hidden behind closed doors, encouraging public dialogue and raising social awareness about mental illness, individual distress, and gaining insight into people's relationships, which is also a psychological interest. (2)

Myriad recent British theatre productions and performance artists focus on mental health-related story-telling in a 'quasi-confessional' mode and thus provide insights into individual psyches: in his live art practices, James Leadbitter (also known as 'the vacuum cleaner') recalls his experiences with British mental health care and calls for a radically reformed asylum system (Harpin, *Madness* 45-77; see also DisabilityArtsOnline). Kim Noble, an artist and activist, creatively engages with her Dissociative Identity Disorder (kimnobleartist.com), and American actress and campaigner Ruby Wax started the charity Frazzled Café (frazzledcafe.org), which provides a space for open conversation about the experience of mental illness. Critically acclaimed performance artist Bryony Kimmings' piece *Fake It Til You*

Make It is another case in point.[64] The Edinburgh Festivals 2014 and 2015 boasted a plethora of performances based on personal experiences of mental illness, owing to the festival's status of platform for fringe and experimental theatre and performance. The Sick Of The Fringe gala 2015 also brought together artists, scientists, and audiences in order to foster communication between the performing arts, the sciences, medicine, and audiences.

Knowledge transfer through collaborations of the performing arts and sciences has become increasingly important over the past decades and a whole range of performance departments in the UK and the US now teach and devise research-based work (Heddon and Milling; see also Somers). Performer-activists and performer-academics such as Anna Deavere Smith, Anna Harpin, Anna Furse, and the above-mentioned Persephone Sextou and Paul Patterson create mental health-related performance art and conduct research-in-practice in order to bring topics such as women's mental health, the untold history of the British asylums through first-hand accounts, and interpersonal relationships in bipolar disorder into the public eye. Harpin is one of the first scholars to frame critically the kind of psychiatry-critical and socially engaged mental health drama that this chapter is concerned with in her recent volume *Madness, Art, and Society: Beyond Illness* (2018). In it, Harpin contends, along similar argumentative lines to such figures as R. D. Laing and clinical psychologist Peter Kinderman, that contemporary psychiatric practice is inherently flawed and "that art illuminates the generative capacity of madness and helps us to understand its manifestations as acts of political expression" (Harpin, *Madness* 2).

Against this backdrop Ridiculusmus' and Macmillan's plays have emerged both as creative responses to the topics of psychosis and suicide, respectively, and out of personal experiences with mental health. Added to that, both projects are deeply invested in showing that "there is profound value, meaning, and insight in madness that can teach us how to live better with ourselves, and each other, if only we would take the time to properly listen and to care," as explained by Harpin (*Madness* 2). In an interview with HBO ahead of the production of a documentary on *Every Brilliant Thing* in 2016 (filmed at Barrow Street Theatre New York in 2015), Macmillan made a reference to the gendered underpinnings of mental illness when he explained: "We felt it was important to do something that is very rare for Brit-

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[64]   Kimmings' project was co-commissioned by the Southbank Centre London and Theatre Works in Melbourne, premiered at the Edinburgh Fringe in 2015, and repeatedly toured the UK afterwards. In the autobiographical piece, Kimmings and her then partner Tim Grayburn depicted their changing relationship since she had learnt, after being in a relationship with him for six months, that he had hidden his severe clinical depression from friends and family for years. The performance collapsed boundaries between theatricality and reality by putting the real Bryony and Tim on stage and into the shoes of their former selves. The play was a profound exploration of the taboo topic of male mental illness and the artists hoped to provoke change with it by also speaking publicly about their work and relationship. The play is no longer performed after Kimmings and Grayburn ended their relationship in 2016 (Kimmings).

ish men, which is to talk about emotions. It had to be funny, and it also needed to be open and generous and inclusive of an audience and not scare people off." and "We wanted to take the stigma out of talking about your feelings" (HBO). Similarly, one critic remarked after a performance of Ridiculusmus' play: "It is an open door to understanding, which is the first step to removing the stigma around the condition" (Halford). To recall, mad and mentally ill people have always been ostracised from communities: in the middle ages mad people were removed from towns, in the Renaissance 'madmen' were sent out to search for reason on the 'ship of fools,' and in the eighteenth and nineteenth centuries, madness was confined to asylums (Foucault, *Madness* 9). Democratising madness in contemporary mental health plays and performances can be understood as raising awareness of and decreasing the stigma that is still largely attached to mental illness. By breaking down the fourth wall, the two plays analysed in the following pursue theatrical strategies that foster empathy and dramatic dialogues in the auditorium in order to counteract silence and shame, and the notion that madness is a threat to the community.

6.1 Theatre as Open Dialogue in Ridiculusmus' *The Eradication of Schizophrenia in Western Lapland* (2014)

The impact that theatre can have on individuals and communities is a key concern in the work of Jon Haynes and David Woods, who met on an acting course at London's Poor School (thepoorschool.com) and founded the theatre group Ridiculusmus in 1992. Since then, they have written, produced, and performed in numerous devised plays, touring nationally and internationally (Ridiculusmus, "About").

The Eradication of Schizophrenia in Western Lapland, which premiered in 2014, is part of a mental health-trilogy that marks the continuation of a concern for creatively engaging with matters of the mind.[65] Since both artistic director/performers have been confronted with mental health problems in one way or another and because the impulse for devising their plays largely derives from personal encounters and experiences, mental health has always been a focus of their work. Woods acted as a carer for his father and brother who were both diagnosed with bipolar disorder, and Haynes had to spend time at Maudsley Hospital as a patient in the 1980 (J. Haynes, Personal interview 14 May). The play *Yes Yes Yes* (1999) was the first to deal with mental health experiences and constituted "the light out of depression," hinting at the therapeutic effects of their creative work (Ridiculusmus, "Yes").[66] Ridiculusmus returned to the topic in the small-scale project *Da Da*

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[65]   The play will be referred to as *Eradication* from here.
[66]   "Although research for their 1999 piece *Yes Yes Yes* took them to psychiatric hospitals in India and the finished work included manic-depressive chants recollected from Jon's time on the

Music, which features a character based on Haynes' encounter with a fellow patient at Maudsley Hospital (J. Haynes, Personal interview 14 May). The second play of the mental health trilogy, *Give Me Your Love*, was first performed in 2015 and involves cutting-edge research on MDMA-assisted therapy for post-traumatic stress disorder (PTSD) (Talbot 83-92). It responds to the first trial of MDMA for treating PTSD in soldiers carried out by Annie and Michael Mithoefer in the US between 2008 and 2012 (84). The trilogy's third play was inspired by the inclusion of grief as a mental health condition in the *DSM-V* and premiered in November 2018 as *Die! Die! Die! Old People Die!* (Ridiculusmus, "Die"). Ridiculusmus has now created a uniquely polyphonic production process (a combination of devised and authorial theatre) deeply concerned with questions of audience responses and public engagement. At the heart of their recent creative work lies a keen interest in questions of perception and experience (83).

Eradication depicts a family (Mum, Dad, the sons Rupert and Richard, and Dad's new wife Jade) with a history of mental health problems and trauma, and links this with therapeutic encounters of a doctor and his patient. The play is for four actors. It is important to mention that neither Dad nor Jade ever appears on stage as individual characters even if some of their lines are spoken (by the actors playing the doctor and Mum).[67] The family is dysfunctional; they do not communicate with or listen to each other, not unlike the characters in a Pinter play, as Anne Cooke observes ("Ordinary Chaos" 422), or like the Strangs in *Equus*, and Susan's family in *WiM*. The doctor himself is caught up in a dysfunctional family situation (as the audience learns through phone calls he receives) evoking the trope of the struggling psychiatrist who is unhappy within his professional and personal life, as examined in detail in chapter 4.

Form and content of the play inform each other in the sense that Ridiculusmus seeks to make experienceable auditory hallucinations, which can occur as a symptom of psychosis. Psychosis, in turn, can be a symptom of schizophrenia, hence the title. The play is aurally and visually challenging and foregrounds the notion of dissociation. Thus, it provides what Dingwall-Jones calls "a specific instance of experiential discontinuity" (51). With its focus on auditory hallucinations, it forces the audience not to look with but to *hear* with mental distress, in line with the aesthetics of plays that make the audience look *with* rather than *at* mental disorder referred to throughout this study (Harpin, "Dislocated" 212). The play's focus on the auditory brings a new facet to the discussion because it invites an altogether different perceptual practice. By discursively challenging the

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ward, it was ostensibly a shaggy dog story told by a couple of Anglo Indians that only hinted at the madness that lay beneath. It's as if all this time they have been unable to face the subject head on." (Haynes and Woods 244)

67   The original cast included Jon Haynes as Richard, Patrizia Paolini as Mum, Richard Talbot as Rupert, and David Woods as doctor (Ridiculusmus, "The Eradication").

hierarchical and authoritarian power structures of psychiatry in heterotopic theatre spaces that turn into 'counter-sites' (Foucault, "Other" 24), Ridiculusmus aims at democratising madness.

6.1.1 Performing Open Dialogue

In order to ascertain the metacognitive effects that *Eradication* might produce, it is important to look more closely at the play's complex structure. It has three acts, the first and third of which are performed at the same time. The audience is divided in two before the performance and both halves see Acts I and III simultaneously while receiving auditory impressions from the other act. A wall splits the stage into two, which can be realised with end-on stages, in which case a partition wall (or a curtain) is placed between the two audience halves and continues onto the stage space, or on arena-style stages, in which case a wall cuts audience and stage in half. After the interval, audiences switch sides and see the act they have not seen, but partly heard, before. The two audiences watch a very short act together at the end of the play. In order to achieve this simultaneity, the stage world is also split into two halves, the 'domestic' and the 'public' side, with a minimal set indicating the distinction (*Eradication* 7). The actors take down the dividing wall between the two sides for the final act (which is confusingly termed Act II in the script). The split stage and the simultaneity are the technical vehicles for recreating the effect of auditory hallucinations. In fact, the audience actually *experiences* auditory hallucinations in the sense that the spectators hear voices but cannot control, identify or make sense of them. Added to that, as an extension of the hallucinatory 'repertoire,' audiences encounter characters that appear and disappear without explanation. During a performance, it is most challenging when voices from one side of the stage take over and drown the dialogue on the other side. This can lead to misunderstandings and confusion as well as to sensory overload due to the multitude of visual and aural stimuli. In addition, to complicate matters, the play's narrative is inconclusive, the characters are not fully developed or never appear on stage, and the plot is neither linear nor stringent.

