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The Blueness of Oranges: **Representations of Mental Illness in Theatre**

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Declaração a incluir na Tese de Doutoramento (ou equivalente) ou no trabalho de Mestrado

DIREITOS DE AUTOR E CONDIÇÕES DE UTILIZAÇÃO DO TRABALHO POR TERCEIROS.

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STATEMENT OF INTEGRITY.

I hereby declare having conducted this academic work with integrity. I confirm that I have not used plagiarism or any form of undue use of information or falsification of results along the process leading to its elaboration.

I further declare that I have fully acknowledged the Code of Ethical Conduct of the University of Minho.

Resumo.

The Blueness of Oranges: Representações de doenças mentais no teatro.

Durante séculos, a raça humana tem explorado variadas teorias ligadas às origens de doenças mentais. Uma explicação para a origem de certas condições aparenta ser uma necessidade para que a humanidade consiga tanto prevê-las como a aprender a reagir à sua presença. Uma cronologia tem vindo a ser construída com todos os conceitos e padrões investigados em relação ao tópico das origens e potenciais causas de doenças mentais, sendo que o século 20 provou ser um dos períodos mais fortuitos com o enorme avanço da psiquiatria. Este avanço no campo científico funcionou como catalisador para a criação de uma sociedade mais bem-informada e de uma maior variedade de expressões artísticas. Esta tese irá focar-se nas representações de doenças mentais na performance teatral, escolhendo não seguir um argumento ou visão específica. As representações de doenças mentais no teatro irão permitir um maior conhecimento sobre as variadas maneiras em que determinadas doenças foram classificadas na cultura popular ao longo do tempo, através de uma visão contextual. Questões sociais, tais como o nascimento de estigmas e outras convenções sociais serão também explicados através da análise de três peças que funcionarão como casos de estudo, de maneira a oferecer ao leitor uma visão mais expansiva de saúde mental. Estes casos de estudo serão analisados em secções distintas com o apoio de textos de natureza científica, de modo a estabelecer certos componentes, e serão considerados pelas suas semelhanças e as suas diferenças. Esta tese será concluída com algumas considerações finais sobre a importância do teatro como uma forma de arte na representação de saúde mental.

Palavras-chave: saúde mental, estudos performativos, estigma, doenças mentais, teatro.

Abstract.

***The Blueness of Oranges*: Representations of Mental Health in Theatre.**

Over the centuries many theories on the origins of mental illnesses have been explored by humankind. An explanation for the happening of certain mental states is a necessity for human beings to either prevent them or to learn how to cope with them. A clear timeline has been progressively built with all the conceptualizations and patterns researched regarding the topic of the origins and potential causes of mental illnesses, being that the 20th century proved to be one of the most fruitful times in the advances of psychiatry. This spread of scientific information served as a catalyst for a more well-informed society and to a greater variety of artistic expressions. This thesis will focus on the representations found in theatrical performance, not choosing to follow a specific biased argument or viewed. The singular representations of mental illness in the theatre will allow a better understanding of the way such illnesses may have been regarded in popular culture throughout the ages, through a contextualized view. Social issues, such as the birth of stigmas and other social conventions will be thoroughly explained through the analysis of three case study plays, in order to offer a more expansive view of the concept of mental health. These case studies will be analyzed in sections with the aid of scientific sources to establish specific characteristics, and will be explored for their similarities and differences. The thesis will conclude with some final thoughts on the importance of theatre as an art form in the representation of mental health.

Keywords: mental health; performance studies; stigma; mental illness; theatre.

INDEX.

PART I.

1. INTRODUCTION.

Finding ways to keep a sane mind and healthy body has been one of the main concerns of many generations prior to our time. Ensuring these living conditions is often a great indicator of a long and prosperous life, without many obstacles or drawbacks. To keep a healthy body may be theoretically easier than to keep a sane mind, but both are essential for an individual to live for as long as possible within an organized society. Nonetheless, as of late, a greater spotlight has fallen on the outsiders; on the individuals who fail to keep what society perceives as a sane mind. This spotlight has explored the severe consequences of signalling these individuals as more is learned about mental health, and as more talking is done about what it entails. In our contemporary society it has become more common to read about mental illness, or to follow the life experiences of those struggling with it through personal records. Moreover, there are still many questions to be answered and problems to be addressed within our societal organization when it comes to mental health. Often portrayals of mentally-ill individuals in mass media devices and/or art forms help to achieve a greater sense of communication between individuals and may offer greater educational support. Nonetheless, there are still a variety of predetermined notions attached to individuals suffering from mental illness, which are related in some. Some of these notions are quite recent and have been crafted through life experiences and/or certain portrayals in public devices, while others have been constant throughout the ages.

In this thesis, the focus will not be given to the portrayal of mental illness in mass media devices, but rather, as mentioned, to the theatrical perspective. This perspective proves to be very diverse, rich and full of changes. Representations may find some common themes or ways of communicating, but, much as with real life cases, each representation is singular and unique. Thus, the manner in which some of the characters mentioned throughout the plays are portrayed in accordance to their temporal and spatial locations will be compelling to analyze. In what manner do the temporal notions attached to each of the mentioned playwrights' societies help to shape the way these illnesses are presented to audiences? One of the main focuses of this thesis will thus be to understand the way representations of mental health have progressed and changed over the centuries in the West, and how these changes relate to social stigmas and predetermined concepts.

2. MENTAL ILLNESS AND ITS PLACE IN WESTERN SOCIETY: A BRIEF OVERVIEW.

2.1. Understanding mental illness.

This thesis cannot begin with a proper definition of what a mental illness is or what it entails. The understanding of it will have to come from a mixture of scientific and personal knowledge and/or life experience. There is a reason for such. The reason being that a singular, uniform definition of mental illness is quite hard to be fully redacted. Due to a large variety of different illnesses with distinctive characteristics and origins, it is quite a Herculean task to narrow it down to a single concept without falling into the error of generalization. Thus, it may be a greater option to understand the conceivable causes and effects, which may lead to such cases. This section will be committed to this understanding of the different ways in which an illness of the mind may find its place within an individual.

In their 2017 article[1], Paul Patterson and Persephone Sextou construct and present a vast array of the most popular causes for mental illnesses to occur. As they argue (2017: 1) "mental ill-health per se is related to a combination of socio-environmental, psychological and biological factors". This idea suggests that there could be many viable combinations to be made within this spectrum of distinctive factors, which may give rise to different types of mental illnesses (e.g. depression, bipolar disorder, schizophrenia, etc.). This is not to claim that there aren't recurring, and fixed symptoms associated with specific mental illnesses, especially since these fixed symptoms will, in the second part of this thesis, be taken as evidence in the analysis of case studies. While individuals can experience their illness in their own unique way, as consequences of a special combination of the previously mentioned factors, there are many similarities in symptoms and ways of being to be found upon the comparison of different individuals. Most mental illnesses do share some fixed traits with each other. The point to be made is that life experiences, biological traits, possible traumas, etc. are all unique to a singular person. As found within Patterson and Sextou's article, in the majority of analyzed cases, a patient's mental condition arises from issues related to his/her life experiences, social environment and upbringing. Accordingly, most cases date back to the early years of someone's life. As Patterson and Sextou exemplify (2017: 2):

[1] All references will be drawn from Patterson, Paul & Sextou, Persephone (2017), *Trapped in the Labyrinth - exploring mental illness through devised theatrical performance.* Medical Humanities. DOI:10.1136/medhum-2016-011094.

> Most mental health conditions have been found to first emerge in childhood and adolescence, half by age 15 and 75% by age 25 with at least 30% of mental ill-health directly attributable to adversity in childhood such as *abuse, neglect and domestic violence*[2].

Within the given adversities, sexual abuse is the primary cause of both childhood and adult psychiatric disorders. Such statistics do portray individuals in a dehumanizing manner, turning their personal stories into numbers, nonetheless they are a tell-tale sign of the way society may perform a crucial role in the development of many mental illnesses. It demonstrates that, in most cases, the root of the problem is social, thus most likely to be prevented. Abuse, neglect and domestic violence are not biological issues, which can be studied and somewhat cured by medicine. These are social concerns, which are still recurrent today. However, fully eradicating these issues would be immeasurably hard. I argue that the best possible course of action would be to try and lessen the opportunities for such demonstrations of abuse and lack of conditions to arise. Nonetheless, human beings are, in most cases, aware of the dichotomy between good and bad. They understand that their actions are condemnable, but they still perform them to satisfy their selfish needs. Thus, abuse and violence will, most likely, always be a constant within society, as well as a source of both fear and shame for the individuals they affect.

This fear and shame are often the products of a grave scrutiny of others, which individuals in a society perform, or a product of some established beliefs and opinions regarding specific situations. Amidst a very progressive state, there are still many predetermined ideals attached to mental health conditions, which are condemnable but difficult to alter. Using terms such as "crazy" (in a depreciative manner), "depressive", or expressions such as "not playing with the full deck" may insinuate that the mentally-ill individual is the one at fault for lacking something or that his/her behaviour does not fit in with the norm. Thus, it is through such conceptions that stigmas are born.

The word "stigma" derives from Ancient Greek and refers to, as referenced by Patterson and Sextou, (2017: 3):

> the type of visible marking that was cut or burned into the skin of individuals identified as **"***morally polluted***"** [...] and thus forcing individuals to literally carry shame and disgrace as a *"tattoo"* of dishonour.

[2] These are my own italics.

Individuals will thus be branded as (2017: 3) "morally polluted", as some of their actions may fail to meet with the standards of morality and normality, which are established by the society they live in. The concept of normality has to do with these boundaries. Therefore, to speak of normality is to fall into the trap of being biased by one's own views, which have, clearly, been shaped by the society one has grown up in. R. D. Laing, in his 1964 essay, *The Divided Self: An Existential Study in Sanity and Madness*[3] places this question of normality within a wider context. Laing argues that (1964: 11),

> In the context of our present pervasive madness that we call normality, sanity, freedom, all our frames of reference are ambiguous and equivocal [...] A man who says that men are machines may be a great scientist. A man who says he is a machine is 'depersonalized' in psychiatric jargon.

What Laing suggests is that an individual is either sane or insane, in accordance to what his/her own society considers being normal and abnormal behaviour. That is why marking is such an important part of the concept of stigma, as it offers sane individuals a safe distance from the insane. It works almost like a defence mechanism against the threat of mental illness. Mental illness can attack anyone; however, by claiming that a separating line is established between normal and abnormal, mentally sane individuals may feel safer from the threat of being perceived as ill. Obviously, mentally-ill individuals' (2017: 3) "tattoo of dishonour" is not of a physical nature, but I argue that it could be understood as a metaphor for a likely diagnosis. In many cases, once the diagnosis is known, the individual is immediately branded with all the known stigmas pertaining to the illness. That is why most psychiatrists follow the morality of keeping silent about their patients' state. The mark may not be noticeable from the outside, but once discovered, it becomes quite a Herculean task to reverse the stigma attached to it. Society becomes the most significant factor to consider in the origin and overall classification of mental health issues, as well as both the concept of self[4]- and public[5]- stigmas.

2.2. The impact of stigma.

[3] All references will be drawn from Laing, R. D. (1964), *The Divided Self: An Existential Study in Sanity and Madness*. Pelican Editions. London, United Kingdom.

[4] (Patterson, Sextou, 2017: 4) "the degree to which an individual internalises negative beliefs and stereotypes about mental illness".

[5] (Patterson, Sextou, 2017: 4) "the local consensus view of mental illness."

As Patterson and Sextou (2017: 4) argue:

> Erving Goffman [...] described the impact of stigma on an individual as a spoiling of self-identity in relation to a perceived flaw or undesirable characteristic when judged against the norms or expectations of the society in which the person lives.

Stigma is described as a probable trigger to the building of negative feelings within individuals (e.g. shame, silence, ignorance, isolation, etc.). These feelings may have direct consequences on the way such individuals seek help, with many choosing not to do so for fear of being stigmatized. History tells us that stigmas associated with mental health have been recurrent throughout the ages, albeit with a few changes. What is also somewhat recurrent are the chosen scapegoats. Minorities are commonly targeted the most with people from other races[6], women (and homosexuals) being the major sources of exploitation. Women are often linked to hysteria, due to another set of separate stereotypes, which are linked to gender[7]. Within racial stigmatization, black people are often the most targeted. These stigmas are mainly related to history and to feelings of overall power imbalance between a dominant race and its inferior counterpart. Focusing mainly on the U.S., the African and African American population have the highest ratio of mental illness in the country. According to a study on the official Mental Health America website[8], which has been conducted through an extensive time frame, about 13,2% of the population in the U.S. identify themselves as African American or Black. Out of those, about 16% have been previously diagnosed with a mental illness. The result is that about 6 million people, within this specific community, suffer from a mental illness (not counting the undiagnosed). The colour of an individual's skin turns to be an important social factor to the origin of many of these cases, as it is also often linked to adverse social conditions, racism or negative experiences stemming from attached stigmas. Black people have been badly treated over centuries (e.g. slavery, persecution, segregation, etc.). The historical knowledge of one's own race being treated with inferiority for nothing more than biological traits entails that many may still perceive the colour of their skin as an indicator of inferiority or something which is not up to the

[6] Other than Caucasian.

[7] The way women are considered to have a more emotional side when compared to men is often explored in novels, and other art forms, as a source to hysteria and over dramatization.

[8] All data is referenced from Mental Health America (2010-current), *Black & African American Communities and Mental Health.* http://www.mentalhealthamerica.net/african-american-mental-health

standards of beauty or normality. In the U.S., many neighbourhoods with less than ideal life conditions are heavily populated by black people, proving that the percentage of African or African-American individuals living in poverty is higher than with any other race. This concept of race being heavily linked to mental illness will be explored in more detail in the second part of this thesis with Joe Penhall's play *Blue/Orange* (2001) as the main source of discussion.

For now, the question becomes the way mental illnesses are treated. Psychiatry has become the greatest focus of scientific knowledge by aiming to consider the biology behind mental health conditions. The evolution of psycho- and chemotherapies has provided a seemingly haven for society's outsiders, as well as a hope for a cure or favourable treatment. This next section will thus contemplate the way psychiatry has evolved, mainly in the 20th century, focusing mainly on the creation of psychotherapy sessions and their connection with theatrical performance. Chemotherapies, while important, will only be mentioned as a source of treatment, as they do not provide us with the necessary information for the fulfilment of this thesis.

3. THEATRICAL PERFORMANCE AS A MEANS OF EDUCATION.

3.1. Psychotherapy as a dramatic performance of catharsis.

By the early 20th century, the theories of Sigmund Freud (1856-1939) gave birth to a new form of therapy known as "psychotherapy" or "talking cures". Freud argued that the human mind was divided into three layers: the conscious[9], the preconscious[10] and the unconscious[11]. The point of Freud's therapy was to release the repressed instincts of the unconscious into consciousness by providing the patient with a safe place to discuss his/her inner turmoil in the style of a catharsis. The patient was to lie on a couch and go through several established points, while the psychoanalyst monitored his/her speech. The analyst could sporadically intervene with clinical concepts. From a drama-biased point of view, such therapy sessions could have the potential to use theatrical performance as a force in the understanding of the patient's mind. It was this realization that birthed drama therapy. Drama therapy focuses on allowing the

[9] Where our thoughts and feelings live.