What has been described so far suggests that *Eradication* is a self-absorbed project that denies its audiences any form of engagement by being deliberately obscure; however, the opposite is the case. From the devising process to the finished piece and public engagement efforts made, Ridiculusmus' work process is intrinsically dialogic, collaborative, and democratic in the sense that practically anyone and everyone could get involved (Talbot 83). A synergetic and interdisciplinary devising process is a common feature of much of contemporary theatre, with companies such as Complicite and Clod Ensemble basing their work methods on "change and collaboration" (Shepherd-Barr, *Science* 205). As was seen in previous chapters, other more traditionally text-based theatre productions, such as of *4.48 Psychosis* and *The Effect*, brought experts into the rehearsal room in order to substantiate the plays' mental health or science-related aspects. Medicine and

science are topics often explored dramatically in this way, which results in pieces that embody the mediating qualities Snow attested to the 'third culture.' Clod Ensembles' piece *Performing Medicine* is a case in point, as Nicola Shaughnessy shows (9). In this 'third culture'-space, creativity enables mediation, which is one of the key assumptions that Ridiculusmus' work rests on. While their interdisciplinary approach resembles the devising process of Clod Ensemble and others, Ridiculusmus' Haynes and Woods go one step further by fully immersing *themselves* in the psychotherapeutic practice they engage with and by adopting these practices for their own devising, rehearsal, and production process. Thus, their work is located in an in-between space "where meaning is made as new epistemologies predicated on *process*, create bridges between different discourses, theories and practices" (Shaughnessy 4; italics in original). A good example of this immersive devising process is an improvised Open Dialogue meeting with Finnish psychotherapists that the actors in character took part in in 2014 (Ridiculusmus, "Our").

For *Eradication*, Ridiculusmus built a creative bridge with the therapeutic practice of Open Dialogue, a "network-based language approach to psychiatric care" established in Keropudas Hospital in Western Lapland in 1984 and pioneered by Finnish psychotherapist Jaakko Seikkula (Seikkula and Olson 403-04). At the time, the Finnish mental health care system was facing complex challenges but the introduction of the new method led to a significant decrease in psychosis cases in the region (403-04). Now Open Dialogue is the standard psychiatric service in Western Lapland (Seikkula 179-93), hence the play's title. It is based on dialogue within a network consisting of patients, family members, friends, medical professionals, and therapists, and resembles group therapy. Open Dialogue is practiced in order to take the tension out of the experience of either acute or chronic psychosis (Open Dialogue UK). The difference to group therapy is that the running of the therapy sessions does not rest on the therapist's authority but that openness, equality, and participation are required from everyone involved before, during, and after each session (Seikkula and Olson 408).

It is important to point out that Ridiculusmus does not perform Open Dialogue because it "is not dramatic. It's successful at diffusing tension, so if we were to stage an Open Dialogue process, it would be really quite boring," as Woods explains (Ridiculusmus, "Inside"). Put differently, rather than involving the audience in a therapy session, Ridiculusmus seeks to immerse the spectators in an experience while fully immersing themselves in the practice.[68] While Haynes is reluctant to *directly re-enact* his experience claiming, "I really don't fancy reproducing that. It wasn't even mildly entertaining" (J. Haynes, "Nordic Lesson"), when researching for *Eradication*, Woods shared a personal memory of his father's

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[68]   With regard to *Give Me Your Love*, which emerged out of a similar devising process, Talbot points out along the same lines that "the play is not an instrumental therapeutic tool for the audience or a form of representational acting out, a role-play on behalf of sources and collaborators" (83).

anxiety attacks with 300 psychologists at a conference on Open Dialogue in Finland (Talbot 89). The goal of interlinking all the collaborative strands is the creation of experiential rather than didactic theatre (92).[69] The play's objective is offering alternatives to the normative system of psychiatry, and by extension, of 'normal' aural and visual perception. Both the therapy form and the play thus counteract Foucault's notion of power/knowledge and the unequal power structures of psychiatry.

As a means of breaking with the notion of hierarchical power/knowledge, Haynes and Woods incorporate Open Dialogue's three defining principles, tolerance of uncertainty, dialogism, and polyphony, into their work method. 'Tolerance' and 'uncertainty' as key terms of postmodernist discourse put *Eradication* and Open Dialogue in the context of far-reaching epistemological debates on normative thinking in the theatre and beyond. At the same time, the terms tie in with discussions of the precarious notion of psychiatry's objective knowledge interrogated in preceding chapters. In theatre history, uncertainty is a defining feature, for instance, of Ibsen's, Pinter's, and Beckett's work. All three playwrights challenged their audiences by denying them what Errol Durbach calls "verification," and by foregoing *catharsis* at the end of their plays in an attempt "to advocate nothing at all" (125). Acknowledging Ibsen's constitutive role for employing uncertainty for dramaturgical means, Martin Esslin points out that "[t]he introduction of this principle of uncertainty into drama certainly represents a fundamental revolution in dramatic technique, a revolution which is still with us and continues to dominate dramatic writing of all kinds" (74). That Esslin is still correct in assuming the continued relevance of the uncertainty principle on contemporary stages can be seen in *Eradication*. It is true that Ridiculusmus denies audiences verification; however, the play's potential for ethical criticism has to be located precisely in the utilisation of ambiguities and the creation of uncertainty in the auditorium. In this sense, the play functions as a mental health play because it advocates accepting this uncertainty as part of the performance, and by extension, of the human condition.

In Open Dialogue, tolerance of uncertainty refers to the fact that "[t]he therapists […] enter without a preliminary definition of the problem in the hope that the dialogue itself will bring forward new ideas and stories" (Seikkula and Olson 408). It goes without saying that 'tolerance of uncertainty' is a concept that applies to any theatre visit because, ultimately, one never knows exactly what to expect or how one is going to respond. Spectators might, of course, have certain preconceptions before entering the theatre after consulting the 'paratext' in Gérard Genette's terms, i.e. the script, the production websites, the programme, and reviews, or

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[69]   In *Science on Stage*, Shepherd-Barr observes a similar work method in 'alternative science plays': "Often the theatrical production derives from a collection of ideas, a set of writings that serve as a springboard for further workshopping, rather than a fixed and final, stable, and authoritative script that is simply to be acted" (202).

because they are familiar with the group's work. Still, one's emotional and intellectual reactions are always unpredictable. Or, as Bruce McConachie explains in *Theatre and Mind*:

> A spectator who has read a play before coming to the theatre to watch it might imagine what a character looks and sounds like in his 'mind's eye' (and mind's ear) and empathize with that imagined body, but once inside the playhouse the former reader becomes an active spectator and the blend of a flesh-and-blood actor with the author's character always takes the place of the imagined figure in the reader's mind. (55)

Extending what McConachie describes as active spectatorship, Ridiculusmus demands emancipated spectatorship, i.e. a spectator who "is confronted with the spectacle of something strange, which stands as an enigma and demands that he investigates the reason for its strangeness" (Rancière 272). As strangeness and obscurity are key features of Ridiculusmus' work, audiences have to tolerate uncertainty and engage actively in the creative process in performance.

It is useful to consider the play's textual fabric in this regard because in its structural evolution, it has undergone marked changes designed to deliberately intensify its eccentricities and obscure its meaning. These changes are crucial for fully realising the play's epistemological potential as mental health play. Since Oberon published the script in 2014, the play has evolved constantly and one of its metadramatic features, a chorus originally envisaged to open the play's acts, was removed in the process. In the published script, the voices in Act I are a remainder of the deleted chorus and mention some of the principles of Open Dialogue, while the ones in Act III add to this a clearly stated agenda:

> FOUR VOICES. We are a *polyphony* of voices.
>
> We are who we are because
>
> We listen to all voices in the group
>
> And adhere to basic principles.
>
> *Tolerance of uncertainty* is one.
>
> A new approach to psychiatric care's emerged
>
> In which the basic element of *dialogue*
>
> Can lead to healing or,
>
> If you don't like the word,
>
> To positive change.
>
> What we want to do is

> Open up the boundaries
>
> And integrate family perspectives
>
> Into psychotherapy. (*Eradication* 44; my emphasis)

There are two possible interpretations of these voices. On the one hand, they provide helpful additional information by contextualising the play. Added to that, they make explicit that the play's agenda is instigating changes in mental health care. On the other hand, they might be perceived as disconnected from the rest of the play and as rather too obviously geared towards a particular agenda. After initially including them in performance, Ridiculusmus decided to drop them, as Haynes explains:

> We tried realising the voices both at the premiere in Brighton's Sick! Festival [in February 2014] and then again at Shoreditch Town Hall [in March 2014]. It didn't work, I suppose, is the simple answer. It didn't feel right. They didn't feature sufficiently to seem an integral part of the work. They were losable. (J. Haynes, Personal email exchange)

Considerations of the play's narrative were another reason for deleting the chorus. Although there is an underlying plot, *Eradication* does not adhere to principles of linear narrative, narrative logic, or narrative closure:

> As what we were attempting with the play became clearer (i.e. a representation of auditory hallucination rather than visual) and we had the confidence to reaffirm our dislike of conventional narrative structure as well as resist pleasing the audience element that hankered after conventional narrative rewards (a convention any kind of 'chorus' only reinforced) then they became redundant. (J. Haynes, Personal email exchange)

In essence, Ridiculusmus attempts to forego clarity and simple explanations in the same way as the experience of a psychotic episode often defies linearity and logic (NHS). This way, the play's structure and content go hand-in-hand. The aim of such a theatrical strategy is to communicate that "we belong to a shared world, and we have a responsibility to be aware of the effect that different ways of perceiving that shared world might have on our interpersonal interactions" (Dingwall-Jones 59).

Another example of the invitation to tolerate uncertainty, and one that is still part of the play as it is performed in its current form, is the first scene on both the domestic and the public side. Act I is aptly titled "Chaos" although, initially, audiences are confronted with an everyday domestic situation: the mother and her sons Richard and Rupert are discussing dinner plans. Two grown-up actors play the sons, so it is not readily apparent what age they are supposed to be. In addition to the family members holding a conversation, it seems that the mother is upset about something that cannot be explained without context and by judging

the situation as it is presented. While it is a common feature of many plays to begin *in medias res* or without exposition (Pavis 245), in the case of *Eradication* the confusion is an integral and wished-for component of the play's fabric that carries on throughout the play.

Bewilderment is heightened when the mother shouts: "I've had enough of this bollocks. I'm not mad here. What are you talking about? You have to shut up because you're twelve and you don't know what you're talking about" (*Eradication* 11). Her outburst is completely disconnected from the preceding conversation. However, it is also an indirect audience address. After all, previously, the mother threatened to kill the family with a machete at Christmas. Many of the audience members, especially those with a penchant for horror films (such as Stanley Kubrick's *The Shining* or Rob Reiner's *Misery*), might question her state of mind, especially considering the fact that the play has only just started and the characters have not been established. Ridiculusmus clearly plays with stereotypes and notions the spectators might have brought to the theatre.

The mother's statement, "I'm not mad here." contains an intertextual reference to Lewis Carroll's *Alice in Wonderland*, in which, similar to *Eradication*, dialogue very often does not make any sense because the interlocutors keep talking past each other and conversation ultimately fails.[70] Only later in the play is it made explicit that the mother has mental health problems and is hospitalised, which appears to account for her failing to communicate and her behaviour at the end of Act I, when she starts hopping around like a frog, burping. Acts I and III are bound to leave the audience confused, due to the use of such ruptures that are challenging to fill with meaning based on what the play provides (Pavis 246).

The development of the play's final scene further exemplifies that Ridiculusmus resists closure by working with ruptures that create "a gap within our habitual modes of making and imposing meanings" (Dingwall-Jones 59). Such gaps mirror the experience of mental distress since "mental illness provides a specific instance of experiential discontinuity," as Dingwall-Jones explains (51). Although in the play's script the plot's loose ends are tied up by an accident to explain the trauma experienced by the family, in an early performance at Shoreditch Town Hall in March 2014 (*Eradication* performance Shoreditch), this idea had already been dropped in favour of a short scene in which all the actors wore large cow's horns or rabbit ears and danced to a Finnish tune (*Eradication* 92-93). This is a prime example of experiential discontinuity, which, by extension, asks for "a reconceptualisation of empathy" (Dingwall-Jones 51). While the dancing, as a reference to the play's Finnish links, became a permanent feature of the play, the dialogue changed substantially until the run at the Edinburgh Fringe in August 2014. Since then, a short dialogue involving all four actors precedes the Finnish folk dancing:

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[70]   A good example is the conversation between Alice and the Cheshire Cat in which the cat uses the phrase quoted above and in which Alice is unable to comprehend the cat. See Carroll, 66-67.