[10] Where everything we can recall from memory is placed.

[11] The deepest level of our minds where reside the processes that drive our behaviour. Mainly primitive and instinctual desires.

patients to release their inner turmoil through the means of improvisation and theatrical performance. It borrows greatly from psychotherapy's environment of doctor/patient. Much like an actor on stage, the patient "performs" a monologue to an audience, the analyst. The analyst may sometimes interrupt to initiate dialogue. If there are no interruptions throughout the session, the analyst performs the role of the audience, left to figure out the intrinsic patterns of the character's mind and how the individual chooses through language and gestural signs to portray his/her inner issues. This similarity between the psychoanalyst and the audience of a play is further explained in Derek Russell Davis' 2002 essay *Scenes of Madness: A Psychiatrist at the Theatre*[12]. The author asserts that, (2002: 14) "The audience, like the psychotherapist, have to make do with what is expressed and communicated, verbally and non-verbally, in speech, gesture, or body-language". It is through signs in speech, gestures and body-language that a mental condition may be understood, and it is the work of the observer to gather enough information. In his essay, Russell Davis also argues that the underlying dramatization of speech and action in the performance of the patient's monologues (and/or dialogues) is a crucial undertaking for fruitful therapy sessions. The way theatrical performance is organized enables patients to speak about certain taboo issues without the overwhelming feeling of proximity[13]. This thought is a companion to the notion of aesthetic distance. This is explained in Russell Davis, (2002: Foreword, vii.):

> [...] (aesthetic distance) enables people in the audience to understand things in different ways, or to see things that they had not seen before. [...] The paradox of distance is that it allows us to come closer (Jennings op. cit.) and themes that perhaps are too hot to handle in any direct way are presented to us in dramatic form.

The overwhelming paradox is posed in the way this aesthetic distance allows patients to exile the weight of their turmoil to other contexts, while simultaneously becoming more aware of it through this contextualization. The distancing of the individual from his/her own personal story through the aid of theatrical performance may allow for a better understanding of such issues, as they are analyzed in a greater, impersonal manner. As opposed to chemotherapies which are based on the premise of controlling the patient's mind using prescribed drugs, possibly clouding the patient's own judgement;

[12] All references will be drawn from Russell Davis, Derek (2002), *Scenes of Madness: A psychiatrist at the theatre.* Taylor & Francis e-Library.

[13] The patient may regard his/her issues as a part of the play, monologue or dialogue being performed, placing its heavy weight on another world.

these forms of therapy allow the patient to have a clearer judgement regarding his/her illness. Thus, psychotherapy sessions gain this theatre-like quality, which proves to be essential.

Other similarities arise when comparing psychotherapy contexts with theatrical patterns. In their majority, plays evoke similar feelings of inner conflict within the protagonist. The protagonist's mission is to explore and enquire about the conflict's origins in order to undertake it. That is also the mission of therapy patients. Patients are incited to look for the origins of their turmoil, in order to understand it and to express it through dramatic performance to achieve a sense of cathartic purgation. This notion of catharsis as a conductor to psychological healing was first explained by Aristotle in his *Poetics* (335 B.C. - 323 B.C). Aristotle presents the concept of tragic catharsis[14]. This concept is built around the premise that for an individual to purge herself/himself of specific negative emotions, (s)he must come into protected contact with them. Joe Sachs gives, in his article on Aristotle's *Poetics*, the example of fear and how human beings search to feel fear, in order to redirect such emotion into a more concrete, albeit not threatening situation. That is what the contextualization of theatre may offer. A purgation of one's negative feelings helps to achieve a better understanding of the world around oneself. Sachs explains how the word catharsis, in the original Greek, has purification as one of its meanings. By purging negative emotions through the help of external triggers, humans try to purify such emotions of their base/worse parts. To summarize this notion, Sachs states that, (n.d.) "Aristotle's use of the word catharsis is not a technical reference to purgation or purification but a beautiful metaphor for the peculiar tragic pleasure, the feeling of being washed or cleansed". This intrinsic quality of theatrical performance in psychotherapy sessions allows a greater understanding of how important theatre may be in the realization and education of mental health issues.

3.2. Contextualized representations of mental illness in theatre.

As Russell Davis comments, plays describe scenarios of "madness". With a few exceptions, they say little or nothing about either the mental mechanisms or the biological factors involved in the illnesses they represent. The finding of the basis of trauma and origins of illness is what psychoanalysis is concerned with, in order to offer suitable treatments to purify the patient's inner turmoil. As we have been discussing, theatre is mostly concerned with placing mental illness in specific contexts, that is, presenting

[14] The concept shifts around with the notion that theatrical performance may be a form of purgation, as described by Joe Sachs in his work *Aristotle: Poetics,* written for the Internet Encyclopaedia of Philosophy (n.d.). https://www.iep.utm.edu/aris-poe/#H4.

situations in which the audience can better understand and relate to what is being performed by the actors on stage.[15] Models of mental illnesses are thus created following a specific temporal and spatial frame. As explained in Russell Davis' *Scenes of Madness: A Psychiatrist at the Theatre* (2002: 2):

> [...] playgoers can learn as much about madness at the theatre as from textbooks of psychiatry, and that the understanding plays give of madness is all the more vivid because the events are presented dramatically, evoking feelings as well as intellectual curiosity.

It is easy to understand how audiences in a theatre are granted a closeness to the stories being portrayed, more so than an individual watching a film or reading a book. The closeness to the actors, story and stage may seem contradictory to the ideal of aesthetic distance, which is often mentioned, nonetheless both qualities complement each other to create a neutral space where the audience can be immersed within a play, but still perceive it with exterior perspectives. Furthermore, the contextualization of certain themes may help to better shape and determine someone's views regarding the theme itself. The issue becomes the lack of guarantee that the ideals represented in theatre are more socially unbiased than those in psychiatry. Psychiatry has many pros, nevertheless there are some ethical issues that arise from the analysis of certain operations. The before-mentioned psychotherapies are the greatest source of help in the treatment of mental illness. However, they present certain flaws, namely the manner in which they create an imbalance of power between patient and analyst. The analyst is given power over all the information of the patient's life. There is an unequal balance between both individuals, as the therapist offers little to compensate for everything the patient gives. The major concern is the shaping of patients' views in accordance to the psychiatrist's own predetermined ones. As R. D. Laing explains in his essay The Divided Self: An Existential Study in Sanity and Madness (1964: 24) "The behaviour of the patient is to some extent a function of the behaviour of the psychiatrist in the same behavioural field". It entails that the analyst has the power to shape the way the patient behaves or thinks in/about specific situations. This issue will be further explored in the second part of this thesis, as the analysis of the three case studies will touch upon the questioning of relationships between patients and doctors in medical environments, and respective influences. Returning to the question at hand, in a world filled with distinctive representations of mental illness, how can one guarantee that playwrights and actors may choose to portray mental health in non-stereotyped manners? How can one guarantee that the influence

[15] Mainly to do with theatre's characteristic of being a dichotomy of reality and illusion.

of theatre may be more fruitful than that of psychiatry? The issue in answering this question is the following: mental illness is experienced in different manners.

It entails that the analyst has the power to shape the way the patient behaves or thinks in/about specific situations. This issue will be further explored in the second part of this thesis, as the analysis of the three case studies will touch upon the questioning of relationships between patients and doctors in medical environments, and respective influences. Returning to the question at hand, in a world filled with distinctive representations of mental illness, how can one guarantee that playwrights and actors may choose to portray mental health in meaningful and productive ways instead of stereotyped ones

> It is also understood that individuals experiencing mental ill-health have differing, backgrounds, cultures, class, race, sexuality, identities, histories and experiences and theatre can never portray a comprehensive representation of mental illness per se on stage.

Thus, it becomes hard for the playwright to conjure up the same feelings and thoughts on mental illness within an audience, as the same portrayal might give rise to different views and opinions depending on each person's life experience. It is possible to build a non-stereotyped representation of mental health and still lead some members of the audience into nurturing stereotyped views. Hence, there is no absolute right or wrong when it comes to the portrayal of mental illness in theatre, as all views may have different interpretations and degrees of impact, as identified in the ensuing case study.

In 2014[16], analysts Livingston, Maxwell, Hole, Hawke and Parikh conducted research on the influence a one-woman theatrical performance on bipolar disorder could have on different audience members, with contrasting experiences. The study focused upon a show named *That's Just Crazy Talk*, where the character targets the different attitudes individuals may harbour towards individuals suffering from bipolar disorder. It counted with 33 participants, 14 patients and 19 healthcare providers and/or family members, whose interviews after the show offered the analysis' content. The conclusion reached was that, as cited from the original article, (2004) "The performance was judged to have the potential to affect stigma, as 67% people with BD [bipolar disorder] and 85% of healthcare providers thought the play

[16]Michalak, Erin E.; Livingston, James D.; Maxwell, Victoria; Hole, Rachelle; Hawke, Lisa D.; Parikh, Sagar V. (2014), *Using theatre to address mental illness stigma: a knowledge translation study in bipolar disorder.* Int J Bipolar Disord. 2014; 2: 1. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4215813/

could change public acceptance of BD". Such high percentages encourage the notion of art being an impetus to a more educated societal space. The way the highest percentage of change comes from healthcare providers reveals a lack of information and bias, which is somewhat prevalent in some cases. Qualitatively, both groups showed enduring positive changes in the understanding of the illness, mainly the way it can be comprised by a number of stereotypes. All in all, the analysts concluded that (2014) "Theatrical traditions clearly hold the potential to impact audience members, both at affective and cognitive levels, and to foster insight and deepened understanding". Thus, it becomes essential to understand how delicate the issue of a rightful representation of mental health in theatre can be. Each representation will have its own interpretations, nonetheless the playwright is given the arduous task of communicating a message that will not reinforce harmful stigmas or worsen the views of his/her audience.

4. AN OVERVIEW OF THE REPRESENTATION OF MENTAL HEALTH IN WESTERN THEATRE.

4.1. Introduction.

In this thesis, the spotlight on the representation of mental health in theatre will be mainly given to the West. In what way has the portrayal of mentally ill individuals been developing through the centuries in Western culture and drama? To explain its development, it is first essential to understand in what ways mental health issues can be communicated to audiences. More often than not, playwrights borrow from specific established conventions as a basis for the building of their characters. Femi Oyebode enumerated in his 2012 essay "Madness at the Theatre"[17] the conventions, which are most often chosen by playwrights to disclose a mental illness. Oyebode considers that, in order to portray the necessary message to audiences, the playwright must borrow from, as quoted, (2012: Preface, vi) "conduct, bodily posture, gait, gestures and facial expressiveness, language, and dress". Much like a code, these conventions work as basis for actors to, as the author continues to explain, (2012: Preface, vi) "signal internal, inner feelings by visible behaviour". Thus the character's afflictions are to be expressed through external symbols, which audiences may understand as a product of the character's mental state, due to it following the established social conventions of the time. As the perception of audiences about mental

[17] All referenced quotations will be taken from Oyebode, Femi (2012), *Madness at the Theatre*. RCPsych Publications. Royal College of Psychiatrists. London, United Kingdom.

health and how mentally-ill individuals conduct themselves evolves, through a more accessible education on the matter, these established codes are also caught in a constant state of change. Moreover, the playwright's task becomes more complex. It is not only to portray the mentally-ill character as (s)he may view them, but to study the audience of his/her time as an important element in the spreading of the message (s)he wishes to convey. Thus, there is a clear timeline one may draw when speaking of the methods of representing mental health in Western theatre, beginning with the blooming period of Ancient Greece to the contemporary society of the 21st century. As Derek Russell Davis explains in *Scenes of Madness: A Psychiatrist at the Theatre* (2002: 94), "There was then (Greek Antiquity) a widespread belief (animism) that spirits pervade and control the world". This is the first point of reference. Furthermore, the constant growth of scientific knowledge opened the door to other perceptions and ways of understanding mental health. As is noted in Oyebode, a trajectory is found upon following the prescribed timeline through the analysis of different bodies of work.

> This trajectory moves outwards from unobserved but described behaviours in Greek tragedies to fully observed, truly tragic and public enactments of madness on a grand, Shakespearean scale. Following from this grand method, there is the domestication of madness in the theatre [...] In the 20th century, the importance of the personal history of the writer in the development of both characters and plot became obvious.

In this overview, the focus will be given to the different components which make up this timeline, e.g. the heroic tragedies of Ancient Greece, Shakespeare's tales of obsession and jealousy, *Hamlet* (1599-1601) and *Othello* (1630), Henrik Ibsen's domestication of theatre, Tennessee Williams' perspective on difference and the disintegration of self in the works of Sarah Kane. Most of the information will have as source and basis Femi Oyebode's work *Madness at the Theatre* (2012).

4.1.1. Maniacal behaviour in Ancient Greek tragedies.

The art of theatrical performance was born and developed in the city-state of Athens in 6th century B.C. The origins of this performative art form are unknown and debatable. Some scholars are adamant that its origins are linked to the festival Dionysia, created to honour of the God Dionysus.[18] Within this

[18] Dionysus is known for being the god of grape-harvest, winemaking and wine, of fertility, ritual madness, religious ecstasy, and became consequently known as the god of theatre in ancient Greek religion and myth.

festival, plays were to be performed, in an open-air environment, in front of an audience, as another part of the festivities. Other scholars argue that theatre may have just organically developed through the rise of an earlier art form, namely epic poetry. Regardless of its origins, theatrical performance was eventually dispersed into three different dramatic genres: tragedy, comedy and satire. The focus of this section will be on tragedy.

Most Ancient Greek playwrights utilized myths and other cultural stories as the basis for the development of their plays' action. The depiction of the lives of mythological heroes, monsters, demi-Gods and/or Gods are some of the most popular themes. Mental illness, or as denominated in some theoretical works, *madness*, is also a recurrent theme[19]. Some examples include Sophocles' *Oedipus Rex* (c. 427 B.C.) and Euripides' *Heracles* (c. 416 B.C.).

Oedipus Rex is one of Sophocles' three surviving Theban plays. It tells the tale of Oedipus, whose fate is known at birth. The premonition speaks of how he is destined to murder his father, the king of Thebes, and become his mother's lover. The play opens with Oedipus as king of Thebes after the old king Laius had been mysteriously murdered. The city is being plagued with something unknown, which prompts Oedipus to search for an oracle's wisdom. The oracle claims that the only way to get rid of the plague would be to find the one who had murdered the previous king. Oedipus is told by Tiresias, the blind prophet, that he had been the murdered of Laius, which prompts Oedipus to vehemently reject such absurd notion. The queen, Jocasta, tries to calm Oedipus down by telling him about a prophecy, which had been given to her and her husband about their son, and how this prophecy could not have come true as the baby had died in abandonment. As a young man, Oedipus had learned about his fate of killing his father and bedding his mother, which had prompted him to leave his family and move to Thebes. After speaking with the only witness of the murder, a shepherd, Oedipus discovers the truth. The queen kills herself while Oedipus tries to get redemption through the gouging of his own eyes.

Euripides' Heracles tells the tale of one of the great Greek heroes of Antiquity. Heracles gains fame for his doings in the ten years of the Trojan War. Euripides' play follows him from his return from the underworld. Heracles becomes aware that the lives of his family are being threatened by the usurping king, Lycus, which drives him to commit murder. As his punishment, the messenger, Iris, leads him to be overcome by a bout of momentary delusion. During this bout, Heracles proceeds to murder his entire

[19] It was often used as a scapegoat to justify the main character or hero's hideous or unnatural actions.

family, as he confuses them for enemies. After the frenzy of delusion leaves him, Heracles is overwhelmed by grief, seeking refuge and peace of mind in exile.

In this thesis, we will categorize the way these characters are portrayed through the usage of certain codes and conventions attached to the ideal of mental illness of their playwrights' age. The first point of interest is that the vile actions of these, and other mentally-ill characters, are never to be performed on the actual stage. The visual interpretation gives place to the auditory performance of an explanation and contextualization of events. In Ancient Greek theatre, this role is offered to the Chorus or the Messenger, who, according to Russell Davis (2002: 160):

> [...] narrate, inform, comment, interpret and mediate. They may supply background information and reporting from a different perspective, show how others, who are outside the action, are affected. Although taking part in the events of the drama, the chorus is more or less detached from them and does not influence directly what the characters do.

The Chorus/Messenger help to establish the moment of the play; the context in which the actions are performed; and the moral issues attached to certain events. They also assist in later audiences' understanding of what was to be considered a sign of a descent into a mental illness or delusional episode. In *Heracles*, the Messenger relays to the audience an account of Heracles' first signs of abnormal behaviour, as quoted in Oyebode, (apud. 2012: 11):

> His face had changed; his eyeballs rolled unnaturally, / Showing their roots all bloodshot; down his curling beard / A white froth trickled. Then with a maniac laugh he cried.
>
> Then he pretended he had a chariot; leapt in, / Gripped on the rail, and like a man using a goad, / Kept thrusting. [...] With no one; then proclaimed to an invisible crowd / Himself as victor.
>
> (lines 931-933; 940-942; 960-961).

The actions being described are of a physical nature; nonetheless they are not made to be directly portrayed to the audience. There is no mention of Heracles' speech; however his behaviour is described as erratic and simply incomprehensible to those who surround him. The Messenger gives the context of this behaviour in contrast with what audiences would presume as normal. It is animalistic, divesting him

of any human qualities he may have possessed as a great hero. In our age, Heracles would most likely be diagnosed as suffering from PTSD (Post-Traumatic Stress) due to the traumatic events of ten years of war. This disorder has as some of its symptoms disturbing thoughts, feelings or dreams. I argue that in this case the Messenger's description paints Heracles as someone struggling with hallucinations. He experiences a momentary bout of delusion, which drives him into perceiving he is surrounded by a crowd, while the messenger tells the audience that the crowd is non-existent. It also drives the great hero to perceive his own family as enemies, proceeding to murder them. Moreover, it is quite the Herculean task to explain Heracles' actions as a product of a mental illness, which audiences of Ancient Greece did not yet understand as such in a scientific manner. Thus, the explanation given to Heracles' actions is straightforward; it comes as a punishment from the Gods. The crimes of Oedipus are offered a similar explanation. These bouts of "madness" or delusion have been recurrent since the epic poetic tradition with sources linking their origins to Gods or other divine entities. On David Z. Bartolome's 2017 essay on the notion of "madness" in Ancient Greece[20], the author argues that (2017):

> [...] Therefore in epic poetry, where the first descriptions of recognizable madness appear, these altered mental states have two characteristics: they are god-sent or come from some other outside force, and they are not an illness but a frequent, often even beneficial state of mind.

This take on the origins of mental illness raises an issue of responsibility. In our age, many defendants in Court have made use of mental illness to avoid being harshly sentenced. Psychoanalysts are often summoned to court to testify on the defendant's past and present mental conditions. In many cases, the presence of a mental illness may imply that the defendant, upon the doing of his/her crime, was not in a sane condition, meaning that the performed actions may have been outside of the defendant's control, as if the individual was being controlled by an external source, which connects with the Ancient Greek's belief of the power of Gods. In *Oedipus Rex*, Oedipus does allege that, as cited in Oyebode (apud. 2012: 10) "But the hand that struck me was none but my own" (lines 1329-1331)", which again brings to light the question of the degree of sanity mentally-ill individuals may experience in moments of delusion. This issue of responsibility also connects with Aristotle's concept of catharsis, which

[20] Bartolome, David Z. (2017), *The Notion of Madness in Literature, Philosophy, and Tragedy: Evolving Conceptions of Mental Illness in Athens.* Young Historians Conference. 3. Portland State University. Portland, United States. http://pdxscholar.library.pdx.edu/younghistorians/2017/oralpres/3

was previously related. Aristole presents a general definition of tragedy in his work *On the Art of Poetry*[21] (2009). This definition relates to the conception of tragic catharsis, but borders on the mention of pity, which arises as a product of the questioning of responsibility in Ancient Greek theatre. Aristotle defines tragedy as, (2009):

> [...] a representation of an action that is worth serious attention, complete in itself, and of some amplitude; in language enriched by a variety of artistic devices appropriate to the several parts of the play; presented in the form of action, not narration; by means of pity and fear bringing about the purgation of such emotions.

The conceptual framework of a Greek tragedy follows the tripartite scheme of crisis, exploration and reorganisation. Coincidentally, the process of analysis in the psychoanalytical field is also heavily focused on these three stages. The crisis manifests itself, which leads the affected individual to look for manners to understand it (exploration) until consensus (reorganisation) is reached. In Greek tragedies, the crisis is offered by divine entities, the exploration is performed through a mixture of actions, and the reorganisation mostly entails that the transgressive individual ends up in exile or dead. Thus, the centre of the tragedy becomes an exploration of the individual's conduct, which was believed to influence both the intimate world of the character (moral world) and the material world of society. Any transgression would bring not only shame on a personal level, but it would also pollute the society the transgressor lived in (e.g. any natural disaster would be seen as a God's punishment for the tragic hero's wrongdoings, but it would affect the entire city or village in the forms of strong sea currents or earthquakes). A time away from society in the form of exile, or in modern days, of mental institutions, where contact with the outside world is restricted, seem to be the best manner to achieve some insight into the origins and causes of certain actions. However, how can the individual's conduct be at the centre of tragedy if the responsibility of his/her main actions stem from exterior entities? That is the unanswered question, which ultimately leads audiences to pity the tragic hero for the fate bestowed upon him/her, as opposed to condemning him/her for his/her wrongdoing.

Tragedy is also, in the words of Aristotle, (2009) "a representation of an action that is worth serious attention, complete in itself, and of some amplitude; in language enriched by a variety of artistic devices appropriate to the several parts of the play". I have previously alluded to the way behavioural cues in Greek theatre serve as an important indication of the way mental health was both perceived by

[21] Aristotle (2009), *On the Art of Poetry.* EBook #6763. http://www.gutenberg.org/files/6763/6763-h/6763-h.htm

and exposed to the audiences of the time. Hideous actions being performed in a moment of sheer "madness" or delusion can only be fully communicated if the audience is made aware of the symbols associated with it, or in other words, the stereotypes that are most often harboured about it. In the case of Heracles, Oyebode states that, (2012: 12) "These include sudden onset derangement that is not necessarily understandable in context, bodily gestures such as rolling eyeballs, maniacal laughter, pretend actions, violence resulting in uncharacteristic conduct, and recovery". Visual hallucinations are also a crucial part of Heracles' portrayal of madness as it is through a visual hallucination that he is led to commit the murders[22].

The language of tragedy is, as mentioned, enriched and of a higher nature. Most tragedies in Ancient Greece portrayed either mythological events where the focus would be given to great heroes and divine entities or the lives of great kings and their doings, thus it is fitting that the primary characters would not be speaking the average language of the commoner. This enriched way of speaking allowed playwrights to conceal, through metaphors and other stylistic devices, as much as they unveiled. As I have previously established, the climactic scenes where the main character performs a hideous crime were not directly performed, but rather narrated by another character. Thus, we speak mainly of the language of the Chorus or the Messenger, whose job is to present to the audience what the playwright cannot or will not. What is interesting is that the audiences of the time had in mind their own stereotypes on mental health, which were associated with "mad" spectacles of rolling eyes and maniacal laughter. Nonetheless, these stereotypes were never performed in front of their eyes, but rather described. The playwright was still capable of conveying his/her main message without unnecessarily frightening or disgusting the audience. Again, Aristotle's concept of tragic catharsis illustrates this premise.

To briefly summarize, the manner of representation of mental illness in Ancient Greek theatre is displayed by a refusal of performing "mad" behaviour directly in front of audiences. Language became the most important factor within the plot, as it gave audiences the necessary context and clues to follow the play's device without being overwhelmed by its savageness. Most plays followed a specific tragic framework in which a great hero was on the receiving end of a curse or a whim from a divine entity. That is the main explanation given for the origins of mental illness. The "curse" would be lifted after the character had committed the horrendous act, conveying that "madness" was to come and go easily. Exile was the necessary measure to achieve a cleansing of both moral and material self, leading most

[22] He is led into a belief that the people he is seeing are his enemies from Troy, instead of his family.

audiences into feeling pity for the fallen hero, as well as fear over the possibility of being struck by the same delusionary state.

4.1.2. Jealousy and feigned "madness" in William Shakespeare.

The major hurdle many playwrights face when trying to visually portray a mentally-ill character (suffering from a psychological condition) on stage is to find effective manners of representing something belonging to the realm of the inner self to an external audience. As Russell Davis suggests (2002: 61):

> The inner life of the character is revealed through what the actor does or says, as well as how he is dressed. The playwright thus conveys something of the quality of the experience of madness. Of course not all the representations of madness are authentic in the sense that they are based on sound observations or sound ideas. [...] Almost all the meaning is conveyed in the language.

A play dramatizing mental states can only do so through corporeal or linguistic means. That is the reason why physical stereotypes and other symbols become of great importance to a more enhanced communication between playwright and audiences. This is most evident in William Shakespeare's plays. The two case studies in this section will be Shakespeare's *Othello*[23] (2006) and *Hamlet*[24] (2015). For *Othello*, the focus of our thesis will inevitably shift to Othello's own character development. The aim will be to understand how Othello's "madness" stems from jealousy and the manipulation of an outer vessel, much like in Ancient Greek theatre[25]. Due to this external influence, there will be a focus on the way jealousy can develop to an extreme within a specific set of biological and social conditions, and on how an individual, in a specific state of mind, may attribute higher meanings to neutral symbols. In *Hamlet*, two characters offer two distinctive views on mental health, Hamlet himself and Ophelia. Ophelia's mental illness won't be as explored within this thesis as Hamlet's, nonetheless it is important to recognize that it origins from the same lack of identity Hamlet seems to be a victim of throughout the play. Hamlet's mental health has been thoroughly debated by many critics over the centuries. He is portrayed both as a symbol of feigned "madness" and of feigned "madness" turned real. Moreover, the focus of this section

[23] All references will be taken from: Shakespeare, William (2006 edition by Michael Neill), *Othello*. Oxford World's Classics.

[24] All references will be taken from: Shakespeare, William (2015 Bilingual edition), *Hamlet*. Assírio & Alvim.

[25] In *Othello* this outer versel is not a God or a divine entity, but Iago, one of Othello's companions.

will be on the way Hamlet chooses to portray his feigned "madness" to outsiders, much like a playwright decides on which symbols to use to convey a message to his/her audiences. Thus, how does Hamlet perform the role of a mentally-unstable individual and how does this role affect his personal identity in the end? Could it be that this disintegration of a personal identity coupled with some external factors (e.g. grief over his father, jealousy towards his mother after marriage, a lost love with Ophelia) may have steered Hamlet into an actual mental condition? Could it be that the external sources in *Hamlet* weigh as heavily as they do in *Othello*? In order to answer these and other questions, it is a priority to understand the way Shakespeare has constructed both tragedies, according to the perspective of audiences of his time.

4.1.2. a) Othello's jealousy: the innocent man turned "mad".

Jealousy is a complex emotion. It has as a basis many other emotions, which stem from specific external situations. Those complex emotions may have various degrees of intensity, which in turn make each individual experience distinct. In Othello's case, his jealousy becomes extreme as the play develops, due to specific living circumstances. Othello is acclaimed as a great military leader within the Venetian society. Even so, he is often described by others as a Moor, which hints a great deal at him being a perpetual outsider. When he wishes to marry Desdemona, a white woman of great status, problems ensue due to the dark colour of his skin. Desdemona's own father is sure that their relationship had to have been a product of witchcraft as it was unlikely that his daughter could have fallen in love with Othello. Nonetheless, the master plan comes from Iago's, one of Othello's companions, hands. Iago's own jealousy over both Othello and Othello's great companion, Cassio, leads into the building of a plan to deceive Othello into a belief that his wife is committing infidelity with Cassio. Iago's plan coupled with the established fragilities of Othello's social and personal perceptions within the Venetian society as an outsider become the greatest exterior sources of manipulation of Othello's emotions, which ultimately culminates the performance of his wife's murder. Iago works here as the external source of "madness", which in Ancient Greek tragedies was found to be the role of the Gods or other divine entities. As the play advances, the audience is aware that Othello's head is increasingly filled with questions and feelings of self-doubt, which are born from Iago's influence and the recurrent racial prejudice of the time. Sekhar Roy and Ziaul Haque wrote an essay in 2018 in which they explain how the colour of Othello's skin served

as a basis for many prejudices at the time. The authors point out that (2018: 28)[26] "The conventional European judgement [was] that black cannot be beautiful and that a dark-complexioned individual [...] [was] by nature dangerously sensual (apud. Cockin, 2003: 92)". Othello's own physical features, and an internalized feeling of alienation, are what transform him into an easy prey to Iago's deceptive plan. Added to this, his relationship with Desdemona presents no trust from the start. They come from different social conditions and have different coloured skin, which leads their relationship to be infected with outside judgement from the beginning of the play. Desdemona's own father advises Othello of his daughter's deceiving nature, as she had been capable of deceiving him. As quoted from Shakespeare (2006 edition, 1.3: 233) "Look to her, Moor, if thou hast eyes to see: / She has deceived her father, and may thee". From this initial point of distrust, Othello continues to build his perception that Desdemona is betraying him with the help of Iago.