Dad shuts the door

JADE. I love that sound of the door.

DAD. Love you as well.

RUPERT. Love you dad.

JADE. I love that sound. It's like music. It reminds me of him coming home.

RICHARD. I love you Dad.

DAD Sorry. Is that too much? (*Eradication*, post-Edinburgh 78; italics in original)

This ending seemingly unites the family linguistically by virtue of using the word "love" but it does not provide any resolution to the narrative or any conclusive denouement. Ending the play on a question complicates this impression while, at the same time, it adequately concludes the obscure piece because it is not supposed to provide catharsis. What is more, it might inspire some spectators to answer the question internally with yes or no. Critic Maddy Costa commented after the performance at Shoreditch Town Hall: "There's something electrifying yet oddly reassuring about this experience: what does it matter if nothing makes sense?" (n.p.). Clinical psychologist and expert collaborator on Ridiculusmus' mental health trilogy, Peter Kinderman, similarly remarked:

> The play's protagonists are grappling with emotionally-charged, meaningful, important issues. If they can't make their points clearly, without talking over one another, without introducing irrelevant material, without non sequiturs and even outright delusion – well, that goes with the territory. ("Northern Lights" e12)

What both critics point out here was already touched upon in the analysis of Kane's *4.48 Psychosis* and Neilson's *Dissocia*: a mental health play dealing with the highly complex landscapes of a distressed mind does not have to and, in fact, cannot always make sense because the experience of mental distress is so often devoid of meaning. Clinical psychologist Anne Cooke explains in her review of a performance at the Battersea Arts Centre:

> This may be partly my pre-existing bias, but to me, the very confusion and disjointedness of the play was part of its strength, and I found it strangely uplifting. As in life, and certainly in the complex, disputed area of mental health, those looking for a single truth, one clear, unambiguous, story would have been disappointed. I was reminded of something my colleague Jim Geekie likes to say: '*Uncertainty is not a failure in mental health work. It is essential.*' ("Ordinary Chaos" 422; italics in original)

The inconclusive ending invites the audience's engagement with the topic before leaving the theatre, and confirms that the piece has no cathartic effect. Rather, recalling Ibsen's dramaturgy of uncertainty, it has a destabilising effect on the audience, which has been a dramaturgical strategy known since Sophocles' *Antigone* (Durbach 129). As pointed out above, this sense of uncertainty is largely recognised as a defining feature of Pinter's and Beckett's plays; it is "an uncertainty, both ancient and familiar, that forces upon us the complexity of existence and compels a dialogue between the dramatist and ourselves" (129). Haynes explains that in *Eradication* the uncertainty is deliberate and thus speaks out against a possible utilisation of the piece in theatre therapy:

> We're trying to recreate an experience, and to make you experience an experience; that you add meaning to this play because meaning is to be located in the experience of it rather than in the conventional places that one would look for meaning. Like in the ending, all things being tied up, but it's not there. It's just to be found in surrendering to this experience. (J. Haynes, Personal interview 29 October)

Returning to Kinderman's comment, it can be said that the invitation to tolerate the play's uncertainties is a very effective strategy to mirror the experience of mental distress even if – or precisely because – it leaves some audience members baffled or frustrated (Brown). Drawing on Wolfgang Iser's notion of 'blanks,' if the story of *Eradication* appears trivial and inconclusive, it is a defining feature of the dialogic relationship of audience and performance that the audience has to fill in the gaps (qtd. in Counsell and Wolf 182). According to Iser, "[w]hat is said only appears to take on significance as a reference to what it not said; it is the implications and not the statements that give shape and weight to the meaning" (182). As a result, even when confronted with seemingly trivial scenes from family life, the individual spectator might develop critical awareness regarding their own means of observing and judging, and thereby come to profound conclusions by filling in the blank spaces (182). Moreover, even if neither the characters on stage nor the spectators will be able to make meaning after all, it is in this "shared subjectivity," i.e. the shared experience of incomprehensibility and uncertainty, that "radical empathy" can arise (Dingwall-Jones 51). In this sense, *Eradication* democratises mental illness.

6.1.2 Hearing Voices as Polyphonic Dialogue

The second and third principles of Open Dialogue, dialogism and polyphony, are derived from work by literary theorist Mikhail Bakhtin and anthropologist/social scientist Gregory Bateson, and go hand-in-hand in *Eradication* on a number of

levels.[71] Both are useful concepts for considering the play's epistemological dimension as they are concerned with how knowledge is created and how adhering to specific modes of communication makes meaning.[72] Bakthin, in particular, sought to create "a pragmatically oriented theory of knowledge; more particularly, […] one of several modern epistemologies that seek to grasp human behavior through the use humans make of language" (Holquist 15). To recall, that language is as much a defining as a contested feature of both dramatic and psychiatric practices was outlined in chapter 2 of the present study. In the context of Open Dialogue, it seems coherent that almost in opposition to the supposedly rational language of psychiatry, Open Dialogue rather seeks to relate to a number of registers in order to make sense of psychosis. In line with this, polyphony means that "there are multiple subjects, forming a polyphony of multiple voices" (Seikkula and Olson 409). The idea is that by allowing many voices into the therapeutic process and by discussing the experience of psychosis together, the patient's symptoms will be eased.

Ridiculusmus initially subverts the notion of dialogism on the plot level and uses polyphony as a means of establishing uncertainty. When the play opens, while on the domestic side the action begins in *medias res*, silence is the predominant feature on the public side. However, even if it is quiet on this stage side, "no silence in the theatre is ever an empty silence" (Durbach 127). The audience on the public side of the stage can still hear the voices from the other side, which hints at the play's polyphonic nature but, more importantly, creates a peculiar atmosphere. Tellingly, the scene begins with the doctor facing the audience, in an almost confrontational stare, which, according to Helen Freshwater, has "become a recognisable theatrical trope" (50). The only way to work out that this side of the stage is supposed to be set in a clinical environment is the doctor's costume, as he wears green (or blue) scrubs, as well as the same greenish paint of the dividing wall.[73] The patient, Richard, as it will turn out, is not present at first because he is involved in the conversation on the other side of the wall. After a long pause (not unlike an uneasy 'Pinter pause') the somewhat misplaced doctor appears to address the audience directly. In between, Richard walks in with a large kitchen

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[71]   Both concepts are inspired by and appropriated from Bakhtin's reflections in *The Dialogic Imagination* in which he applied them to the novels of Dostoevsky. See Bakhtin, *The Dialogic Imagination,* especially 259-422, and by the same author, *Problems of Dostoevsky's Poetics*.

[72]   Bateson and his research group introduced the so-called 'double bind theory' of schizophrenia in 1956 and argued that a person who is caught in a situation where they "can't win", they "may develop schizophrenic symptoms." The researchers tried to account for a schizophrenic's individual utterances as being characterised by '*unlabeled* metaphors,' which might disrupt the process of meaning-making as well as of making oneself understood (Bateson et al. 251-53).

[73]   As the analysis in chapter 4 demonstrated, doctors and psychotherapists on stage are not necessarily always recognisable by costume: Richard Griffiths in the revival production of *Equus* wore all black, Bill Nighy and Andrew Lincoln in the original production of *Blue/Orange* wore everyday shirts and trousers; only Tom Goodman-Hill and Anastasia Hille in the first production of *The Effect* wore white coats from time to time that clearly marked them as doctors.

knife and disappears again without engaging with the doctor. In performance, David Woods delivers the lines slowly in order to increase the sense of unease.

> DOCTOR. You seem very quiet today. […] Nothing? […] You seem to have a rather fanciful picture of psychotherapy. […] It involves you sitting there, smiling sometimes, saying nothing, or very little, and me sitting here watching you, wondering what you're thinking. […] I'm not sure how I can help you really. (*Eradication* 46)

On the one hand, the doctor's utterances suggest that he is in a psychotherapy session with a patient who refuses to engage in conversation. At the same time, due to the physical absence of the patient, the doctor is describing his own situation on stage. On the other hand, Richard's knife is an allusion to sensationalist, stereotypical depictions of mental distress in films such as *The Shining* or *Halloween*, and might therefore raise expectations as to what he might be doing with the knife. But tension is defused when nothing happens. Richard only forces the knife into the wall between the domestic and public side where it remains until the end of the play. To some audience members, it might be a visual reminder of the destructive power of stereotyping and stigmatisation; to others it will just be a knife forming part of an inconclusive action.

Ridiculusmus applies an aesthetic strategy that many science plays follow when they "employ a carefully crafted metatheatricality that constantly reminds the audience that they are in a theater, not eavesdropping on actors who are unaware of them" (Shepherd-Barr, *Science* 43). The effect in the scene is comical because the doctor might just as well be talking to or about the spectators in front of him. The principles of tolerance of uncertainty, dialogism, and polyphony merge in the scene, and the spectators' engagement with the stage world is likely to be laughter as a natural response to the doctor breaking the fourth wall (Ridout 70-95). The scene is also a prime example of the fact that theatre spectatorship is always active. It shows that perception directs meaning-making when the audience is left to fill in the blanks created by the doctor's monologue, Richard's appearance and disappearance, and the knife. In this sense, Ridiculusmus challenges audiences towards emancipation in Rancière's sense. The insistence on spectating as an action coupled with the effects this has, ties in with the idea brought forward in the present study that mental health plays invite audiences to reconsider convictions they might have regarding mental disorder. Ridiculusmus' dramatic strategy of employing ruptures to create uncertainty is directed at a deliberate play with the need for interpretation as well as with developing metacognition among the spectators. The idea of democratisation relates to the fact that everyone present in the auditorium hears voices and that, ultimately, audiences are encouraged to call into question categorisation such as 'sane' and 'mad.'

One of the most direct examples of Ridiculusmus asking the spectators to question their own modes of interpretation and categorisation is confronting them

with R. D. Laing's work. In this moment, *Eradication* actualises the notion of heterotopia since the real and the imagined merge. Furthermore, Ridiculusmus thus approaches the "hard problem" of consciousness, addressed before. It is important to highlight that, unlike many psychiatrists, critics, and creatives, Ridiculusmus takes Laing's work completely seriously but builds a comic scene around its presentation as yet another means of deliberately blurring their activist agenda.[74] In one of the therapy scenes on the stage's public side, the doctor gets undressed and recites the following:

> I see you and you see me. […] I experience you and you experience me. This is R. D. Laing. I see your behaviour. You see my behaviour. But I do not and never will see your experience of me. […] Just as you cannot see my experience of you. My experience of you is not inside me. It is simply you as I experience you. And I do not experience you as inside me. Similarly you do not experience me as inside you. […] My experience of you is just another form of words for 'you as I experience you' and 'your experience of me' equals 'me as you experience me'. […] Your experience of me is not inside you. […] My experience of you is invisible to you. […] I cannot experience your experience. […] You cannot experience my experience. […] We are both invisible. […] We are both invisible. […] I do not experience your experience but I experience you as experiencing. I experience myself as experienced by you. […] And I experience you as experiencing yourself as experienced by me. (*Eradication* 51-52)

Ridiculusmus borrows from the first chapter of Laing's book *The Politics of Experience* in which he outlined fundamental principles of perception and power that formed the basis of his criticism of what he regarded as authoritarian psychiatry in the 1960s (15). In essence, what Laing called "the crux of social phenomenology" and its consequences became one of the guiding justifications of anti-psychiatry (17).

The doctor gives voice to the problem of *qualia* to explicate the difficulty of knowing what it is like to have an experience without actually having it (Levin 693). Since the mentally ill character is mostly absent from the scene, the doctor might be addressing him or the audience. In other words, he might be telling the spectators that it is impossible to empathise with the mad characters on stage if they have not experienced mental distress themselves. However, in articulating the problem, he foregrounds that this problem is a shared concern. In the context of

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[74]   Jon Haynes explains: "Personally, I've had a long 'relationship' with Laing going back to when I went to university, so in the 1980s, I started reading Laing; I think everybody was in those days. You know, I read *The Divided Self* first and it was a revelation to me reading that, as it was for other people. So he had a big personal influence on me" (Personal interview 29 October). Compare this appraisal of Laing's work with the utilisation of Laingian and anti-psychiatric notions as negative and confrontational in *Equus* and *Blue/Orange* in chapter 4 of this study.

doctor-patient interaction, it is bi-directional, as the repetition of the phrase "We are both invisible." proves. If the "we" includes the doctor, the absent patient, and the spectators, then the doctor draws on the very "shared subjectivity" that Dingwall-Jones sees as inspiring "radical empathy" (51). Thus, in *Eradication, qualia* is not only an epistemological but also an ethical concern.

Viewed from a different angle, Laing's explications form a rich resource for considering how our experience of the world is always already shaped by power discourses. By extension, this means that interpretation (for instance, in psychiatric anamnesis) is inherently subjective, and that this subjectivity is determined by and reinforces existing power structures.[75] This circular structure has consequences for the process of diagnosing mental illness as much as for judging characters and actions on stage. It is easy to see that, from Laing's negative perspective, when subjectivity has such power, this can have severe repercussions for individuals. By confronting audiences with this complex dilemma, metacognitive knowledge of questioning one's own assumptions is furthered.

By including the direct quotations from Laing's work, Ridiculusmus puts forward the idea that there is a sense of arbitrariness to how someone comes to be diagnosed as mentally ill. When the doctor juxtaposes Laing's phenomenological notions with the distribution of power, the fact that he is still undressed puts further emphasis on the absurdity of his authority and raises doubts about his professionalism. Put differently, the scene challenges Foucault's notion of power/knowledge in psychiatric discourse because the representative of this system exposes himself to the audience: "Some people experience themselves in ways that are strange and incomprehensible to most people. […] Including themselves. […] And if that person's experience becomes visible to broader society then broader society is liable to diagnose you as subject to a condition called Schizophrenia" (*Eradication* 53-54). This is a self-referential comment on what audiences have just witnessed. After all, the doctor tries to explain very complex thoughts and he might not have been making sense along the way. A possible response of the spectators might be considering the doctor mad, thereby confirming the notion that psychiatric power is not effective here despite the fact that he explains (in simplistic terms) how schizophrenia is diagnosed. As a result, the comic scene serves as a deconstruction of mental health expert authority because the juxtaposition of Laingian phenomenology with the physical act of a doctor getting undressed confuses perceptual frames whereby it impacts the process of meaning-making. Most importantly, it challenges the power/knowledge nexus of psychiatric discourse to the point of absurdity.

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[75]   On the interconnection of ideology and subjectivity, Louis Althusser coined the term 'interpellation' in order to argue that the individual fulfils various subject roles in different institutional contexts and thus their subjective experience is always already determined by such systemic interactions and ideologies (1-60).

The dialogism of Open Dialogue, which Ridiculusmus subscribes to, mainly takes place after performances and involves medical professionals, psychiatrists, representatives of the NHS, nurses, carers, and audiences in question and answer-sessions and post-show discussions. These talks offer the audience a chance to ask questions, to raise concerns, or to comment on the play and performance. At the same time, they enable the company to enter into dialogue with practitioners and audiences, and to receive immediate feedback on their work. Due to the fact that Ridiculusmus was an Arts Council portfolio organisation and was supported by the Wellcome Trust, such talks and discussions were part of the requirements to be fulfilled, so their impact could be deemed accidental. But they constitute a meaningful way of engaging with the audience and their ideas. What is more, Ridiculusmus considers these sessions a vital aspect of their creative process. Even if audiences are not as directly involved in the performance *as it takes place* (and as the spectators are in a participatory piece like *Every Brilliant Thing*), Haynes explains that Ridiculusmus keeps an open mind in performance in order to offer a delayed response in subsequent performances:

> I think it's more about the feeling we get when we're performing it. We sense what is working or what isn't working. Sometimes it can be quite perverse when we sense that the audience is enjoying something or laughing at something, we might think, we don't actually want them to laugh there, it's an easy laugh; let's take that out to make it more uncomfortable. Or let's take that out because it explains things too much. Because I think our ultimate goal is for the audience to go away puzzling. (J. Haynes, Personal interview 14 May)

Haynes describes how the 'autopoietic feedback loop' informs Ridiculusmus' work from the performers' perspective. According to Fischer-Lichte, the feedback loop "identifies transformation as a fundamental category of an aesthetics of the performative" and is constitutive of a performance's political dimension (*Transformative Power* 50). This holds true for *Eradication* because Ridiculusmus aims at transforming attitudes to mental illness by employing theatrical strategies that foster metacognitive knowledge regarding how such attitudes are formed.

In analogy to the multidimensional conversations Shepherd-Barr attests to science plays (*Science* 45), it can be said that by integrating Open Dialogue into their creative practices while maintaining an awareness of audiences as part of the process, Ridiculusmus successfully bridges the gap between the 'two cultures.' Most importantly, Ridiculusmus' performances "create[] the possibility for all the participants to experience themselves as a subject that can co-determine the actions and behaviour of others and whose own actions and behaviour are similarly determined by others" (Fischer-Lichte, "Interweaving" 391). It is precisely this subjective stance that releases the play's heterotopic and democratic potential because in the there-and-then of the theatrical space, the spectators as a community and as

individuals perceive themselves (and others when staged in the round) as witnessing and participating in an "in-between" or "liminal experience" (392) that unites their own lived experience of madness in the moment of performance with the reality of mental distress (Dingwall-Jones 49) that the play evokes. In this transitory moment, the spectators are invited to reconsider what they might have thought about madness beforehand, and to empathise with the alternative experience of mental distress.

6.2 Sharing is Caring: Audience Participation in Duncan Macmillan's *Every Brilliant Thing* (2015)

Unlike Ridiculusmus, who work with dramaturgical methods that deliberately obscure meaning, Duncan Macmillan intentionally involves audiences in order to make meaning together in performance in his suggestively titled play *Every Brilliant Thing*.[76] This part of the chapter explores how contemporary theatre's mechanisms for forming a space for experiencing community have become a vital aspect for the destigmatisation of madness through creative practices in mental health plays.

Macmillan's work is marked by a keen interest in questions of power, agency, and burning socio-political issues, as his first play *Lungs* (2011), his adaptation of George Orwell's *Nineteen Eighty-Four* (2013), and his latest piece, *People, Places, and Things* (2015), indicate. While *Lungs* captures a couple's anxieties over having a baby in times of global warming and overpopulation, *People, Places, and Things* is an exploration of addiction played out on a woman's body and mind (Harpin, *Madness* 160-68). On the surface, Macmillan's plays are distinct in subject matter and dramatic form, yet they share a concern for inviting the audience "to explore the complex entanglements of the personal, social, and biological: and always in incomplete, contingent, partial manners" (167). In accordance with the biopsychosocial model of mental illness, *EBT* is a prime example of how such entanglements can result in disorders of the mind.

The play was produced by new writing and touring companies Paines Plough and Pentabus in spring 2014 and toured the UK thereafter, particularly going to towns without theatres, echoing Stephen Joseph's mission of bringing theatre to local communities in the 1950s (Auld). The play went on to have a run in New York for four months in 2015, before returning to the UK for another tour. In 2017, it toured worldwide to unanimous critical and audience appraisal. The emphasis on bringing theatre to the community and into local contexts is significant for considering processes of meaning-making. This is because small community spaces, in particular, add an important 'real' spatial dimension to how mental health plays can confront audiences with matters of the distressed mind in visceral ways (Tompkins). In its genesis, the play was adapted from Macmillan's short

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[76]   From here, the abbreviation *EBT* will be used for *Every Brilliant Thing*.

story *Sleeve Notes*, which hints at the importance of music in the play, and was at some point an art installation that travelled various festivals and incorporated participants' notes on things that are brilliant, emphasising the play's community aspects (Macmillan, Acknowledgments).

Directed by George Perrin, the play is a one-man show which involves the audience throughout. Stand-up comedian Jonny Donahoe narrates the story of a family in crisis from first-hand experience in the style of a "monopolylogue," a dramatic form Dolan compares to similar one-person pieces by American actor/performers Anna Deavere Smith, Danny Hoch, and Lily Tomlin (2); there is a slight difference in that Donahoe plays the same character but at different ages. Audiences encounter Donahoe first in the role of a seven-year-old boy whose mother has tried to kill herself, and then follow him into adulthood. In order to convince his mother that life is worth living, the narrator's young self creates the eponymous list of brilliant things that life has to offer. Audiences learn that the mother killed herself and that the son, as an adult, subsequently experienced mental health problems which had an impact on his everyday life, particularly on the relationships with his father and wife. During the performance, some audience members are assigned the roles of the boy's teacher, a vet, his father, his girlfriend/wife, and a university lecturer. In addition, some spectators are handed notes of 'brilliant things' that are called out at various points.

6.2.1 Care in the Community of the Theatre

EBT is a play about mental illness and suicide, so it might be surprising that it also has light-hearted moments. Macmillan recalls in an interview with the British Council the importance of how to "responsibly make a show about suicide" while at the same time wanting to make a comedy (British Council Arts). As a mental health play, *EBT* stands out because it achieves this precarious balance. Critics called it "funny, clever, and surprisingly uplifting" (Barnett), and praised its success at "finding the right balance between conveying the struggles of life and celebrating all that is sweet in it" (Williams).