Much like in Greek tragedies, language is still a focal point within the play. A Chorus or singular Messenger are not present, nevertheless other characters offer audiences descriptions of Othello's mental condition, as exemplified by Iago in the following excerpt, as he describes to audiences how Othello, (2006, 4.1: 328) "[...] foams at mouth and by and by / Breaks out to savage madness". Othello's described behaviour has many similarities to the described behaviour of Heracles and other great tragic heroes. The foaming at the mouth indicates a physical stereotype associated with rage, which arises from the belief that Desdemona is betraying him. His speech as he descends into delusion becomes increasingly more erratic and disembodied. The following quotation works as an example of this confused speech, which is performed after the viewing of the famous handkerchief scene.[27] As cited in Shakespeare (2006, 4.1: 327) "Handkerchief-confessions-handkerchief? To confess, / and be hanged for his labour? / First to be hanged and then / to confess! I tremble at it. [...] Pish! Nose, ears, and / lips! Is't possible? Confess? Handkerchief?". The audience is made to understand the importance of this episode to the full descent into delusion, as it serves as the first and only visual proof of betrayal Othello has. Although the handkerchief is a neutral object, the symbolism attributed to it turns this event into an essential episode on the understanding of Othello's condition. After this episode, Othello murders Desdemona. His speech becomes even more erratic right before he is told the truth, entrusting audiences to understand that the

[26] Sekhar Roy, Himadri; Haque, Ziaul (2018), *The Mad Othello: A Psychological Perspective.* IOSR Journal Of Humanities And Social Science (IOSR-JHSS). Volume 23, Issue 1, Ver. 1 (January. 2018). pp. 26-35.

[27] Cassio returns Desdemona's handkerchief after it gets stolen through Iago's orders. Iago leads Othello into watching the scene enfold. The handkerchief has an importance to their relationship, and through Iago's influence it becomes a symbol, in Othello's mind, of infidelity. It becomes a crucial turning point to the viewing Othello has of both characters, as he has visual proof of their betrayal.

character is clearly not in a stable state of mind. Language and the franticness of it become another symbol, which allows the audience to discern the climax of Othello's delusional episode. In one of his later speeches, just as he is about to perform the culminating act, Othello's speech becomes fully inconsistent. The following excerpt of speech proves this notion. As Shakespeare writes (2006, 5.2: 379):

> **Othello** [...] The noise was high. Ha! No more moving?
>
> Still as the grave. Shall she come in? Were't good?
>
> I think she stirs again - no. What's best to do?
>
> If she come in, she'll surely speak to my wife-
>
> My wife, my wife! What wife? I have no wife.
>
> O insupportable! O heavy hour!
>
> Methinks it should be now a huge eclipse
>
> Of sun and moon, and that th'affrighted globe
>
> Should yawn in alteration.

As soon as Othello unveils the truth, he is repentant. He is free from Iago's thoughts, which leads him into feeling immoral for having murdered his own wife, as everything he had perceived as a symbol of infidelity suddenly loses its fictitious meaning. He commits suicide as a response to the situation at hand, much like Oedipus blinds himself after discovering the truth. Othello's final monologue offers no real reasoning to his actions, as he focuses on the way he wishes to be remembered. Nonetheless, it is perceivable that the "madness", which had struck him had lost its strength as his speech and presented thoughts are more cohesive. He might be a "mad" man, but he is a conscious man at that point. As he frees himself from the lie Iago had made up for him, Othello is allowed to perceive the world in a more rational manner. His last speech represents this rationality as opposed to the previous excerpt, where Othello's speech was much disembodied. As cited from Shakespeare (2006, 5.2: 395):

> **Othello** I have done the state some service, and they know't [...]
>
> Speak of me as I am; nothing extenuate,
>
> Nor set down aught in malice: then you must speak

> Of one that loved not wisely, but too well.

To briefly summarize, Othello's delusional state is both induced and made possible by Iago. It is a consequence from a jealousy, which progressively becomes extreme due to the original self-degrading feelings of doubt, which in turn stem from the colour of his skin and how the colour of his skin identifies him as an outsider both in the fictional society of the play and in Shakespeare's own time. In a way his "madness" is a complex testimony to the power human beings can possess over others and how important it is to keep one's identity and views in mind. This issue with identity will also be analysed in the following section regarding *Hamlet*.

4.1.2 b) Hamlet's feigned madness turned real? : the issue of a loss of identity and madness in *Hamlet*.

Was Shakespeare's Hamlet suffering from an actual mental illness or was his condition a mere plot to achieve his revenge? This is a question, which haunts the minds of many critics and readers of *Hamlet* to this day. *Hamlet* tells the story of a young Danish prince of the same name, who, upon the mysterious death of his father, watches as his uncle assumes the throne. The main design of the tragedy unfolds as Hamlet meets what he understands as being his father's ghost, who reveals to him the true story behind his passing. His uncle, Claudius, had murdered him for a chance at the throne. The ghost bestows upon Hamlet the mission of revenging him, which then turns into the focal point of action in the play. To achieve his end, Hamlet decides to play the part of a mentally-ill individual who is stricken with "madness" as a consequence of grief felt over his father's passing. Hamlet works with his own feelings of grief and disdain to achieve a dramatic performance, which convinces those around him of his worsening mental condition. Hamlet becomes an actor performing to an audience. This is the role this thesis will focus on. He uses a very interesting method to convey his ideal of "madness" to external audiences; the use of the smokescreen method, which is proved to be quite recurrent amidst psychiatric patients as a defence mechanism against threats. Russell Davis explains the conception behind this method by explaining that, (2002: 36):

> By doing so (feigning his madness) he makes his behaviour strange or odd and therefore less understandable. Such a smoke-screen of obscurity and complexity is commonly used by psychotic patients. Being misunderstood,

deliberately or unwittingly, might be included in a list of the features of madness, although not by itself sufficient to make the diagnosis.

Thus, there are three important aspects to Hamlet's character. One is his grief over his father's passing, his being in love with Ophelia and his feigned "madness", which could be argued to stem from the two prior aspects if conceived as real. These three aspects are intertwined into Hamlet's own portrayal of self throughout the play. The way Hamlet chooses to portray his role of a mentally unstable individual gives theatre-goers several hints to the way mental illness was meant to be understood in Shakespeare's age. As previously mentioned, bodily gestures, language, and in the case of *Hamlet* clothing as well,[28] become key-factors in the communication of a message in theatrical performance. Mental illness in Shakespeare's time borrows greatly from the stereotypes Hamlet chooses to abide by when he is performing his role, or the stereotypes he manifests throughout the play if his condition is perceived as real.

His language remains, albeit with a few exceptions, clear and understandable. I argue that these exceptions could be divided into two different segments. The first segment is where Hamlet is quite purposely playing his role and the second is where his dramatic monologue may offer hints to a potential real condition. Following Russell Davis' ideal of the smokescreen method, it is perceivable in a brief dialogue Hamlet conducts with Polonius that the prince plans to confuse him by speaking with no sense. As Polonius speaks to him about the arrival of the actors, who are coming to perform a play in court, Hamlet answers with something completely unreliable and not understandable within the context of the dialogue. As quoted from Shakespeare (2015, 2.2: 172):

Polonius The actors are come hither, my lord.

Hamlet Buz, buz!

Polonius Upon my honour-

Hamlet "Then came each actor on his ass"-

Polonius The best actors in the world, either for tragedy, comedy, history, pastoral, pastoral-comical [...]

Hamlet O Jephthah, judge of Israel, what a treasure hadst thou!

[28] His mother, the Queen, tells Hamlet to cast (2015, 1.2: 56) "thy nightly colour off".

Hamlet concerns himself with the task of utilizing this technique as a manner of diversion from his true objective. In his mind, he is performing a role, similar to the roles the invited actors will also be playing on stage. At many points, Hamlet claims to feel jealousy for the passion with which the actors present their craft, hinting at the necessity of being as passionate within his own role. Nevertheless, the true quality of language in *Hamlet* and other Shakespearian tragedies is the way its true meaning is hidden under a primary layer. Hamlet's own true feelings are debatable within literary circles due to this subtlety of language. In one moment of dialogue within the play, as he speaks to Guildenstern, one of his companions, Hamlet appears to be conscious of an inner issue pulling at himself as a person. Although one may argue that this dialogue becomes a crucial part of his role, the truth is that convincing Guildenstern of his "madness" would not be Hamlet's main priority. He speaks of his loss of happiness and joy in life, which are manifested only upon the meeting with his father's ghost. He is thoroughly conscious of it all, as his language remains clear and understandable, nonetheless this monologue may hint at a deeper issue. Thus, I argue that the following excerpt represents a piece of Hamlet's true feelings, hence his true mental condition. As cited from Shakespeare (2015, 2.2: 164):

> **Hamlet** I have of late - but wherefore I know not - lost all my mirth, forgone all custom of exercise; and it goes so heavily with my disposition that this goodly frame, the earth seems a sterile promontory, this most excellent canopy the air, look you, this brave o'erhanging firmament, this majestical roof fretted with golden fire, why it appeareth nothing to me but a foul and pestilent congregation of vapours...What a piece of work is a man, how noble in reason, how infinite in faculties, in form and moving, how express and admirable in action, how like an angel in apprehension, how like a god: the beauty of the world; the paragon of animals, and yet to me, what is this quintessence of dust? man delights not me - no, nor woman either, though by your smiling you seem to say so.

Hamlet speaks of how wonderful the world and the human being are. Moreover, to him, all of those wonderful qualities amount to dust. The world does not thrill him nor delight him. I continue to argue that this piece of dialogue does not utilize the smokescreen method, as Hamlet's speech is more comprehensible and regular than it was within the previous example. His intention is not to confuse his companion, but rather to speak of his real condition. Hamlet's described state of deep melancholia and inability to feel things is correspondent with several diagnoses of mental illnesses. Thus, at this point, it is safe to argue that Hamlet could have possibly be considered as a mental patient, due to the traumatic sequential events happening within his life coupled with the obsessive nature of his revenge. Shakespeare

himself toys with this notion in a later comic dialogue between a gravedigger, I clown, and Hamlet. Within this dialogue, there is a reference to a young Hamlet, who is mad and sent to England. As transcribed from the original script (2015, 5.1: 372) "**I clown** It was that very day that young Hamlet was born - / he that is mad and sent into England". As Hamlet is also prompted to go to England, it seems ingenious that Shakespeare would joke with the audience, who, at this point, is aware that the gravedigger speaks of Hamlet himself.

My conclusion is that there is a possibility that Hamlet may have been suffered from mental illness from the start of the play. The appearance of his father's ghost may have been nothing more than a visual or auditory hallucination, although the ghost is also perceived by other characters. In any case, if one is to interpret the ghost of Hamlet's father as a hallucination or Messenger from the gods to drive Hamlet into a delusionary state then his mental condition is explainable through similar arguments of those used to justify mental illness in Ancient Greek tragedies. It is through the revelation of this ghost that Hamlet's quest for revenge is initiated, and it is within this quest that he slowly descends into a state of deep melancholia and obsessive revenge. The quest incites Hamlet to lose his own identity to the role he must play. He is entrusted with a task that does not fit with his own being. It creates within the character a division between the *doing* and the *being*, as it is clear he does not want to be classified by his act of revenge, much like Othello, who was conscious that he did not want to be classified by Desdemona's murder. The question of identity becomes a focal point of interest. I argue that this dichotomy explains why Hamlet was reticent to murder Claudius on several occasions, although he himself presents other excuses. This reticence to killing Claudius in cold blood shows a certain degree of sanity, a small part of Hamlet's true identity under the possession of the ghost. Russell Davis explains as such in his essay (2002: 38):

> The knowledge he has gained makes him see Claudius, not as the villain of the fantasies aroused by the ghost of his father, the product of his fevered imagination, but as a real person facing his own guilt and suffering remorse. To see him so makes killing him much more difficult, and he is able to resist the commands of the ghost.

The way Hamlet is capable of resisting the (2002: 38) "commands of the ghost" on certain occasions entails that there is a certain degree of sanity not lost. In a way, Hamlet becomes a pawn of his own destiny, which is created through a supernatural happening (e.g. the coming of the ghost). He cannot go through with the performance of committing a murder, without losing himself to that feeling of

revenge. This loss of identity is what ultimately pushes him into losing his own sense of being within the real world, which explains the grave melancholia presented in the previous transcribed dialogue with Guildenstern.

A similar situation happens in Ophelia's case. There are many layers and symbolic stereotypes associated with mental health to be found in the portrayal of Ophelia. I will not look to provide a thorough character study of Ophelia in this thesis, but rather to understand the way the representation of mental state links with Hamlet's own.

In terms of language, Ophelia becomes target to the stereotyped confusing speech, which is, as Russell Davis argues, filled (2002: 40) "with loose associations and excessive use of metaphor". This speech is often associated to mental patients, as many view them as maniacs who speak with no sense. Ophelia's behaviour is generally distracted and out-of-character with what happens throughout the play. The decay of her relationship with Hamlet contributes greatly to this distractedness and eventual passing. Many critics have suggested that Ophelia's behaviour is heavily linked to the loss of ties with the men in her life[29]. As a woman of her time, her life had been defined by her relationships with others, mainly with men. As she loses ties with each man in her life, she slowly loses her sense of being. Her brother is away, her father is murdered, and her lover is seemingly another person upon the death of his father, as well as her own father's murder. I argue that as Ophelia loses her ties with these three important men, she becomes a product of a lost identity. Her speech acquires a melancholic tone, and her role within the play is over with her death by drowning.

Ophelia and Hamlet experience similar situations. They both lose important figures in their lives and are prey to bouts of deep melancholia as a product of such. Hamlet has a goal to fulfil before he can succumb to his grief, nonetheless both characters share mirrored experiences. Both cases are unique in their complexity of expressing a steady descent into uncertain mental states. The audience understands the conditions, which leads both characters into these states, and recognizes the symbols that represent them.

[29] The three men in Ophelia's life are her father, Polonius, who is randomly killed by Hamlet; Hamlet, the man she is in love with, who begins to behave in ridiculous and strange manners as the play progresses (something which Ophelia does not understand); and her brother, Laertes, who is to face Hamlet in a duel.

4.1.3. Henrik Ibsen and the democratization of theatre.

If Ancient Greek playwrights had been celebrated for playing with the thin boundaries between illusion and reality within their plays, what can one say about Henrik Ibsen, who completely turned the ideal of performance around? His constant work towards the steady democratization of theatre, by changing the focus of the spotlight to figures from other social backgrounds, proved to be an important force in the way audiences perceived the stories being relayed. Ibsen's biographer, Michael Meyes is quoted by Oyebode claiming that (*apud*. Oyebode, 2012: 48):

> Ibsen made three significant contributions to the theatre. First, demonstrating that high tragedy could be written about ordinary people; second, doing away with well-worn artificial plot devices [...] and finally, creating modern male and female characters of depth and complex interiority.