Even though it is not made clear from the outset, *EBT* creates an inextricable connection between suicide and depression. Suicide (and suicidal depression) has been a frequent topic in literature and the arts since antiquity. Even though there was not even a word for self-accomplished death at the time, the writings of Plato and Aristotle, as well as tragedies by Sophocles and Euripides thematise suicide (Marsh 79-89). The first mention of the word 'suicide' can be traced back to Sir Thomas Browne's work *Religio Medici* (written around 1634, published 1642) (Marsh 90-91). One of the literary *ur*-texts on suicide, Johann Wolfgang von Goethe's genre-defining *The Sorrows of Young Werther* (*Die Leiden des Jungen Werther*, 1773), resonates with *EBT* due to its glorifying fashioning of suicide (Garrison), which the narrator firmly criticises. On stage, suicide has a place in Shakespearean drama, in plays such as *Hamlet, Othello*, and *Julius Caesar*, as well as in Jacobean and

eighteenth-century drama, and in August Strindberg's *Miss Julie* at the end of the nineteenth century (Fenwick 6). The twentieth century has even been declared the "suicide century" by Andrew Bennett in his study on representations of suicide in contemporary literature, *Suicide Century: Literature and Suicide from James Joyce to David Foster Wallace* (2017). After Sylvia Plath's suicide, Al Alvarez explored, partly self-reflexively, suicide as both an individual and an individualised act in literature and beyond in *The Savage God: A Study of Suicide* (1971). On contemporary stages, plays featuring suicide include, among numerous others, such distinct pieces as Arthur Miller's *Death of a Salesman* (1949), Marsha Norman's *'night, Mother* (1982), Brian Yorkey's musical *next to normal* (2008) (Harpin, *Madness* 179), and Kane's *4.48 Psychosis*, all of which offer completely different approaches to the topic. To recall, the analysis of Kane's play in the previous chapter already made references to Ian Marsh's study *Suicide: Foucault, History and Truth*, which provides a discursive history of suicide from the vantage point of Foucault's work as a means of arguing for its socio-cultural significance. One of the unifying features of all the texts mentioned is the notion that suicide is most often connected to feelings of loneliness and exclusion, or as Marsh puts it, suicide is "individual, private and pathological in nature" (196).

EBT offers a counterpoint to this understanding with its strong emphasis on community so as to alleviate the sense of isolation attached to the taboo topic. In times when Care in the Community is ever-present and contested in the UK, it seems apt that Macmillan brings the topics of mental illness and suicide right into the heart of the community of the theatre auditorium. To recall, Community Care was established after a large number of asylums closed in the UK in the 1980s and after (Leff 381-83). Although some figures paint a different picture, the scheme is widely perceived as a failure (381-83).

Located at the other end of the dramatic spectrum of *4.48 Psychosis* with its devastating and often inaccessible troubled landscapes, *EBT* provides a much more "tender" thematisation of suicide, to borrow Harpin's term (*Madness* 10-11). The piece's 'tenderness' translates into a gentle treatment of the topic that foregoes confrontation and obscurity. It is the play's dramaturgy in particular, with its focus on story-telling and audience involvement, which gives the impression that madness can be democratised, as the following analysis shows. *EBT* thereby presents a radically different approach to aspects of power and knowledge in mental health discourse, due to the absence of an authoritative psychiatrist figure on stage and because the piece is removed from the clinical context. What is more, the play circumnavigates the "hard problem" of consciousness (Chalmers) because the central concern is not *how to stage* someone else's experience of mental distress. Rather, the narrator character gives the impression of an immediate account of his individual experience that he shares with others, i.e. audiences, and that these others might or might not relate to.

Unlike Kane's play, which divided critics, *EBT* garnered positive responses wherever it was performed. Some of the reviews directly referred to what I call the play's 'dramaturgy of democratisation.' *Guardian* critic Lyn Gardner, for instance, remarked after a performance in Edinburgh: "this is a show that genuinely embraces the audience" ("The Funniest"). Part and parcel of the play's dramaturgy of democratisation is using an in the round-stage, as seen in most of the other mental health plays analysed in this study. The effects that such a stage has are amplified in *EBT* by the small local venues in which it was staged. Most importantly, this spatial component, coupled with the dramaturgical decision to leave the lights on during the performance, dissolves the boundaries between stage and audience. Macmillan explicitly aims for audiences to be "seated in the most democratic way possible, ideally in the round" (*EBT* 7). Audience involvement begins pre-show when the spectators enter the auditorium. Jonny Donahoe's task at the beginning is to figure out which spectator to choose for which kind of participation. In order to achieve this, he is present in the auditorium, mixes and mingles with the spectators as they are looking for their seats, and it is unclear at this point if he is already in character or not. He will then explain to the chosen spectators which role they will be assigned in case they are comfortable with playing their part in the performance (7). When the play begins, although audiences look *at* the narrator, their gazes are not pathologising because of the atmosphere previously established.

In order to examine further the notion of democratisation, it is important to qualify the spectators' involvement. Astrid Breel usefully differentiates between degrees of spectator agency, namely "reactive" (answering a question), "interactive" (completing a task), and "proactive" (self-initiated) (368-87). The uncertainty-principle mentioned in the analysis of *Eradication* also applies to *EBT* in that audience involvement entails the willingness to take risks, the gratification of which will add to the sense of democratisation in the auditorium (Alston 136).

There are three different kinds of involvement that *EBT* works with. At the very beginning, spectator involvement is spontaneous: Donahoe asks for certain props he will need, such as a coat, a pencil, and a number of books. Any spectator can contribute by providing the required. This corresponds to Breel's category of interaction; the audience members complete a task by handing over various props (373).

Secondly, a number of spectators have been given paper cards with numbers and 'brilliant things' written on them. In the course of the play, Donahoe calls out the numbers and the respective spectator has to read out their card. This kind of involvement is scripted and interactive, and requires no improvisation skills. In addition, it is low-risk assuming that the audience members will pay sufficient attention and will not leave the house. Because the respective spectators speak up, this adds more voices to the performance, creating a polyphonic atmosphere. What is more, the cards have a profound effect on the atmosphere in the auditorium since most of the 'brilliant things' from the boy's perspective have the poten-

tial to evoke individual, emotive memories in each spectator. The first items on the list include:

1. Ice cream.
2. Water fights.
3. Staying up past your bedtime and being allowed to watch TV.
4. The colour yellow.
5. Things with stripes.
6. Rollercoasters.
7. People falling over. (*EBT* 7)

When the narrator takes over to list items 8-10 himself, this creates a sense that the spectators and the narrator are momentarily equal in their contributions to the list (16).

Thirdly, Donahoe allocates particular parts to certain spectators: there is a vet, the boy's former school counsellor Mrs Patterson, a lecturer, his future wife Sam, and his father. At two points, the entire audience acts as a group; once as wedding guests and once as a support group the narrator's adult self attends in order to manage his depression. Fischer-Lichte uses the example of performance pieces by Richard Schechner, Einar Schleef, and Hermann Nitsch to point out that the role-reversal of actors and spectators heightens a sense of community in the auditorium (*Transformative Power* 55). Despite the fact that all the actor/spectator-interactions in *EBT* are scripted, it can be argued that, by virtue of breaking the forth wall, by emphasising the bodily co-presence of actor and spectators, and by accepting a degree of uncertainty, all of these strategies create a community out of everyone present (51).

A key scene in which the narrator talks to Mrs Patterson exemplifies this sense of community. The audience member playing Mrs Patterson is asked to remove her shoe and to use her sock as a speaking dog. Not only are the ensuing conversations partly improvised according to the audience member's decisions regarding the dog's name and breed, for example, but they also hold the risk that the spectator might not be willing to take off her sock. In the script, which was published after performances across the UK and the run in New York, Macmillan states that anecdotal evidence suggests that only one audience member ever mentioned being uncomfortable because of a bad toe, which Donahoe then incorporated into the play (*EBT* 18). The scene's uncertainty, in particular, is one of the play's greatest strengths because "a sense of exposure or vulnerability aroused through audience participation may in fact foster a sense of mutual vulnerability between performers and audience," as Adam Alston explains (136). This mutual vulnerability has the potential for creating genuinely integrative performances. At the same time, according to Fischer-Lichte, such an atmosphere might "negotiate processes of democratization and redefine relationships between members of a community"

(*Transformative Power* 50). It can be argued that this is not only true for the moment of performance but can extend into communities outside of the theatrical context.

One of the key dramaturgical elements for creating this particular democratic atmosphere in the community of the auditorium is music. This is similar to *Eradication*, in which sound also plays a major role. Recent research suggests that music is a "strong stimulant to memory" (Reinelt 355). Pavis also states that "[w]ithin performance, music has an utterly unique status" (140). Macmillan makes use of this unique stimulating aspect of music to enhance the spectators' emotional and affective responses. This is made clear from the start when audience members enter the house to "some upbeat jazz – Cab Calloway, Cannonball Adderley, Hank Mobley or Duke Ellington" (*EBT* 7). Asked in an interview if music was not simply an easy way to engage audiences emotionally or even manipulate them, Macmillan convincingly explained:

> The play intentionally walks a fine line between exploitation and sentimentality. Hopefully that creates an interesting tension. It directly addresses those issues so it felt like those elements should exist within the form of the piece. Its aim isn't to make people cry or exploit people's emotions. […] But one intention behind the work is to consider whether or not it's worth living and how we negotiate that question as individuals and as a society. It's about those who are indirectly affected by depression and the emotional cost of that. Both the list and the music support and undermine the seriousness of the endeavor [sic] in, I hope, interesting ways and allow the audience to receive what is ultimately quite a brutal story about hardwired suicidal depression without shutting down. The aim is to find a form to accurately and responsibly talk about the tools we use to protect ourselves from despair and whether or not it's possible to have an impact on others. It's also about methods of communication which are non-verbal and there are few better than music. (Interview)

On the one hand, Macmillan addresses the playwright's ethical problem of finding a responsible way for exploring the complex topic of mental illness. On the other hand, he justifies how in performances, music as non-verbal communicator serves as an emotional calibrator and a narrative tool for guiding audiences through the emotional landscapes of the play.

One example of how music serves as a guide is when the narrator 'teaches' the audience to 'decipher' what he learnt as a child about his father's use of music. The father would listen to particular kinds of music in order to express his feelings non-verbally. For instance, after the mother's first suicide attempt, his father would turn to Billie Holiday's version of "Gloomy Sunday," known as the "Hungarian suicide song" (Stack et al. 350-53). Research suggests that there might be a link between listening to the song and suicides across the world even though the relation between art and suicide is still a neglected research area in suicidology

(350-53). The narrator recalls that his father listened to the song after returning from his suicidal wife in hospital, which puts emphasis on the song's 'suicidogenic' dimension (355). Yet, the use of music enhances the feeling of community outside of the narrator's memory because, on an extradiegetic level, the audience is turned into confidants who learn a deeply personal detail of family life.

Moreover, the music might activate some of the spectators' memory, thereby creating their own stories outside of the play. By including music, *EBT* enables spectators to become emancipated in Rancière's sense:

> Theater should question its privileging of living presence and bring the stage back to a level of equality with the telling of a story or the writing and the reading of a book. It should call for spectators who are active interpreters, who render their own translation, who appropriate the story for themselves, and who ultimately make their own story of it. An emancipated community is in fact a community of storytellers and translators. (280)

The use of music extends audience engagement and becomes a visceral experience not only through the physical responses to music but especially when Donahoe asks two audience members to hold his electric keyboard while he plays a tune.