This statement as relayed by Meyes will be explained in parts. Ibsen's first mentioned contribution is the way he shifted the focus of tragedies to ordinary people. Before his works, tragedies were mainly written about the deeds of high-ranking individuals and/or divine figures and heroes. Thus, theatre-goers were completely aware that there was little in common between them and the characters in plays. This built a sense of security, which is still predominant in our contemporary society. There is seemingly a line separating sanity from insanity. Moreover, Ibsen utterly shattered this boundary as he changed the focus of his tragedies to commoners' tales. Mental illness ceased to be something bound to exclusively afflict those of a different class or plane of existence. The second mentioned contribution deploys Ibsen even further from the Ancient Greek tradition. It implies that Ibsen did away with (apud. Oyebode 2012: 48) "well-worn artificial plot devices". Ancient Greek tragedies often dealt with the same patterns of action[30]. Tragedies ended in a similar manner, with the fallen hero wishing to exile himself to look for redemption or the Chorus singing about the woes of a lost humanity. Ibsen did away with fixed plots and conceptions. A good example of this lack of pattern comes in the form of the 1879 play *A Doll's House*[31]. The play presents a typical family with a father, mother and three children. Their family dynamic is based around an imposed muting of Nora, the mother, so as to please her husband and convey a socially acceptable picture of him as the head of the family. Nonetheless, Nora hides a secret fraud she has committed in the past. Once her husband finds out, he wishes to part from her in order to save face. Usually, a

[30] Refer to the chapter*: Greek tragedy: maniacal behaviour.*

[31] Ibsen, Henrik (1958), *The Master Builder and Other Plays*. Penguin Books. London, United Kingdom.

playwright would find a way of either turning this issue around or in a truly fantastical manner have one of the characters be struck by delusion and kill the other. What is unexpected for audiences, speaking of those in Ibsen's time, is the way Nora becomes independent of her own husband, leaving him and their children behind to become a new woman. In an article by Robert M. Adams (2019)[32], the reactions and expectations of the audiences of Ibsen's time are described as followed:

> Audiences were scandalized at Ibsen's refusal in *A Doll's House* to scrape together (as any other contemporary playwright would have done) a "happy ending," however shoddy or contrived. But that was not Ibsen's way; his play was about knowing oneself and being true to that self.

An inherent lack of pattern or artificial plot was the modernizing factor in Ibsen's plays, distinguishing them from the Ancient Greek tragedies. Audiences were unsure how to act upon the reversal of expectations that such plays caused. Again, Aristotle's ideal of tragic catharsis[33] fits within Ibsen's ideal of instigating a feeling of fear into his audiences. By choosing to portray commoners, as opposed to high-ranking individuals and/or gods, Ibsen exposes his audiences to a more personal view of specific issues. This instigates a new level of fear, as the last separating line between illusion and reality is blurred.

Meyes' final described contribution, as quoted from Oyebode, states that Ibsen created, (apud. Oyebode, 2012: 48) "modern male and female characters of depth and complex interiority". Greek tragedies forfeited the characters' deeper inner feelings by playing their effects out of sight. The expressed inner feelings were to be manifested only after the climactic action had been committed, when the character was already out of the bout of delusion which had struck him/her. Ibsen fully departed from the typical symbols associated with specific issues of the mind and placed his characters in a place where they could freely present their inner woes to audiences. This focus on the inner aspects of the character's mind and the constant search for knowing and being true to oneself are inherent to Ibsen's body of work. His grasp of the inner turmoil of common people and the way he portrayed this turmoil in manners which were more easily recognized by the majority of audiences have claimed to be the most important parts of his revolutionary work. He became the precursor of a theatre of the mind; a theatre that does away with the artificial symbols and plots of the past and focuses on what is attainable to the understanding of the

[32] Adams, Robert M. (2019) *Henrik Ibsen: Norwegian Dramatist and Poet.* https://www.britannica.com/biography/Henrik-Ibsen

[33] Refer back to chapter: *Psychotherapy as a dramatic performance of catharsis.*

ordinary individual, with a great spotlight given to the mind of the characters on stage. Oyebode comments on how, (2012: 48) "Ibsen's understanding of interior life makes his account of madness particularly of interest in so far as it addresses the phenomenology of madness, it's explicit signs, origins and consequences".

Nonetheless, not all in this modern drama parted from the past. The major climactic scenes (e.g. suicides) were still either performed out of sight from audiences or merely mentioned throughout the course of the play. *Rosmersholm* (1886) serves as an excellent example of the latter. The play is heavily dominated by an act of suicide, which has already occurred prior to the main action. The late wife of Johannes Rosmer had taken her own life due to, as the audience learns, the subtle influences of external factors. There is a constant dichotomy between freedom and conservative values to be found in the Rosmer's house, which is believed to have been one of the causes for this suicide. Moreover, the action gains life through the words of other characters and the way they interact with one another, much like a Chorus in Ancient Greece. Direct, visual portrayals of mental illness remain something exterior to the play, moreover the influence of its consequential events control the actions of other characters throughout it. Oyebode encapsulates this ideal by stating that, (2012: 52) "The madness in the play is out of sight but very much in mind".

However, the greatest shifting point in Ibsen's work was the treatment of mental illness as a product of social concerns, rather than of divine intervention. The suicide in *Rosmersholm* is not meant to be understood as a sudden event, triggered by a special intervention, but rather as a consequence of several matters. Other characters believe that the late wife's suicide was a product of her not being capable of bearing children. As quoted in Ibsen[34] (1958: 84):

> **Mrs Helsketh** It's so queer about the mind, Miss. I don't think, you know, she was right off her head.
>
> **Rebecca** But she seemed to go all to pieces when she realised she couldn't have any children. *It was then that the madness broke out.*[35]

[34] Ibsen, Henrik (1958), *The Master Builder and Other Plays.* Penguin Books. London, United Kingdom.

[35] These are my own italics.

Suicide is a recurrent theme in Ibsen's most famous works. In *Hedda Gabler* (1890), the main character, Hedda, is presented to audiences as being a selfish, idealistic woman, who wishes life to be lived according to her own beliefs and standards. She is bored of her marriage to Jørgen Tesman, becoming vengeful once an acquaintance of hers leaves her own husband for another man, a writer named Ejlert Løvborg. Hedda leads Løvborg, the writer, into committing suicide by burning his brilliant manuscript. Her actions are not explained to audiences, and as the play comes to an end, she commits suicide. Her suicide is not easily understood by all. Some critics may argue that it becomes a symbol of resistance against the oppression of the controlled patriarchal society of her time. Hedda is portrayed as an independent woman, who is self-assured about the way she moves in life, nonetheless she is not allowed to thrive as a powerful, intelligent woman within her own society. This ultimately leads her into committing suicide. Other critics have guaranteed that her suicide is not only unexplainable within the context of the play, but also unconvincing. As Oyebode comments in *Madness at the Theatre* (2012: 56):

> Ibsen has created the impression in previous plays that suicide was not an enigma; rather, it was casually or teleologically comprehensible. Hedda Gabler's suicide, however, was a defining end point of a character who was singular, who defined herself against others, not by moulding or adapting herself but by resistance and obstinacy.

The belief that the origins of all mental illnesses may be traced back to one singular converging point and that desperate acts (e.g. suicide) can be thoroughly explained are still intermittent in our contemporary society. The unknown terrifies the human being. Not being capable of understanding the reasons behind a specific condition or action can somehow be more terrifying than knowing its truth. Ibsen is capable of portraying the notion that the causes behind specific actions may at times be traced back to an identifiable origin. However, these origins may not always be understandable for anyone but the individual. What is great about Ibsen's work is the overwhelming quality of this message without the abuse of physical stereotypes and pre-established theatrical cues to convey it. The character's mind is the focal point of the play, granting audiences an understanding of what is happening, which does not require any special physical features. The inner turmoil of someone's mind is displayed in a subtle manner, but without something lacking. It's hard to speak of good and bad representations of mental illness in theatre as they are dependent on a variety of factors; nonetheless Ibsen's body of work surely occupies a positive place on the spectrum of representation.

4.1.4. Tennessee Williams' theatre of the mind: a celebration of difference.

Following in the buried footsteps of his predecessor, Tennessee Williams becomes a landmark figure for a more intimate, personal type of theatre. Williams plays heavily with the concept of theatre of the mind. The concept is drawn from the exploration of the characters' inner turmoil being directly presented on stage. Similarly to Ibsen, Williams focuses the attention of his audiences on the character's inner states, as opposed to relying on physical signs. Femi Oyebode remarks that the characters, in Williams' works, are meant to have (2012: 59) "intense and interesting inner lives", due to the heavy focus given to this topic. What distinguishes Williams' body of work from others of his time is his own personal experience with mental illness. Many critics have claimed that his close contact with his sister, who suffered from a mental illness, has proven to be the greatest source for the subjects and forms of representation of mental health conditions in his plays. This drawing from personal histories does not signify that Williams wished to portray full, detailed accounts of his reality to theatregoers. His goal would not be to give a realistic, detail-oriented portrayal of his own life experiences as one does in an autobiographical work, but rather to present mental illness as he knew it and experienced it. Thus, what characterizes Tennessee Williams' approach to the portrayal of mental illness in theatre is the transformation of personal events into events worthy of being portrayed on the stage through the creativity and individual style of the playwright. Williams presents an embellished reality, coupled with an aesthetic distance, which stops it from being simply a factual account of events.

Moreover, this mode of representation has some unique qualities to it, which reside in Williams' premise of celebrating difference. The differences between sane and insane individuals are what offers the former the illusion of protection. Stigmas are born from the necessity of distinguishing between individuals. This difference was, for many centuries, explored through symbolism and plotted actions, which most often did not coincide with all aspects of the illnesses and would incite negative behaviour towards the affected individuals. This branding of difference is thus marked as a negative thing within the understanding of most societies. Williams' close relationship with someone suffering from a mental illness may have been the primary cause for the different treatment he chose to give to this notion. In most of his plays, being different from the norm is celebrated. Hence, audiences are offered a completely reversed picture of mental health, which does not go according to the perspectives, expectations and social norms of its time. The greatest example of this celebration of difference comes in the form of Laura, a character

from Williams' 1944 play *The Glass Menagerie*[36]. Laura's mother wishes for her to marry one of her son's friends, Jim. Laura is presented as different, due to a physical defect she has in her legs. Her differential status does not come from a psychological origin, nonetheless the way Tom, her brother, speaks about it transcribes a message of full inclusion, which could be applied to other cases. The following transcribed sections of dialogue pertaining to the previously established idea that difference should be celebrated, are quoted from Williams:

> **TOM** Laura is very different from other girls.
>
> **AMANDA** *I think the difference is all to her advantage.*[37]
>
> **TOM** Not quite all - in the eyes of others - strangers - she is terribly shy and lives in a world of her own and those things make her seem a little peculiar to people outside of the house.
>
> (2009: 43)

> **JIM** [...] And all the nicer because of the difference, too...The different people are not like other people, but being different is nothing to be ashamed of. Because other people are not such wonderful people.
>
> (2009: 78)

The last important reference to discuss regarding Williams' portrayal of mental health is the abuse of illusion. It is seemingly ironic to talk about illusion being at the centre of plays when theatre is an illusion in itself. It has a powerful feature of blurring the lines between illusion and reality, due to the way it remains unedited and in close contact with its audiences[38]. In Williams' case, this sense of illusion is expanded through the main plots of his plays, not only the illusionary preconceived state of theatre, but the illusions that are drawn from real-life experiences. With many mental illnesses, patients may experience delusions and hallucinations as effects of their condition. Williams conducts his plays in the sense that theatregoers may experience similar delusions as those of the characters. Williams' *Suddenly Last Summer*[39] (1958) is a good example of the way the lines between reality and illusion may become unrecognizable. Audiences learn about Sebastian, a character, who has passed away in a seemingly

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[36] Williams, Tennessee (2009), *The Glass Menagerie.* Modern Penguin Classics. London, United Kingdom.

[37] These are my own italics.

[38] Refer back to chapter *Contextualized representations of mental illness in theatre.*

[39] Williams, Tennessee (1971), *The Theatre of Tennessee Williams, Volume III.* New Directions Publishing Corporation. New York, United States.

inexplicable flurry of events. His cousin, Catharine, is the only character who knows the truth behind his passing. Nevertheless, Sebastian's mother, Mrs. Venable, is adamant that she is lying about what has really happened, as her story does not seem plausible to their times. Catharine is thus presented to audiences, by Mrs. Venable, as an individual living in an illusionary world. Ultimately, the audience understands that Catharine is being kept at a mental institution under Mrs. Venable's order, with the possibility of leaving only if she tells a truth that will abide with Mrs. Venable's own personal expectations. The main scenario is initiated upon the arrival of a psychologist, Doctor Cukrowicz, whose intention is to extract that truth out of Catharine, while at the same time determine the seriousness of her mental condition. Catharine's truth as presented to audiences is that Sebastian has been eaten alive by a group of young, black boys, while they were on vacation. This section's focus will not be to determine the verisimilitude of Catharine's story, but rather to understand the events and social conditions preceding the traumatic event.

Mrs. Venable has a compelling role on the understanding of both Catharine and Sebastian's mental turmoil. With Catharine, she becomes a figure of oppression that both blames her for the death of her son and sends her away to be enclosed at a mental institution. Catharine's own state of mind is determined at Mrs. Venable's hands, and what she has decided each action should mean. With Sebastian, this burdensome figure remains, albeit with a few changes. Mrs. Venable's relationship with her son is presented as being toxic and too co-dependent. One of her big upsets over the entire situation is that Sebastian had chosen to go on vacation with Catharine, as that had been her role for many years, as cited in the play (1971: 408):

> **Mrs. Venable** There now, the truth's coming out. We had an agreement between us, a sort of contract or covenant between us which he broke last summer when he broke away from me and took her with him, not me!

Some critics of Williams have determined that the main issue within this controlling relationship stems from Sebastian's repressed homosexuality[40]. The play hints at Sebastian taking his mother on vacations for the sole purpose of using her as bait to attract young boys. On Sebastian's final vacation, the role was attributed to Catharine, most likely due to his mother's old age. This created an edge between mother and son, which Mrs. Venable blames on Catharine. Homosexuality was, in Williams' society,

[40] Homosexuals were often targets of stereotyped views on mental illness. Many individuals still believe their sexual orientation to be a product of an illness.

perceived as immoral and feasibly caused by a possible mental condition. Sebastian is portrayed as an unstable individual throughout the play, as his speeches hold depressive notions and characters mention the constant intake of white pills. Catharine becomes a victim of Sebastian's own complexes, as she is led into the trip without full understanding of her role. At that time, she had been struggling with her own mental health condition after she had been raped at a dinner party. Catharine relays to the doctor how she felt her own self dissolving after that night. Catharine presents a similar state of mind as that of other previously mentioned characters (e.g. Hamlet). As Williams writes (1971: 397/98):

> **Catharine** Doctor, my feelings are the sort of feelings that you have in a dream...
>
> **Doctor** Your life doesn't seem real to you?
>
> **Catharine** Suddenly last winter I began to write my journal in the third person.

Thus, she is presented as someone with no mental structure to play the role Sebastian was expecting of her. This led things to not occur the way they were meant to, which ultimately steered Sebastian to his own doom. Dissolution of identity in Sebastian is also present if one is to understand the intimate, heavily co-dependent relationship he held with his mother. The minute he parted from her side, he lost himself to an illusionary world, from where he ultimately could not escape. Mrs. Venable is thus a dark presence lurking over both Catharine and Sebastian, steering them through her influence into their personal delusionary states. Mrs. Venable condemns these two individuals as society condemns the outsiders in either complete isolation or under the watchful eyes of doctors.

There is much to be said about this play and its illusionary ways of leading the audience into a state of unsureness. Nonetheless, the focus is continuously given to the way the main character's fates were traced by powerful external forces.

4.1.5. Sarah Kane's disintegration of self in theatre.

The concept of humans being one singular, unified entity is easy to understand. Each individual comprises a physical form and mental being, which could never be replicated in its entirety. Human beings are unique and whole as they stand. Not until recently have theorists wondered about the possibility that these fixed notions may not hold the absolute truth. The possibility that an individual's soul

may be built around a number of selves, connected only indirectly to one another, as opposed to one singular, unified self has emerged. These ideas have been, in recent years, more forcefully explored by names such as Rita Carter (2008)[41], Shlomo Mendelovic (2008)[42] and David Lester (2010).

This argument gains more weight with the analysis of Sarah Kane's body of work, primarily of the playwright's later plays (e.g. *Crave* (1998) and *4.48 Psychosis* (1999)). This ideal of a non-unified self is explored through the use of theatrical devices and the building of shadowy-like characters, which are never formally introduced (e.g. the identification of characters as *"voice 1/2/etc."*). While mental illness has become a major topic in the analysis of Kane's body of work, due to the playwright's own battle with depression, Kane's career did not begin with explicit representations of mental health. For example, she is primarily known for *Blasted* (1995), her first play, originally staged by the Royal Court Theatre in 1995, where mental illness plays a role but is not central to the plot. Nonetheless, the focus of this short section on Kane[43] will be given to her later work, and how these works became representations of the playwright's own mental decline.

Kane fully departs from the ideal of building whole characters. We have dealt with the different manners of representation each one of the preceding playwrights chose to make use of in their bodies of work. Nonetheless, Kane's representation of character is differentiated by a lack of a fixed character and fullness. Oyebode places the issue in question by arguing that characters in the playwrights that came before Kane had a special set of fixed qualities, which cease to exist with Kane. As Oyebode argues (2012: 83):

> The personalities may exhibit deviant, aberrant behaviour, they may be homicidal or violent, their behaviour may have been irrational in the sense that if failed to meet some criterion of logic and reason. Yet, the characters themselves are coherent and whole individuals.

[41] All references from Lester, David (2012), *A Multiple Self Theory of the Mind.* Volume 1. The Richard Stockton College of New Jersey. https://doi.org/10.2466/02.09.28.CP.1.5 . (2012: 1) "Carter accepts the existence of multiple selves, defined as others have defined them, but she introduced the division of multiple selves into major and minor selves and a number of fragmentary micros".

[42] [...] each version of self includes cognitive elements as well as feelings, drives, values, and behaviors organized around a certain point of view." [...] The sense of a unified self is, therefore, (2012: 3) "a fabricated illusion".

[43] Her work will be more thoroughly analyzed in the second part.

Kane draws inspiration from the findings of the multiple selves' theories to build disembodied, disorganized voices, and present them as characters. In two of her final plays, *Crave* (1998) and *4.48 Psychosis* (1999), the "characters" remain unnamed throughout the entirety of the plot, given only the identification of voice(s). While some critics have argued that Kane's main four plays *Blasted* (1995), *Phaedra's Love* (1996), *Cleansed* (1998), and *Crave* (1998) became a basis for the extension of *4.48 Psychosis* (1999), it is clear that Kane's style of writing and chosen topics of discussion suffered dramatic alterations as her own mental health slowly begin to decline. It is in such cases that the playwright's own life provides audiences with clues. Moreover, there is a clear timeline filled with conceptions and definitions regarding Kane's maturing as both a playwright and a person.

Blasted (1995), is, by definition, a play where there is a shift from the objective and an undermining of a sense of reality. The structure of reality shifts and becomes intertwined with a world of dreams and hallucinations. In a much later play/dramatic monologue, *Crave* (1998), Kane completely intertwines these two worlds and loses the concept of an individual character. In *Blasted* there are many things to note as far as the language and the sense of reality are concerned, nonetheless there are still individual characters being presented in the plays, which provoke certain reactions and have different manners of presenting themselves to audiences. *Crave* is the first example of this disassociation of an individual character, which is replaced by voices. In *Crave*, there is no character, although four different individuals may appear on stage as a personification of the self's multiple personalities. The voice is only one and belongs to all of them.[44] Thus there is no distinction between the individuals presented on stage; they work more as props for the telling of the voice's inner thoughts. *4.48 Psychosis* (1999) presents its audiences with another set of voices, although these voices are more distinguishable and are not representative of just one individual's mind. The play has often been described as a *monologue of disquiet*, although there are moments of dialogue (e.g. when the primary voice speaks with a secondary voice, most likely belonging to a nurse). The language found in the play is almost poetic and understandable in context; moreover the play has scenes where the disjunction of situations emphasizes a need to break with the norms of language. For example, certain sections are just enumerations of numbers and other mathematical forms. As stated by Andrew Dickson in a 2018 article[45] in the Guardian, the monologue appears to not follow some of the most basic theatrical rules. He argues that (2018):

[44] This goes against the notion of a multiple personality disorder, which entrusts one individual with multiple personalities. Here we have multiple individuals, but just one persona.

[45] Dickson, Andrew (2018), "The strange thing is we howled with laughter": Sarah Kane's enigmatic last play. The Guardian. https://www.theguardian.com/stage/2016/may/11/448-psychosis-sarah-kane-new-opera-philip-venables-royal-opera-house

> The text contains not a single speech cue, and barely any stage directions. There isn't a cast list, still less a description of the characters. Some portions appear to be dialogue, perhaps between a patient and a dictatorial clinician [...] Elsewhere, a single voice pulsates with anxiety, and another records sardonic clinical notes.

This voice has been thought by critics to be Kane's own personal voice. She too suffered from mental illness and was at the time of the play gravely ill from the effects of it. Nonetheless, whether the voice belongs to Kane or to a character she has constructed is irrelevant to our research. In relation to *4.48 Psychosis*, Kane stated in an interview in 1998, as quoted in Peters[46] (*apud*. Peters, 2016: 5):

> I'm writing a play called Four Forty-Eight Psychosis. It's about a psychotic breakdown. And what happens to a person's mind when barriers that distinguish between reality and different forms of imagination completely disappear (Kane 1998: 19).

As opposed to the previous complex mentally-ill characters of Greek Antiquity or Shakespeare, whose actions were perpetuated and filled with stereotyped views on mental health, Kane became a reference in the history of mental representation in theatre form due to her disintegrating approach to a point of diffusion. *4.48 Psychosis* will be more thoroughly analyzed in later sections of the work.

[46] Peters, Margaret (2016), *"Utterly Unknowable": Challenges to Overcoming Madness in Sarah Kane's Blasted, Crave, and 4.48 Psychosis.* Faculty of Arts. University of Ottawa. Journal of Evidence-Based Psychotherapies, Vol. 17, No. 1, March 2017, 105-128. Ottawa, Canada

PART II.

5. INTRODUCTION.

The following section will focus on close readings of three main plays, together with referenced excerpts from others when necessary. All of the cited plays have their temporal location in common. As previously mentioned, the audience plays a crucial connecting role within the understanding of the chosen portrayals of mentally-ill characters in Western theatre. Several characterizations draw greatly from specific stigmas and expectations each generation may have in accordance with their society's views. Thus, the following analysis will have as its focus plays which were produced and performed within the temporal space of the 20th and 21st centuries, as their closeness in time provides a more understandable background to the way modern societies may react upon the viewing of certain matters. Although the 20th century, and now the 21st, could be considered to be golden centuries for the medical improvement of conditions and educational means of mental illness, there are still, as previously commented, recurrent stigmas attached to such illnesses. Individual perceptions of mental illness are as diverse as the possible manifestations of it in distinctive individuals, nonetheless the common individual, meaning someone with no direct contact with mentally-ill individuals or uneducated about its associated issues, is in danger of basing his/her opinion on stigma-filled representations found in art forms and/or mass media. Theatre, with its diversity of portrayals, has been found to be an important vessel of communication on the issue of mental health, with its manner of bringing taboo issues to the forefront of social discussion[47]

The focus in the next part of the thesis will be given to the possible influences of Joe Penhall's *Blue/Orange* (2001)[48], Sarah Kane's *4.48 Psychosis* (2001)[49] and Peter Shaffer's *Equus* (2006)[50]; with necessary references to Simon Stephens' *The Curious Incident of the Dog in the Night-time* (2014)[51]. The main goal will be to understand in what ways the portrayals of mentally-ill characters in these plays may hint at certain social issues. These social issues include racism and discrimination against individuals

[47] Reference back to chapter: *Contextualized representations of mental illness in theatre.*

[48] All references will be drawn from Penhall, Joe (2001), *Blue/Orange*. Methuen Drama. London, United Kingdom.

[49] All references will be drawn from Kane, Sarah (2001), *Sarah Kane Complete Plays : Blasted; Phaedra's Love; Cleansed; Crave; 4.48 Psychosis; Skin*. Methuen Drama. London, United Kingdom.

[50] All references will be drawn from Shaffer, Peter (2006), *Equus*. Modern Classics. London, United Kingdom.

[51] All references will be drawn from Stephens, Simon (2014), *The Curious Incident of the Dog in the Night-time*. Barrymore Theatre. New York. New York, United States.

from other races due to recurring social stigmas; the way mental institutions are operated[52]; the way trauma may grow into a specific mental illness or cause the individual to perform certain actions; and the way human beings relate to one another. All three plays represent distinctive relationships and ways of connecting, thus each contribution will be separately analyzed. Another major focus will be on the way each playwright has chosen to represent these characters according to their illnesses and pertaining social stigmas. Do these representations share similarities? Are there tendencies, which may have been borrowed from older playwrights to use certain symbols and signs to represent mental illness on stage? We will look to answer these questions and others through a profound analysis of the plays in the light of the issues with which this thesis is concerned.

The first subject to establish will be the concepts of observational and experiential theatre, as they may offer clues to issues of representation. Following this, the analysis of the case studies will begin. Each play will be divided into three different sections: a section on the language and behaviour associated with the mental illnesses presented in the play, which will borrow from scientific sources; a section on the way the main character's identity is constructed surrounding the scientific knowledge associated to such; and a final section on the relationship between doctors/mental health carers and patients.

The final part of this chapter will discuss the impact of these three works. In what ways do they share identical ideals, while still offering different portrayals? Is it possible to break from certain stereotypes, which are still maintained today to achieve a better understanding of mentally-ill people through the better study and understanding of such works? These and other questions will serve as the basic focus for this final part.

6. THE INDIVIDUAL PORTRAYAL OF MADNESS: EXPOSITION OF THE PROBLEM.

6.1. The two methods of representing mental illness in theatre: the observational method.

As cited by Greta Hoffman, the author of the thesis *Mental Illness through the Lens of Theatre*[53] (2016), Yannick Ripa is quoted as saying "We should always remember that there are two ways of looking

[52] This subject involves the way patients are treated, the way medicine may be used in unethical situations and the way in which doctors and other professionals may be filled with their own prejudices and stigmas.

[53] Hoffman, Greta (2016) *Mental Illness Through the Lens of Theatre*. University of Tennessee Honors Thesis Project. Tennessee, United States. http://trace.tenneessee.edu/utk_chanhonoproj/2033

at madness; it can be observed from the outside or experienced from the inside". This is to say that an individual may either experience madness or be a mere observer in the audience of someone else's. The latter might find it hard to fully grasp what certain illnesses entail, considering that its effects and causes differ from individual to individual. In several art forms, as well as in theatre, these two ways of experiencing madness are represented through two different methods of portrayal, the observational and the experiential. The observational method, as the name suggests, is a way of representing madness without fully immersing the audience in all its effects. With the observational method, the playwright may portray the character's erratic behaviour, as the audience observes and understands the illness in a superficial manner; nonetheless, that is all there is to it. The audience is merely a spectator to the illness afflicting the character on stage. Hoffman gives the example of Penhall's play *Blue/Orange* (2001) to exemplify what this method of representation entails. The example given is of a very particular scene, which gives the play its name. The scene occurs in Act I, when the three main characters: two doctors, Bruce and Robert, plus patient, Christopher, are speaking in Bruce's office after Christopher's required twenty-eight days of treatment are about to expire. Bruce is adamant that Christopher should stay longer at the facility, as he is sure that there are symptoms of schizophrenia to be diagnosed. Robert is against such a grave diagnosis as it entails Christopher having to remain in the facility when the number of beds is limited. Thus, in order to prove to Robert that Christopher is far from well enough to return to a normal life within society, Bruce asks Christopher to describe what he sees in a bowl of oranges. As Penhall writes (2001: 39):

> **Bruce** What's in the bowl, Chris?
>
> **Christopher** Oranges.
>
> [...]
>
> **Christopher** They're blue oranges.
>
> **Bruce** Blue oranges. Really?
>
> **Christopher** Bright blue.

The audience understands that Christopher is experiencing a visual hallucination. He claims that the oranges are bad, as they are bright blue both on the outside and the inside. This suggests that Christopher is well aware that there is something wrong with what he is seeing, although he doesn't recognise the problem as stemming from his illness. To him, the problem lies in the external world, as

the oranges in the bowl are unusual. This is the most significant sign of Christopher's true mental condition throughout the play. The issue with this scene is that there is no scenic indication that the oranges in the bowl are meant to be bright blue. The oranges presented on stage are normal, orange oranges, filling all the predetermined criteria of what oranges should look like. It is with this choice that the playwright ensures the observational method. The audience understands that Christopher is ill, however their own view of the oranges doesn't change with Christopher's claim, turning them into outside spectators to the claims of his own illness. One may hear what Christopher is saying and understand his illness to a degree, but no individual will ever get a glimpse into Christopher's own world, not even the doctors, as this hallucination proves. The audience is not transported into its own visual perception of the oranges in the bowl. Had the oranges on stage been bright blue, Christopher's mind would be open for someone to delve into all its intricacies. We would then have the experiential method. The oranges here work as a separating line between the audience/the doctors and Christopher; the outside and the inside perspectives of madness; the grammatical slash between the colour blue and the colour orange, which is presented in the title of the play. The reality of the audience is not the reality of Christopher, but could have been if his hallucinations were portrayed in the play by doing something as simple as replacing orange oranges with blue oranges. The orange scene in *Blue/Orange* will be further analysed later on.