The most visceral and immediate engagement with the audience can, of course, take place in intimate theatre spaces in the round, as a performance at the Pegasus Theatre in Oxford in October 2015 showed (*EBT* performance Pegasus Theatre). When the narrator celebrates being in love, the very upbeat Curtis Mayfield song "Move On Up" is playing along and he feels the need to share his happiness by handing out high-fives (*EBT* 35). In the small Pegasus studio, Donahoe made an attempt at high-fiving the entire audience, even involving spectators in the back rows who had to lean forward or get up. Through this very simple physical act, the audience became part of the story world, counteracting the idea that physical contact between spectator and actor diminishes or even breaks the theatrical illusion held by a number of theatre scholars (Fischer-Lichte, *Transformative Power* 60-74). Emotional engagement was probably at a high level at the time, considering that, according to cognitive science findings, "[s]pectatorial empathy appears to be strongest when combinations of sound and movement entrain our bodies" (McConachie, *Engaging* 71). The scene thereby balances out notions of stasis and heaviness so often attached to depression because although the narrator has experienced trauma, falling in love and sharing the experience or even just the memory provides a hopeful sentiment, as the positive music highlights.

6.2.2 Sharing the "Werther Effect" in Performance

Together with the emphasis on creating a light-hearted piece, Macmillan is concerned with finding a balance between emotional accessibility and accounting for the realities of depression and suicide. After all, as his interview response above shows, *EBT* tells a "brutal story about hardwired suicidal depression," about a

mother who committed suicide and a family who is forever afflicted by the trauma and also experiences mental distress. The notion of depression being "hardwired" is incorporated into the play whenever the narrator refers to important facts on suicide and suicidal depression.

In the process of devising and writing, Macmillan conducted extensive research that found its way into the play (Interview). The most obvious dissemination of factual knowledge takes place when the narrator quotes directly from the UK charity Samaritans' guidelines on media coverage of suicide and when he refers to key literature on the 'Werther Effect' (samaritans.org). As one of the play's key moments, it has two important functions. First, the scene actualises the play's heterotopic potential because the real and imagined merge, since the term 'Werther Effect' refers to a real-world fact, namely an increase in suicides after the publication of Goethe's *The Sorrows of Young Werther* in Germany in 1773 (Stack et al. 355). Extensive research suggests that a particular way of reporting suicide in the media can lead to an increase in suicides because the media coverage might be perceived a 'inspiring' (Pouliot et al. 488-96). In order to decrease occurrences of 'inspired' suicide and to raise awareness, the World Health Organisation created recommendations for journalists, television and radio stations entitled *Preventing Suicide, A Resource for Media Professionals* in the year 2000 (Marsh 45). The Samaritans' publication "Media Guidelines: Portrayals of Suicide" and England's Department of Health's "National Suicide Prevention Strategy for England" followed in 2002 (46). These guidelines target the use of language, pictures, and details published in newspapers or on television and the Internet after a suicide, especially after the suicide of a celebrity (Cameron at al. 389-96), and call for caution when reporting on such incidents (Samaritans, "Media" 5). By including such facts into the play, Macmillan enters into real-world ethical discussions similar to the ones that concern science plays, especially those dealing with controversial issues like cloning or new cancer treatments (Shepherd-Barr, *Science* 53).

The scene's second important function relates to how the sharing of knowledge about the 'Werther Effect' aids the democratisation of madness. While the Samaritans' guidelines were initially supposed for journalists and other media professionals, suicide becomes a matter that concerns everyone when the narrator tells the audience: "Suicide is contagious." (*EBT* 28). He goes on to quote the Samaritans' recommendations directly:

Avoid descriptions of suicide as 'successful' or 'unsuccessful'.

Avoid dramatic headlines, terms like 'suicide epidemic' or 'hot spot'.

Avoid sensationalist pictures or video.

Avoid using the word 'commit'.

Avoid excessive detail.

Don't publish suicide notes.

Don't publish on the front page.

Don't ignore the complex realities of suicide and its impact on those left behind.

Don't speculate about the reason. That's crucial.

Don't supply simplistic reasons, such as 'he'd lost his job' or 'she'd recently become bankrupt'.

Offer advice to people at risk and those worried about family members and friends. (28-29)

Confronting the audience with such a long, instructive list is powerful and thought-provoking. It is highly reminiscent of the overwhelmingly long medication list on the medical chart in *4.48 Psychosis*. Yet, it is far more accessible than Kane's enumeration because it does not confront the audience with subject-specific terminology but speaks to them directly (if instructively). In particular, the recommendation to avoid the word "commit" might come as a surprise because it is such a common turn of phrase. In this way, Macmillan positions his play within real-world discourses on mental illness and engages directly with current pressing mental health issues. By employing the concrete example of the media coverage of suicides, Macmillan gives his play an explicit ethical dimension. He achieves this by democratising madness and facilitating a metacognitive stance because all spectators in the auditorium are addressed and called on to reflect on their own use of language, and to care about their acceptance or uncritical application of stigmatising terms and phrases.

   Delving deeper into cutting-edge research, the narrator tells the audience that "[s]tudies have shown that children with depressed mothers have a heightened reactivity to stress. Mothers who are withdrawn leave children to fend for themselves and it actually changes the chemistry of the brain, the fight or flight impulse" (*EBT* 39). As a means to confirm that suicide is contagious, the narrator recalls experiencing mental illness himself. Indeed he addresses this when he tells the audience of the complex juxtapositions of his emotions:

The real risk, that I'd felt my whole life, was

that I would one day feel as low as my Mum

had and take the same action.

Because alongside the anger and

incomprehension is an absolute crystal clear

understanding of why someone would no

longer want to continue living. (39)

This crucial moment bears the risk of being received as an endorsement of suicide since the narrator confesses to his tolerant attitude on suicide. However, this impression is swiftly counteracted by the narrator not pausing over the statement but moving into the happy memory of introducing his later wife to his parents. Earlier in the play, Macmillan employs a similar strategy when the narrator recalls learning about Goethe's *The Sorrows of Young Werther* in a university lecture. Rather than relating to the protagonist and his actions, the narrator passes the following frank judgement: "I read the book. *The Sorrows of Young Werther*. It was shit. I didn't connect with it" (*EBT* 29). Not only does the dismissive statement provide comic relief but it also substantiates the notion that a democratic approach to madness does not mean praising or glorifying mental distress. Democratising madness in the way that Macmillan interprets it in *EBT* relates to the idea that it should be possible to engage empathically or emotionally with mental illness without pity or disdain. Making madness everyone's concern during performances coupled with the narrator's sharing his personal experience simultaneously individualises and democratises madness. This concurrence provides a persuasive counter-point to the silence and stigma so often attached to mental illness.

Ultimately, *EBT* is decidedly life-affirming. When the performance ends with Ella Fitzgerald and The Ink Spots' song "Into Each Life Some Rain Must Fall" this is not at all diminishing of the suffering mental distress can induce. The light-hearted piano melody accompanied by lyrics that tell of someone who is overwhelmed by sadness, captures the mood of *EBT* with its constant juxtapositions of sadness and hopefulness, of laughter and tears. Donahoe's final act is shaking hands and even hugging audience members. The physical act breaks the fourth wall, decreases the distance between actor and audience, and corroborates the sense of community in the shared space of the theatre. As a result, *EBT* can be described as what Dolan's calls "utopian performative" that "gives us a mode of thinking and seeing; it can't be confined to a set of stable, immobile criteria, because it relies on the magic of performance practice, on our belief in social justice and a better future, on the impact and the import of a wish, and on love for human commonality despite the vagaries of difference" (171). In other words, the experience of *EBT*'s breaking through the taboo and stigma around mental illness has a utopian dimension and holds the potential for change outside of the theatre. As a mental health play, *EBT* shows that Care in the Community need not be a failed attempt at outsourcing mental illness but that a genuinely communal approach to madness is possible.

6.3 Chapter Conclusion

To sum up, both plays seek to democratise madness in several ways. First of all, both break the fourth wall in order to emphasise that madness can be a communal phenomenon and that it concerns everyone, voluntarily as well as involuntarily. Unlike the plays analysed in the preceding chapter, Ridiculusmus and Duncan Macmillan highlight the importance of sharing an experience. In Ridiculusmus' case, it is sharing a strong sense of uncertainty and the call to accept perspectival and perceptual challenges. In Macmillan's case, it is the open approach to the taboo around suicidal depression. I argue that sharing these experiences in performance opens up avenues for engaging differently with mental illness and mentally distressed people. In this sense, both plays make creative attempts at destigmatising mental disorder without being prescriptive or didactic. It can be said that the two plays show that mental illness can be 'institutionalised' in a new way – it is taken out of the psychiatric hospital and re-integrated in the theatre. The theatre then functions as a heterotopia, but a heterotopia that attempts to reconfigure power dynamics and thus rivals psychiatric institutions.

Hence, the plays have a high political relevance that is based on this active engagement with mental health not only during performances but also beyond. Post-show talks and Q+A sessions involving the creative team, psychiatric and medical professionals, service users, and spectators serve the purpose of reaffirming this socially engaged agenda. What is more, they offer audiences the opportunity to contribute their thoughts and ideas to the discourse. Ridiculusmus' more obscure play requires such a contextualisation for realising its full potential and for communicating its objectives. Due to its participatory form, *EBT* more straightforwardly actualises its potential for re-defining how matters of the distressed mind can be shared and discussed.

The plays' sophisticated employment of heterotopic stages in the round, particularly of small community centre stages and halls, corroborates the sense of community evoked because such stages foster empathetic engagement. Although both plays ask audiences to tolerate uncertainties, the sense of uncertainty ultimately has a positive effect since it unites actors and audiences in their attempts to make meaning. Meaning is not to be equated with the type of power/knowledge that psychiatry holds over mental illness. Rather, *Eradication* conveys the strong sense that it is possible to live with mental illness, while *EBT* suggests that one can move on from mental distress and trauma. Both plays are actively and socially engaged because they seek to democratise madness and call for it to be accepted as part of the human condition. Even though they also partly highlight the epistemological difficulties of understanding the experience of mental distress and employ creative strategies to do so, the plays analysed in this chapter ultimately frame mental disorder as an ethical and a communal concern.

7 Conclusion

This study set out to outline the poetics of the mental health play. A definition of the two different discourses under analysis, the madness discourse and the mental health discourse, based on a critical reconsideration of Michel Foucault's understanding of the concept, was necessary in order to position the theatre as 'inter-discourse' in Jürgen Link's extension of Foucault's terminology. Understanding theatre as an inter-discourse helped to substantiate the notion that the theatre both as institution and space enables and fosters communication and exchange not only between said discourses but also between audiences and the stage. The study established that audiences, when watching a mental health play, partake in the complex power/knowledge-dynamics that are constitutive of the madness and the mental health discourse. Audiences are thus active and emancipated in Rancière's sense and their role in mental health play performances is crucial for the renegotiation and production of mental health knowledge.

I coined the term 'mental health play' because it is timely and necessary for capturing contemporary theatre's central role in addressing one of the most pressing concerns of our time. The term was applied to a formally and structurally diverse corpus of plays that, despite their heterogeneity, share a number of distinct features. To begin with, they have in common the concern for and awareness of the madness and mental health discourse of the time in which they were written.

Moreover, the plays variously voice critique of psychiatric practices and stigmatisation in the mental health discourse. What is more, most of the plays operate with the gaze as a theatrical strategy that problematises the notion of power/knowledge, i.e. hierarchical constructions that determine what is 'normal.' This critique is often corroborated by heterotopic stages in the round that have the potential to foster metacognitive knowledge because such stages enable audiences to reflect on conventional modes of perception. Due to the fact that such stages problematise the complex operations of gazing, participating, and contributing in performances as they take place, this can illuminate how knowledge is produced. Thus, mental health plays show audiences what often remains hidden and engage emancipated spectators in creating a different kind of mental health knowledge. This is of particular importance with regard to mental illness because it remains a taboo in Western societies. The more silence there is around a topic, the more scope there is for myth. Silence and myth around mental illness lead to stereotyping and othering. I showed that mental health plays counteract this tendency and do both cultural and socio-political work because they provide different approaches to the experience of mental distress and mental illness.