6.2. The two methods of representing mental illness in theatre: the experiential method.

With the experiential method, the audience has direct access to the character's inner turmoil (e.g. any visual or auditory hallucination is directly presented to the audience in the same natural manner as it is presented to the ill character). As opposed to the observational method presented in Penhall's *Blue/Orange*, Hoffman promptly gives the example of Simon Stephens' *The Curious Incident of the Dog in the Night-time* (2014), which works around similar concepts, but presents the illness of the main character in a different manner. The main character is Christopher, a fifteen-year-old child, who is a direct spectator to the discovery of a dead dog in his neighbour's garden. This is the opening scene of the play, and the scene which will give rise to Christopher's desire to find out who murdered the dog. It is argued that Christopher shows typical signs of suffering from Asperger Syndrome. Hoffman explains that the following syndrome may be manifested by inappropriate social interactions and overall challenges with speech and expression, which are all clear through the analysis of Christopher's interactions with others throughout the play. Nonetheless, while Christopher remains the main focus of the audience, the analysis of the experiential method is more clearly seen in the character of Siobhan, Christopher's teacher, and

in certain stage directions presented by the playwright. Siobhan works as a recurrent voice within the play, as she interacts both with the audience as a narrator and with Christopher in past and present events. Siobhan's voice is the one that Christopher hears in his head when he finds himself in times of indecision or trouble. Thus, the audience listens to the exact same voice as Christopher, and is granted access to what the voice tells him in several instances of the play. The way is open for the audience to be completely aware of what Christopher experiences, at least in auditory terms. Nonetheless, Hoffman's chosen scene to exemplify the experiential method of representation does not include Siobhan. The way Christopher's brain relays and filters a number of different voices at the same time and how he reacts towards these voices is the main concern of this specific scene. It is in scene 40 that Christopher runs away from his father's house with the purpose of finding his mother who is currently living in London. Christopher has just found out his father was the one who murdered the dog. Upon his arrival at the train station, Christopher is bombarded with the usual loud announcements and publicity adverts, which seemingly repeat over and over at the same time. Following is a short excerpt from the scene in question (2014, 40: 61):

> **Christopher** Is this train going to Willesden Junction?
>
> *The voices here are recorded.*
>
> **VOICE 1** There are 53,963 holiday cottages in Scandinavia and Germany.
>
> **VOICE 2** VITABIOTICS.
>
> **Christopher** Is this train going to Willesden Junction?
>
> **VOICE 3** 3435
>
> **VOICE 5** Penalty £25 if you fail to show a valid ticket for your entire journey.
>
> **VOICE 4** Discover Gold, then Bronze.
>
> [...]
>
> *Christopher closes the map. His voice quietens the more he talks. And as he talks he squats. And then huddles into a ball. Christopher sits silently, huddled for a while.*

The voices are pre-recorded and meant to be played simultaneously in the same style Christopher is experiencing them. For a child suffering from Asperger Syndrome, who is portrayed in the play as being very sheltered and not knowing much about the way the real world works, this tangle of loud voices would

be enough to frighten him into huddling into a ball. Audience are prey to the same experiences Christopher goes through, even if they are not necessarily a component of his illness. As opposed to Penhall's *Blue/Orange*, where the oranges did not change colour to provide the chance to experience the world in the same way as Christopher did, the pre-recorded voices in *The Curious Incident of the Dog in the Night-time*, plus the character of Siobhan allow a more in-depth delving into the mind of an individual suffering from a mental illness and the way they experience the world around them. It would seem that the experiential method may be favourable for a deeper understanding and sense of compassion regarding individuals suffering from mental illness, thus it should be viewed as preferable in plays, which handle these types of topics. Nonetheless, I argue that Penhall chose to keep a line between Christopher and his audience so he could bring the focus onto other issues. Towards the end of the play, audiences understand that the main focus of *Blue/Orange* is not exactly Christopher's illness, although it works as the catalyst for all that occurs. The main topic of discussion is the way his illness is handled by the professionals around him. The social and racial prejudices, as well as the authority of medicine are the main topics in Penhall's *Blue/Orange*. For that reason, the choice of writing the play using the observational method seems like a strategy to keep the focus on other matters rather than Christopher's illness, in order to denounce these issues to audiences at hand and potentially open up brand new batch of social discussions

7. INFLUENCES OF PSYCHIATRY IN THE BUILDING OF MENTALLY ILL CHARACTERS.

In the earlier parts of this thesis, the way older playwrights borrowed specific conventions and symbols attached to clear-cut signs to characterise their portrayals of mental health was an important component in the analysis of theatrical representation. I return to Oyebode's citation, which I have previously quoted in my introduction to Western theatre. Oyebode argues that a reading of "madness" can be achieved by analysing a character's (2012, Preface: vi) *"conduct, bodily posture, gait, gestures and facial expressiveness, language, and dress"*. There is not much regarding dress in any of the chosen plays, thus the focus of the first parts of the case studies' analysis will be given to the patterns of language and behaviour, which have been scientifically recognized as predominant in a vast majority of cases[54]. Patterns of behaviour include conduct, bodily posture, gestures and facial expressiveness. It is not easy

[54] It is essential to report that these scientific findings are not to be generalized.

to speak of definite symbols as they vary according to time, place, personal experience, as well as on the type of play it was meant to be and on how much the playwright borrowed from both scientific knowledge and predetermined personal stigmas. For that reason, establishing a guide with some characteristics of the illnesses will be crucial for a better understanding of the character's complexities, in accordance to certain scientifically and medically established components. Nevertheless, the main spotlight remains on theatrical performance, and on its quality of presenting a vast array of diverse representations through the usage of similar symbols.

8. CASE STUDIES.

8.1. *4.48 PSYCHOSIS.*

8.1.1. A brief introduction.

Sarah Kane's *4.48 Psychosis* (2001) relays the depressive episodes of an unnamed voice. All indicates that the voice is located in a mental institution, where it comes into contact with other unnamed voices, nonetheless most of the play is told through the form of a dramatic monologue, and explores the inner feelings of the main voice. The main voice suffers from depression and while one cannot have direct access to its mind, the monologue exemplifies how the voice feels towards doctors, the cult of medicine and even society itself. Kane wished to highlight the illness, without ignoring the importance of the social errors of society regarding its position on mental health. The play does not follow the conventions of a typical play with continuous dialogue and established characters; rather it presents almost a technique of stream of consciousness[55], detailing the course of thought of one's mind filled with interruptions and seemingly weird connections. Audiences listen to the voice explaining its relationship with doctors and medicine, its anguish over the loss of a lover and its way of viewing the world. It is above all a discontinued monologue, where there are few links between episodes, with sudden bursts of thoughts, which appear to be disjointed. As Margaret Peters explains in her essay *"Utterly Unknowable": Challenges to Overcoming Madness in Sarah Kane's Blasted, Crave, and 4.48 Psychosis* (2016):

[55] In literature, stream of consciousness is narrative method that attempts to depict the multitude of thoughts and feelings which pass through the human mind.

4.48 includes no dramatis personae, no setting or character descriptions, and almost no stage directions. However, 4.48 arguably follows more closely from *Blasted*'s aims than from *Crave*'s, as *4.48* refuses to center sanity or resolve the madness of its characters.

It is above all a play about feelings. The focus is thoroughly given to the character's mind, not paying mind to a specific plot or the creation of interpersonal relationships. Moreover, there is a certain focus on the denouncing of specific components and/or social issues, which create a charged environment and place taboo notions in the first stage to be understood by audiences.

8.1.2. The language and behaviour of depression.

In an article published in the British Medical Bulletin on the stigma of depression, Lewis Wolpert (2001)[56], diagnosed with the illness himself, considers that (2001, Abstract: 1):

> The stigma of depression is different from that of other mental illnesses and largely due to the negative nature of the illness that makes depressives seem unattractive and unreliable [...] A major contributing factor is that depression for those who have not had it is very hard to understand and so can be seen as a sign of weakness.

Depression is one of the most stigmatized mental illnesses, both regarding self- and public-stigma. There are, to this day, many popular misconceptions in the way individuals suffering from depression are meant to act, which in turn, often leads many to act as such, so as to cater to the expectations of others. Following the author's essay, it is important to understand that the main concept associated with depression is a prevailing sadness, which manifests itself in the negative or at times anti-social behaviour that may be performed by some individuals. Mentally depressed individuals are often perceived as being extremely self-reflexive, which, as Wolpert suggests, may develop into other perceptions of egoism and self-centrism. This self-centred behaviour finds its reflection in the way these individuals use language. This tendency exhibits the way depression can often become more of a self-imposed illness, characterized by a lack of connection with the other. This lack of connection often stems

[56] Wolpert, Lewis (2001) *Stigma of depression - a personal view.* British Medical Bulletin, Volume 57, Issue 1, March 2001, Pages 221–224. https://doi.org/10.1093/bmb/57.1.221. Oxford Academic. Oxford, United Kingdom.

from a self-belief that the other won't fully understand the illness or know how to cope with it. In other words, it is a form of self-spoiling of the individual. In the following section, examples of scientific-based articles and/or essays will be used as basis for a better understanding on the way speech may offer important clues to an understanding of depression.

Mohammed Al-Mosaiwi, a Phd candidate at the University of Reading, writes in his online article *People with depression use language differently - here's how to spot it*[57] (2018) about how the language of depression can be divided and classified into two different groups: content and form/style. Regarding content, Al-Mosaiwi argues that affected individuals tend to use an excessive amount of words relaying negative emotions, more specifically, as quoted, (2018) "negative adjectives and adverbs - such as "lonely" "sad", or "miserable"". The self-centred nature of depression manifests itself in language through the greater use of first person, singular pronouns (e.g. me; myself; I), as opposed to second and/or third person. On a 2018 essay about the ways speech may grant ways to a better awareness of illness, author Mohammed Al-Mosaiwi partners up with Tom Johnstone to explain the results of three conducted studies. *In an Absolute State: Elevated Use of Absolutist Words Is a Marker Specific to Anxiety, Depression, and Suicidal Intention*[58] (2018) examines the findings of three studies conducted around 64 different online mental health forums with over 6,000 members to examine the use of absolutist words at a linguistic level. The results show that absolutist words, such as "always", "nothing", or "completely", are even more recurrent than pronouns and/or negative words. It is stated in their joined article (2018) "Words, phrases, and ideas that denote totality, either of magnitude or probability, are often referred to as "absolute". Absolutist thoughts are independent of context and unqualified by nuance". More experiments regarding the classification of mental health using computers and other machines will most likely continue to grow in number, as there is an ever-growing necessity to understand both depression and how to cope with it. It is not so much about preventing it, but rather understanding its complexity. Most importantly, the classification of these findings will only find greater improvements as more research is carried out. Al-Mosaiwi ends the first article by stating that (2018) "[...] it is of course possible to use a language associated with depression without actually being depressed". However, having a greater insight into the language and behaviour associated with the illness may prove to be important to an improvement

[57] Al-Mosaiwi, Mohammed (2018), *People with depression use language differently - here's how to spot it.* University of Reading. Reading, United Kingdom. https://theconversation.com/people-with-depression-use-language-differently-heres-how-to-spot-it-90877.

[58] Al-Mosaiwi, Mohammed; Johnstone, Tom (2018), *In an Absolute State: Elevated Use of Absolutist Words Is a Marker Specific to Anxiety, Depression, and Suicidal Ideation.* Sage Journals. Thousand Oaks, California. https://doi.org/10.1177/2167702617747074

in health facilities and easier diagnosis. It may not do much to eradicate some stereotypes; nonetheless the varied representations offered by other means of communication would be capable of filling such a void.

8.1.3. The primary voice in *4.48 Psychosis*: indicators of depression.

The goal of this section will be to link the data exhibited in the previous section with the quality of speech found within Kane's *4.48 Psychosis* (2001). Thus, the focus will be given to language and the way the primary voice uses it, as compared with the scientific findings of Wolpert and Al-Mosaiwi. Thus, the first connection is drawn by the ideal that language of depression is heavily based on an excessive use of words relaying negative emotions. A great example of this condition can be found in one of the larger portions of Kane's play. Kane writes (2001: 206/207):

> **(Primary voice)** I am sad / I feel that the future is hopeless and things cannot improve / I am bored and dissatisfied with everything / I am a complete failure as a person / I am guilty, I am being punished / I would like to kill myself [...] I am terrified of medication / I cannot fuck / I cannot be alone / I cannot be with others.

The section opens with the sentence (2001: 206) "I am sad". Immediately the audience is transported to a negative state of mind. Previous authors have mentioned, as examples, words such as "sad", "lonely", "depressed" and others. Some of these words do not appear either in this section or throughout the play, nonetheless most of the chosen vocabulary refers audiences to a negative plane. Negative emotions are a constant throughout the play. The use of first person pronouns is as well. There are in total about 29 sentences in this singular section alone which are initiated by the personal pronoun "I". The primary voice is relaying its feelings towards the world, medicine, love, its inability to associate with others, all in a similar style of sentence. From the start the voice is drawn into itself, only speaking to the audience in the first person singular. What is also curious is the sequential use of the sentences, as quoted from Kane, (2001: 206/207) "I cannot be alone" and "I cannot be with others". Wolpert mentions that the self-centred nature of depressive patients leads them into not being capable of more easily connecting with those around them. They might feel trapped within their own minds, nonetheless they are, at times, incapable of escaping it. The other, the ones who do not understand the complexity of the illness, may find it hard to be around those who suffer from it, due to this lack of communication. The issue becomes finding the point of connection. Lewis Wolpert, in his autobiographical account on the

stigma of depression, contributes to this idea by explaining that (2001) "Worse still, depressives are almost totally negative in all their attributions and also obsessively self-involved which makes them unattractive company". This thought is manifested in a later part of Kane's play when the primary voice affirms that, as cited from the play, (2001: 215) "I've never in my life had a problem giving another person what they want. But no one's ever been able to do that for me. No one touches me, no one gets near me".

The greater use of absolutist words isn't as noticeable throughout the play. However, words such as "everything", "never", "nothing", and "always" do appear, as it is exemplified in the following excerpts:

> **(P.V.)** I miss a woman who was *never* born / I kiss a woman across the years that say we shall *never* meet / *Everything* passes / *Everything* perishes.[59]
>
> (2001: 218)

> **(P.V.)** I can fill my space / fill my time / but *nothing* can feel this void in my heart.
>
> (2001: 219)

Regarding behavioural conditions, there are some established stigmas associated with depressive behaviour. As previously specified, one of the most recurrent is that these individuals find themselves in a state of perpetual sadness. Portrayals of depression in mass media devices or social media have followed similar conceptions. I argue that the behaviour of depression is closely linked to the behaviour of psychosis: erratic in nature, with hallucinations and delusions playing a part in their view of the world and performance. In *4.48 Psychosis* this erratic manner is mainly manifested by the play's writing style. The primary voice speaks with a tone of urgency and the constant change of topic is an example of an overall flow of emotions. There are occasional bursts of anger, which come suddenly and without warning, as if the primary voice loses track of its speech. The following excerpt is an example of one of these bursts. As quoted in *4.48 Psychosis* (2001: 215):

[59] These are my own italics.

> **(P.V.)** Do you think it's possible for a person to be born in the wrong era?
> (*Silence*.)
> Fuck you. Fuck you. Fuck you for rejecting me by never being there, fuck you for making me feel shit about myself, fuck you for bleeding the fucking love and life out of me [...] FUCK YOU FUCK YOU FUCK YOU.