Theatre as an 'inter-discourse' has interdisciplinary potential which requires further consideration beyond what I addressed in the present study. Recently, a number of plays have been used to educate medical practitioners, and some mental health plays might also invite such usage as a means of exchanging knowledge across disciplines. On the importance of interdisciplinary research that bridges the gap between the two cultures, Vanessa Thorpe states,

> it looks as if the long struggle to break down barriers between science and creativity has entered a new phase. Not only is it conceded that scientific discoveries are fertile artistic territory, but scientists are being increasingly open about the value of the arts when fresh perspectives are required. (n.p.)

A good example of how plays provide new perspectives in non-theatrical contexts is the interdisciplinary AHRC-funded research project "Beckett and the Brain" at Warwick, Birkbeck and Reading Universities, which comprised of a number of workshops held in 2012. The project's exploration of Samuel Beckett's work aimed at coming to new understandings regarding mental experiences, and brought together theatre scholars such as Elizabeth Barry and Jonathan Heron and psychiatrists like Matthew Broome (239). The workshops' other aim was to educate trainee doctors in order to inform clinical care (Barry et al. 239). Barry, Heron, and Broome argue that Beckett's *Not I*, which was used in one of the workshops, "becomes a phenomenological case history and the methods of the workshop offer strategies for interpersonal treatment" (239).

Some of the plays analysed in the present study would be equally suited to examining alternative states of the mind in educational contexts. In fact, Macmillan's *Every Brilliant Thing*, due to its set-up and premise is designed to start conver-

sations around suicide and the stigma that comes with it. Thanks to the inclusion of material taken directly from the Samaritans' guidelines, the play is *per se* educational because it dispenses information on how to address suicide not only in the context of media reporting but beyond. Plays set in hospitals such as *Blue/Orange* and *Equus* lend themselves to discussions with doctors and therapists because their negative portrayals of clinical and therapeutic practices are likely to incite strong views. However, it would not be productive to have discussions revolve around the accuracy of the depictions of mental conditions or the correct representation of the psychiatric profession. Rather, the plays might inspire self-reflections on bedside manner or about how the language used when talking to patients could be perceived as alienating or unhelpful.

One of the greatest achievements of the mental health plays discussed in this study is a profound engagement with the audience's gaze. In terms of an ideal typology, it is possible to differentiate between three different types of gaze on the theoretical level. First of all, there is the 'pathologising gaze,' in line with Anna Harpin's idea that some plays let audiences look *at* madness. This particular kind of gaze tends to contribute to stereotyping and the othering of madness and mad characters. Secondly, when audiences look *with* madness, i.e. when plays convey a sense of what it is like to live with mental disorder, the 'experiential gaze' is at work. Thirdly, when plays utilise what I call the 'second-order-gaze,' this can produce metacognitive knowledge. This applies whenever audience members develop critical awareness of their gaze and its ideological underpinnings. These types of gazes are by no means mutually exclusive but they can overlap in a performance. I showed that mental health plays variously operate with these different types of gazes and achieve a number of goals.

Another of my key points was that, when staged in the round, mental health plays offer a unique environment for realising a critique of psychiatry's power/knowledge system. The concept of heterotopia, introduced by Foucault and adopted and extended by theatre scholar Joanne Tompkins, was brought into the discussion to corroborate the idea that theatre's spatial dimension is inextricably linked to mental health drama's highly political and politicised nature. According to Tompkins, "[h]eterotopic theatre may not in itself directly create political change (theatre almost never has the capacity), but it is possible that a performance might affect audiences significantly by demonstrating how change for the social good (however incremental) might take place off stage" (29). I argued that mental health plays on heterotopic in the round-stages in particular challenge audiences in visceral and immediate ways because this kind of staging can engage the 'experiential' and the 'second-order gaze' in ways that foster metacognitive processes and thus open up dialogues (spoken or otherwise) that have the potential to initiate the social change Tompkins envisions.

My critical reading of Alan Ayckbourn's *Woman in Mind* and Tony Kushner's *Angels in America* in chapter 3 located madness not in the expected space of hospi-

tals and asylums but in dysfunctional domestic contexts. The chapter traced how the plays use the notions of domesticity and of hysteria to pathologise the female characters in an attempt to subvert hegemonic ideas of mental illness. However, although both plays seemingly counteract the notion of 'female malady,' in Elaine Showalter's sense, by employing the dramaturgical twist of utilising the 'experiential gaze,' this does not necessarily result in undermining the aforementioned stereotyping. In Kushner's homonormative stage world in particular, Harper Pitt is not so much the object of laughter as of incidences of what I called 'double-othering': as a mentally distressed woman suffering from agoraphobia with a closet homosexual husband, she is largely confined to hallucinating in the domestic sphere. Mental distress and new forms of what Showalter has called 'hystories' emerge in all the play's episodes and within all character constellations (e.g. in the form of AIDS hysteria) but only in Harper's case is madness contained within and inextricably linked with the female body. The fact that *Woman in Mind* has recently undergone a rather radical transformation towards being perceived as a mental health play by critics and audiences alike proves that through the play's comic elements, Ayckbourn does not expose Susan to laughter but that laughter is a weapon to expose notions that audiences might hold regarding female mental distress. The analyses showed that both plays' theatricality could be regarded as attempts at subverting notions of gendered madness, although I demonstrated that Ayckbourn's theatrical strategy yields more critical results. Kushner's play ultimately others the female madwoman and recent productions that move away from his interpretation of Harper and the play's imagined ending without Harper suggest that this othering is problematic. Coupled with the heterotopic in the round-stage used for many productions of *Woman in Mind*, in performances, the experiential gaze overturns perceptual frameworks that determine what is 'normal.'

The fourth chapter presented three plays that problematise psychiatry's power/knowledge and which directly incorporate into their theatricality the 'pathologising gaze.' All three plays engage actively with both the madness and mental health discourse on the plot level. They also in their very structures realise what Rachel Clements has termed 'issue-consciousness.' It is this very issue-consciousness, i.e. the awareness of current burning real-world issues, that accounts for Shaffer's integration of anti-psychiatric thinking into *Equus*, for the open attacks on the psychiatric profession in *Blue/Orange*, and for Prebble's dialectical approach to the thematisation of the medical and the biopsychosocial models of mental illness alongside the most recent developments in psychopharmacology. In addition, this consciousness adds to the radical rethinking of profound epistemological questions that all three plays inspire regarding normative binaries such as ill/healthy, insane/sane, normal/abnormal, which dictate psychiatric practice and the contemporary mental health discourse. Echoing the political and societal sea change of relocating mental illness out of institutions and into the community,

the three plays literally place the issues at hand at the heart of the theatrical community and into sharp focus on heterotopic in the round-stages. I argued that staging in the round and variations used for a number of productions realised the notion of heterotopia because this particular spatial dimension coupled with the discussion of real-world issues subverted the very certainty that psychiatric discourse suggests. What is more, by thus playing with the gaze, all three plays reinforced the notion of the instability of power/knowledge dynamics in psychiatric contexts.

Putting the experientiality of mental distress centre stage is at the forefront of the two plays analysed in chapter 5. While the question how mental distress can be communicated dramatically in performance was central for all the plays under analysis, in *4.48 Psychosis* and *The Wonderful World of Dissocia* the problem of *qualia*, i.e. the question how to experience someone else's experience, is particularly rewarding to discuss. Added to that, the communication between page and stage and the differences between *mise-en-page* and *mise-en-scène* are of the utmost importance for considering the two as mental health plays. I argued that the two playwrights answered the *qualia*-problem by providing theatrically innovative stagings of the distressed mind. The postdramatic features of Kane's play, in particular its narrative fragmentation and textual malleability, combined with a high degree of lyricism, simultaneously captures the experience of mental distress and challenges theatre productions. In stark contrast, Neilson, in Beckettian fashion, attempts to keep control over text, narrative and performance in order to achieve the sense of dissociation that the play produces and constantly enacts. While the playwrights' dramatic and theatrical strategies differ in both plays, they achieve similar responses in audiences with their strong emphasis on experientiality. It is precisely this inherently experiential dimension that accounts for the fact that not many productions of *4.48 Psychosis* and none of *Dissocia* have so far relied on staging in the round. The productions and performances analysed demonstrated that the concept of heterotopia still applies in a slightly different way, in that the mirroring of form and content in both plays achieves the notion of the mind as an 'alternative space,' a key feature of heterotopia. Allowing audiences access to this often disturbing alternative space has been the aim of a number of theatre productions of *4.48 Psychosis*, while others have favoured foregrounding Kane's critique of the medical model of mental illness. Particularly the two productions of *Dissocia* that Anthony Neilson himself directed adhered to the extreme differences between the two acts and utilised both the experiential and the pathologising gaze, as envisaged by the playwright, in order to let audiences share the experience of both elation and numbness that often accompanies mental illness. Because of the stringent use of the 'experiential gaze,' both plays thus make an important contribution to giving voice to the patient experience, a perspective still often overlooked in the mental health discourse. What is more, both plays literally embody what it is like

to live with mental illness, which is another perspective usually hidden to anyone who has not experienced mental disorder.

Chapter 6 focused on two recent plays, the devised piece *The Eradication of Schizophrenia in Western Lapland* by theatre company Ridiculusmus and Duncan Macmillan's *Every Brilliant Thing*, to explore the notion that many recent mental health plays 'democratise' madness by building on and perpetuating an altogether more positive attitude towards mental illness. Initiated by the field of Mad Studies, strategies of 'normalising' madness and mental illness inform both plays and permeate their performances, as the analyses illuminated. Rather than pursuing a stereotyped anti-psychiatric appraisal of madness as a formative experience or as providing deeper insight into human existence, Ridiculusmus highlights the importance of appreciating a sense of uncertainty that is not only part of psychosis but, more generally, of being human. Macmillan, like Ridiculusmus, puts emphasis on a dialogic examination of taboo topics such as suicide and family mental illness. The dramatic strategies, i.e. the split stage used for performances of *The Eradication of Schizophrenia* and the participatory mode and the small in the round-stages of *Every Brilliant Thing*'s performances, corroborate the seemingly contradictory notions of uncertainty and dialogue. What is more, the two employ the 'second-order gaze' that fosters a metacognitive understanding of one's own assumptions and attitudes. Part and parcel of this gaze is the inclusion of a second sense, the sense of hearing. As audience members neither look *with* nor *at* mental distress but since there is a strong emphasis on listening and the production of critical awareness and new mental health knowledge, the 'second-order gaze' is at work.

The concept of heterotopia in these two examples accounts for the idea that it might be possible to democratise madness by not pigeon-holing it as illness but by potentially accepting it as one possible experience of the world that need not necessarily be stigmatised as aberrant. The two plays thus contribute to and critically engage with recent debates within the mental health discourse, in which leading clinical psychologists such as Peter Kinderman, Richard Bentall, and Anne Cooke address the shortcomings of the medical model of mental illness towards a more holistic approach to the experience of mental distress in all its expressions.

My analyses demonstrated that mental health plays critically engage with the current mental health discourse because they provide a space for socio-political debate and action not only as a critique of but as a counter-point to psychiatry. The aforementioned potential for discussion is heightened by mental health plays staged in the round because such performances put emphasis on the community's potential to include rather than exclude, and thus counteract the sense of isolation and non-communication that so often accompanies mental distress and mental illness. In this sense, mental health plays reaffirm the theatre's potential as a political institution. This study has sought to show that the subversive power of mental health plays can radically redefine what characterises us as human beings.

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9 Appendix

Play summaries

Alan Ayckbourn, *Woman in Mind* (1985)
The black farce opens in a suburban garden with protagonist Susan regaining consciousness after stepping on a garden rake and family doctor Bill Windsor attending to her. The first act reveals that Susan's relationship with her husband, vicar Gerald, her widowed sister-in-law Muriel, and her absent son Rick is strained. It turns out that Susan escapes into a fantasy world in which she has a seemingly perfect and happy family: husband Andy, her brother Tony and daughter Lucy, who all adore her. The spectators are aware of this because they share Susan's viewpoint throughout. As the play progresses, the real and the imagined world increasingly collide the more pressure Susan experiences, for example, when arguing with Gerald. In the second act, Rick appears, which intensifies the situation and leads to Susan fainting repeatedly when under emotional pressure. Bill Windsor provides some comic relief when he tries to tell Susan that she is not experiencing mental distress but he fails to help her. In a final farcical scene both the imagined and the real characters appear together on stage and take over to a

point where Susan seems to disappear because nobody notices her any longer. The play ends with her mental breakdown.

Tony Kushner, *Angels in America: A Gay Fantasia on National Themes* (1991/1992)
Angels in America consists of two non-linear, episodic plays, *Millennium Approaches* and *Perestroika*. The latter is the continuation of the former, including a similar *dramatis personae*. In the first play, which is set in New York in 1985, two couples, Prior Walter and Louis Ironson, and Mormons Harper and Joe Pitt try to come to terms with Prior's HIV and a failing marriage because of Joe's closet homosexuality, respectively. In a sub-plot, ruthless lawyer Roy Cohn, based on the American lawyer by the same name, who served a chief counsel during the espionage trial of Ethel and Julius Rosenberg in 1954, also contracts HIV and lives in denial. Agoraphobic Harper spends her time at home alone musing on the chaos raging around her, while Joe is at work or out looking for physical encounters with men. Drag-artist Prior discovers the first signs of AIDS on his body and has to face the fact that his partner Louis cannot cope. In a split scene, Harper and Prior meet in the 'threshold of revelation'-scene in which Prior reveals Joe's homosexuality and Harper tells Prior that he is more than his illness. After telling her about his homosexuality on the phone, Joe's concerned mother Hannah Pitt arrives from Salt Lake City. Joe and Louis meet by chance and begin an affair. The eponymous angel visits Prior to tell him that he is a prophet at the end of *Millennium Approaches*. In *Perestroika*, Roy Cohn's condition declines and he is looked after by Belize, a former drag queen turned nurse and friend of Prior. What is more, the ghost of Ethel Rosenberg haunts Roy before his death. He dies. Joe and Louis break up because Louis feels bad about having left Prior but Prior does not want him back. At the end, Harper, who seems to have recovered from deep depression through which Hannah helped her, leaves Joe. In the final scene in 1990, Prior, Louis, Belize, and Hannah gather around Bethesda Fountain under the angel statue there to ponder what the future might hold.

Peter Shaffer, *Equus* (1973)
Seventeen-year-old teenager Alan Strang blinded six horses with a metal spike at the stables where he worked before the play begins. In the first act, Alan is brought to child psychiatrist Dr Martin Dysart who was asked by magistrate Hesther Soloman to treat Alan. Dysart serves as both a narrator and a character throughout the play. He guides the audience through the play's fictional landscapes and traces how the crime happened when he speaks to Alan in therapy sessions, as well as to Alan's parents, over-zealously religious Dora and dogmatically socialist Frank Strang. The play's quest-like structure is interspersed with Dysart's reflections on his own professional doubts and personal crisis with his absent wife. In the second act the action culminates when Alan relives the trauma of stabbing the horses after his first sexual encounter with Jill Mason, a girl he met

at the stables. In a scene which depicts the psychoanalytical practice of abreaction, Dysart helps Alan through his painful memories and promises him to be well afterwards. As Dysart reveals to the audience in the final scene, contrary to what his profession would expect of him, he is highly doubtful about returning Alan to 'normalcy.'

Joe Penhall, *Blue Orange* (2000)
The play is set entirely in a psychiatric NHS hospital in the present. Two consultant psychiatrists, senior Robert and specialist registrar Bruce, have to decide on the diagnosis for patient Christopher, a young black Londoner, whose 28-day assessment period at the hospital has come to an end. Christopher has been sectioned for 'odd' behaviour he exhibited before the play sets in. Initially, the audience is left in the dark about Christopher's condition. As the play progresses, Christopher is the victim of a Darwinian power battle between the therapists that takes precedence over treating him correctly. The eponymous oranges that he perceives as blue rather than orange become the marker of his state. Moreover, Christopher is caught between Robert's overt racism and desire to free hospital beds, and Bruce's wish to climb the career ladder. The play ends with Robert asserting his superiority over Bruce and the decision to release Christopher to be cared for in his community rather than diagnosing him with schizophrenia.

Lucy Prebble, *The Effect* (2012)
In a contemporary clinical trial scenario for a new anti-depressant, *The Effect* juxtaposes the love story of trialists Connie and Tristan with the discussions of Dr Lorna James, who carries out the trial, and Toby Sealey, who represents the pharmaceutical company that commissioned the trial. Both characters are former lovers, which complicates their professional relationship. What is more, it becomes clear that Lorna is experiencing bouts of depression herself but, controversially, refuses medication. It is also revealed that some trialists are given placebos. Following a dialectical trajectory, while Connie and Tristan discuss the authenticity of their feelings for each other under the influence of the trial pills, Lorna and Toby argue over the efficacy of medication for depression. The play culminates when Tristan has a seizure because of an undiagnosed heart condition and subsequently experiences transient global amnesia, which ends the trial prematurely. Short scenes in which Connie and Tristan keep having the same conversation mark the end of the play. The last scene sees a depressed Lorna, unable to come to terms with the trial's outcome, finally taking medication.

Sarah Kane, *4.48 Psychosis* (2000)
Kane's fragmentary and experiential play has no characters, plot, setting, acts or stage directions. With a structure in which form mirrors content, it traces the inner landscapes of a depressed mind in intense monologues and quasi-dialogues, in

hospital scenes, nightmarish scenarios evoking the apocalypse, in snippets of painful conversations with loved ones, and random numbers on a page. The title-giving time of day, 4.48am is when clarity visits, as the depressed character reveals.

Anthony Neilson, *The Wonderful World of Dissocia* (2004)
Neilson's play has two distinct acts. In the first act, Lisa Montgomery Jones has been going through a difficult time before the play sets in. A man who looks much like Sigmund Freud, named Victor Hesse, visits and tells her that, on a recent journey to the United States, she lost an hour. Subsequently, the act is driven by Lisa's quest to find the hour in the land of Dissocia where she encounters a number of bizarre and absurd characters, such a Scapegoat, who tries to rape Lisa, Community Crime Initiative worker Jane who is employed to endure all the crime committed in Dissocia, and a friendly polar bear who sings a song for her. It turns out that Dissocia is at war because the Black Dog King fights against Divine Queen Sarah Of the House of Tonin, both puns involving depression. When Lisa realises that the citizens of Dissocia boycott her search, the first act ends in chaos. The starkly different second act takes place in a hospital room to which Lisa is confined now. It appears that the first act took place entirely in her head and that she was experiencing a state of mania. In the hospital, Lisa is sedated. She receives her frustrated sister Dot and her more understanding boyfriend Vince. Otherwise, she is attended to by nurses and a doctor, and she is supposed to rest. The play ends with Vince confessing that he understands Lisa's conundrum of taking or refusing medication.

Ridiculusmus, *The Eradication of Schizophrenia in Western Lapland* (2014)
The play depicts a family consisting of Mum, Dad, the sons Rupert and Richard, and Dad's new wife Jade, with a history of mental health problems and trauma, and links this with therapeutic encounters of a doctor and his patient. Neither Dad nor Jade appears on stage as individual characters even if some of their lines are spoken (by the actors playing the doctor and Mum). The family is dysfunctional; they do not communicate with or listen to each other. Richard is in therapy with the doctor and it turns out that Mum also has a history of mental illness. The doctor himself is caught up in a dysfunctional family situation, as the audience learns through phone calls he receives. Staged on a bare split stage, scenes at home and in hospital are juxtaposed in Acts 1 and 2. Although the play engages with the therapy form of Open Dialogue, which is the prime treatment for schizophrenia in Finland (hence the title), it does not stage therapy. Rather, its focus is on how mental illness disrupts families. The play's narrative is not entirely conclusive but the play ends when the dividing wall between the two sides of the stage is torn down in order to unite all characters on stage.

Duncan Macmillan, *Every Brilliant Thing* (2015)

Told from the perspective of a man whose mother committed suicide, this one-man participatory piece engages the audience in a journey which focuses on the experience of suicidal depression and its repercussions on families. The adult narrator shares in retrospect how the list of the eponymous 'brilliant things' came into existence after his mother first tried to kill herself when he was younger, and how the list accompanied him throughout his life afterwards. Moreover, the narrator recalls how he met his future wife Sam at university, how they got married, and how his marriage broke down over the strain that his own depression put on their lives. Audience members are assigned the roles of a vet, the boy's school counsellor Mrs Patterson, his future wife Sam, his father, and a university lecturer. Audience participation and the use of music is key in the play, particularly in the retelling of important events in the narrator's life. At two points, the entire audience acts as a group; once as wedding guests and once as a support group the narrator's adult self attends in order to manage his depression. What is more, a large number of spectators receive cards with numbers and 'brilliant things' on, which they are asked to call out at various points during the performance. Despite the severity of the subject matter, the play sustains a light-hearted tone and ends on a hopeful note.

„Göttinger Schriften zur Englischen Philologie": Zum Konzept der Reihe

Frauke Reitemeier

Die Reihe „Göttinger Schriften zur Englischen Philologie" umfasst Schriften zur Forschung aus den Disziplinen englische, amerikanische und postkoloniale Literatur- und Kulturwissenschaft, englische Fachdidaktik, englische Sprache, Literatur und Kultur des Mittelalters, Linguistik des Englischen. Veröffentlicht werden können:

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This study traces key developments in theatre's engagement with mental health since the 1970s. It introduces and applies the concept of the 'mental health play' as accurate and timely in addressing the way mental distress and mental illness have been brought to the stage. The study argues that the theatre is a central calibrator for reflecting developments and tensions in, as well as attitudes towards, mental health care, and thus opens up a domain that still has stereotypes and myths attached to it. Theatre's representations of mental distress inform and shape cultural production and vice versa. Mental health plays are central in encouraging and fostering conversations about mental health, and they thus intervene in ongoing debates. Due to its interdisciplinary approach, this study contributes to and extends existing research in multiple fields, including theatre and science, performance studies, and the medical humanities.

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