The voice enquires, seemingly to the audience, about the possibility of having been born in the wrong era. The meeting with silence leads to a sudden anger, which culminates in the shouting of the general sentence "FUCK YOU". Delusional speech appears as a companion to these bursts. It is hard to pinpoint whether some examples may be considered delusional, as the common sense of the audience may be shaped into fitting within the specific universe of the play. Nonetheless, the primary voice presents certain scenarios, which are clearly ludicrous if audiences hold them up to the standards of societal common sense. As transcribed from Kane (2001: 227):

> **(P.V.)** I gassed the Jews, I killed the Kurds, I bombed the Arabs, I fucked small children while they begged for mercy, the killing fields are mine, everyone left the party because of me, I'll suck your fucking eyes out send them to your mother in a box [...].

The audience is obviously aware that the voice is most likely not one to gas Jews and kill Kurds unless it is possible to do as such in the world of the play, thus this speech becomes a prime example of a delusional episode, represented by a speed of speech, which is not recurrent throughout the entirety of the play.

8.1.4. The secondary voice in *4.48 Psychosis*: the unbiased nature of medicine.

The beginning of the 20th century encountered a boom in the psychotherapy field. I have in past chapters mentioned the way psychotherapy sessions borrowed greatly from dramatic performance. This chapter will not be about those dramatic qualities or psychotherapy in itself, but rather about the way mental carers and health professionals relate to their patients' illnesses as outsiders. The three plays serving as case studies for this thesis portray different, complex relationships between doctors and

patients. The way individuals communicate and influence each other throughout the plot points of the plays will be essential to the understanding of the state of psychology in a contemporary society.

4.48 Psychosis has an interactive section where a secondary voice communicates with the primary voice, creating a break from the predominant dramatic monologue. For the purpose of this thesis I will assume that this secondary voice has as its source either a doctor/nurse or other health carer, due to both the nature of the dialogue and the belief that the primary voice is located within a mental institution. The dialogue begins with the secondary voice, also unnamed, who questions the primary voice about the reason behind the action of slashing one's own wrists. In itself, the dialogue acquires a very childish tone, particularly as the progression of speech from the secondary voice presents a lack of essential knowledge and is filled with prejudice. In the following excerpt, it is easy to perceive the way prejudice is embedded in the beliefs of the secondary voice. As quoted from Kane (2001: 216):

(Secondary Voice) Oh dear, what's happened to your arm?

(Primary Voice) I cut it.

(S.V) That's a very immature, attention seeking thing to do. Did it give you relief?

(P.V) No.

(S.V) Did it relieve the tension?

The secondary voice repeats the question "did it relieve the tension?" about five more times, before arriving at the final conclusion that cutting your arms is a coping mechanism many patients use to relieve tension. The voice shows disapproval towards this act by calling the action immature and attention seeking, which is the most worrying section of dialogue within the play. Having personally dealt with people suffering from depression, who have resorted to cutting their wrists and arms to relieve tension, I have been a witness to the treatment these individuals were subjected to once their cuts were revealed to others. I have been a witness to claims that someone's cut wrists served as a method to gain attention or to be up with the online trends. This is quite a worrying perspective, as it only allows these individuals to choose one out of two options. They can either hide from the world in fear of judgement, which may give rise to new-found self-stigmas related to these physical marks, as well as a worsening of the mental illness for the lack of treatment, or they may expose their marks and be branded by public stigma. There is seemingly no way to escape the persecution society imposes on these individuals, which could be avoided if certain minds could be more thoroughly educated regarding certain issues. The worry

is extended with the notion that the person enunciating such primary, uneducated thoughts is a medical professional, whose job is to help the patient understand and cope with their own illness. As the dialogue between the two voices in *4.48 Psychosis* progresses, the secondary voice continues to show signs of being deeply ingrained with prejudice. Kane writes (2001: 217):

> **(S.V.)** I thought you might do this. Lots of people do. It relieves the tension.
>
> **(P.V.)** Have you ever done it?
>
> **(S.V.)** No. Far too fucking sane and sensible. I don't know where you read that, but it does not relieve the tension.

The way the secondary voice responds to the primary voice's question undoubtedly emphasizes the premise that the individual behind the voice believes themselves to be a better person, as (s)he is more, as quoted, (2001: 217) "sane and sensible" than the primary voice. Again, it shows the difficulty of being completely unbiased towards specific issues, even as a professional health carer. These feelings of superiority are also manifested in Penhall's *Blue/Orange* (2001), as towards the ending of the play, both doctors, Bruce and Robert, treat Christopher, the patient, in a very patronizing manner. If the feeling of shame attached to certain actions continues to be perpetuated by our society, these individuals will continue to feel marginalized and more often than not will find other resources to put an end to their suffering. I argue that slashing one's wrists is not an action to be appreciated or glorified, but rather that speculating about possible causes for the action may be more prejudicial to the individual's sanity than expected. I'd like to finish the analysis of this section of dialogue by mentioning this last piece of text, where the nurse finally enquires as to why the main voice has cut their arms. Kane writes (2001: 217):

> **(P.V.)** ASK.
>
> ME.
>
> WHY.
>
> *(A long silence.)*
>
> **(S.V.)** Why did you cut your arm?
>
> **(P.V.)** Because it feels fucking great. Because it feels fucking amazing.

All the primary voice wanted was for someone to stop speculating about the reasons or events which may have led to the final action, and instead ask him/her about it. It only confirms that individuals often look for solutions and/or explanations in medicine when, at times, it is impassable to gather such answers. In Ancient Greek theatre, a mental illness was justified as a supernatural occurrence, whose origins were traced back to the divine. In a contemporary society, mental illness is explained by the means of medicine. There is a promptness to compare medical professionals to Gods, as they seemingly provide their patients with "cures" for illnesses that haunt them. Society may accept these "cures" as definite solutions as they are easier to acknowledge than the lack of a cure. The problem becomes the concept of a divine figure, which holds the power of the individual's mental sanity in their hands. That situation may create great imbalances of power between patients and doctors, which only worsens their communication. In his essay, R. D. Laing presents the idea that a doctor's attempt (1964: 25), "to reconstruct the patient's way of being himself in his world, although, in the therapeutic relationship, the focus may be on the patient's way of being with-me" entails that, in the majority of cases, the focus of health carers is on the instantaneous behaviour the patient exhibits when in close quarters. There is a lack of effort to fully acknowledge all the complexities of the illness. It is such relationships that Kane wishes to illustrate with the dialogue in *4.48 Psychosis*, aiming to denounce the biased nature of the health carer, who speaks to the patient in a patronising manner.

8. 2. *EQUUS.*

8.2.1 Brief introduction.

Shaffer's *Equus* (2006) is a fictional account of a real-life event where a young boy blinds a group of horses. In the play's prologue, Shaffer explains to audiences how he had read about the events in passing, encouraging him to write about the potential causes and effects of such acts. Thus, *Equus* tells the tale of Alan, a young boy, arriving at a mental facility. The action starts after he has committed the act; nonetheless, flashbacks are presented and performed throughout the play. Dr. Martin Dysart is Alan's assigned doctor. His character gains great importance in the play as he is the one encouraging the sharing of Alan's experience. In the end, issues of religious obsession, dichotomous beliefs, past traumas and possible hallucinations amount to a diagnosis of psychosis, which, while never stated within the play, is clear due to the actions of Alan. He speaks of his relationship with horses, and the way his horse worship rose to new levels as he began to listen to their secrets through the form of hallucinations. One night at the stables, as he tried to spend some time with Jill, a girl he worked with, Alan had become overwhelmed

with the notion of never truly achieving the freedom he had so unassumingly craved, which pushed him into blinding the horses at the stable. *Equus* becomes a play about mental illness, both of Alan's and subsequently of Dysart's, but it also explores social, familiar and religious matters, which come into discussion as possible catalysts to trigger specific behaviours.

8.2.2. Understanding the language and behaviour of psychosis.

In 2015, a group of analysts conducted research into the way computer-automated analysis of free speech can predict future psychosis[60]. The experiment had as a basis thirty-four young people (eleven females and fifteen males), aged between 14 and 27. Any child under the age of 18 provided written assent from a parental figure. The researchers insist this age range was essential for the study as mental illnesses typically emerge or begin to manifest their effects on young people, as explained by the authors, (2015: 2) "Schizophrenia and related psychotic illnesses typically emerge in young adults at the point of maximal societal and parental investment when individuals are poised to begin to contribute socially and economically." The speech features used in the analysis of these interviews managed, according to researchers, to predict with 100% accuracy later psychosis development in a number of individuals. Thus, interviews were conducted with the goal of recording one hour long, open-ended narratives by the participants about changes they had experienced in their lives and the results of these changes. Interviews took place between 2007 and early 2012. As established in the article, the goal of researchers was to employ within these interviews (2015: 3) a "novel combination of semantic coherence and syntactic assays as predictors of psychosis transition", that is, to use these two linguistic features as the basis for the analysis of the language the participants chose to use in their interviews. The two syntactic markers of speech complexity used in the analysis were: maximum phrase length and the use of determiners (e.g. which, that, etc.). Speech becomes a good source due to its unique quality. The results of this experiment dictated that five of the individuals who were interviewed would eventually progress into psychotic states. The results indicate that semantic coherence was minimum between two consecutive phrases, proving that the studied language is often discontinued. Random outbursts may occur. The syntactic measure determined that there is a high usage of determiners such as "that", "which", "whatever", "whichever", and "what". Researchers also concluded that it was necessary to analyze the recurrent pattern of the

[60] Bedi, Gillinder; Carrillo, Facundo; Cecchi, Guillermo A.; Slezak, Diego Fernández; Sigman, Mariano; Mota, Natália B.; Ribeiro, Sidarta; Javitt, Daniel C.; Copelli, Mauro; Corcoran, Cheryl M. (2015). *Automated analysis of free speech predicts psychosis onset in high-risk youths.* Nature Partner Journals. Schizophrenia volume 1, Article 15030.

maximum of words per sentence. They justify this choice of analysis by explaining that, as quoted in the article, (2015: 4) "speech in emergent psychosis often shows marked reductions in verbosity[61] (referred to clinically as poverty of speech), we also included the maximum number of words per phrase in the classification". Nonetheless, it is hard to establish an analysis solely based on this impoverishment of speech, as mentally healthy individuals may also show signs of such a condition. It is then vital to perceive this analysis as both important, but limited. There haven't been many studies done within this field of research, thus it is still hard to establish whether these methods will experience success in the future. One may argue that these researchers managed to get a perfect result in their diagnosis; nonetheless their data was still very comprised. More than thirty participants with a result of only five transitioning into psychosis is still a very small number for such bold claims.

These experiments have become an important feature in the constant research on mental health issues. There are many positive points regarding this research and planning. However, it is essential to understand that not all is positive when it comes to such studies. Scientific knowledge on mental health may grow as a direct effect, but, much as with psychotherapy, there are several ethical and social issues to consider. Thomas Insel, former NIMH director, posted an article on the possible prevention of psychosis (2014)[62], where he raises the question of possible social consequences young people may experience if their diagnosis is made too early and without certainty.[63] The diagnoses are experiences, and may not hold a great degree of certainty, as the focus of such studies is to prevent the illness, not to comprehend it. The chances of a misdiagnosis are somehow greater, and may affect the way the individual conducts himself/herself within society. Insel also raises the question of ethics. Each individual case of mental illness should be thoroughly considered as unique. Although it may share some qualities with others, each individual should be treated according to the full understanding the mental professional has of his/her illness. By treating each case as data, and finding links to tie everything together, this personalized behaviour is lost. The individuals are replaced by numbers and statistics, which dehumanize them and their struggles. These are some issues to consider when speaking of such experiments.

8.2.3. Alan's smokescreen technique.

[61] Verbosity is the quality of using more words than needed.

[62] Insel, Thomas (2014) *Can We Prevent Psychosis?.* National Institute of Mental Health. https://www.nimh.nih.gov/about/directors/thomas-insel/blog/2014/can-we-prevent-psychosis.shtml

[63] These experiments are still being developed and are not certain.

Some of these issues are brought to light through the array of different representations theatre has to offer. The personalized behaviour of doctors, which treat patients in hierarchical and patriarchal manners is defied by some of these representations, which place specified issues into a context that may bring a greater understanding to audiences. This context is, as previously mentioned, the most essential quality to theatre's representations. This is one of the topics, which will be more thoroughly analyzed through the aid of Peter Shaffer's *Equus*. How is Alan presented to audiences as a mentally unstable individual? His unique behaviour and quality of speech during the first days spent at the institution offer the most interesting clues to the way Alan wishes to portray himself to others. This portrayal of himself becomes necessary to the establishment of his mental condition, both to himself and others.

In his first conversation with Dysart upon arrival, Alan borrows cues from Shakespeare's Hamlet. The patient utilizes a similar smokescreen mirror technique to avoid answering some of Dysart's questions. Again, there is within Alan a conception that this is how he is expected to behave as a mental patient, much like Hamlet performed such acts with the notion that those around him would understand their connotations. Thus, Alan answers every question Dysart asks him with the singing of popular, commercial songs. As Shaffer writes (2006, Act I: 22/23):

> **Alan** *[singing]* [...] There's only one "T" in Typhoo!
>
> **Dysart** *[appreciatively]* Now that's a good song. I like it better than the other two. Can I hear that one again?
>
> [...]
>
> **Alan** *[singing]* [...] Doublemint gum.
>
> **Dysart** *[smiling]* You know I was wrong. I really do think that one's better. It's got such a catchy tune. Please do that one again.
>
> *[Silence. The boy glares at him.]*

Alan is completely aware of what he is doing. As Dysart asks him to sing the same song again, he quickly shifts to another. His singing does not have as its goal a true representation of his mental state, but rather to establish his denial in giving Dysart any information regarding it. His choice of singing as opposed to answering is carefully chosen. By acting in accordance with what he believes to be the predetermined concepts of a "mad man's" speech, Alan hides his true self from Dysart by giving him what he is expecting of him. It works as a criticism against the medical pre-established conventions regarding mental health. Hamlet does something similar in his dialogue with Polonius, as he avoids his enquiries and confuses him with non-coherent speech, improvised with the purpose of leading him into

the belief that Hamlet is not well. Both characters draw from the norm that the speech of a mentally unstable individual has moments of no sense mixed in with sense. Moreover, Alan's speech throughout the play is direct and clear. His carefulness towards what he says is constant, nonetheless after breaking from singing commercial jingles, the boy speaks with nothing but clarity and order. Dysart notices this, commenting with Hesther, his assistant nurse, about how clear Alan's way of speaking is, as opposed to what one may believe. As quoted in *Equus* (2006, Act I: 26):

> **Dysart**: Treating him is going to be unsettling. Especially in my present state. His singing was direct enough. His speech is more so.
>
> **Hesther** [*surprised*]: He's talking to you, then?
>
> **Dysart**: Oh yes. It took him two more days of commercials, and then he snapped. Just like that – I suspect it has something to do with his nightmares.

The previously-mentioned study on psychosis relates the patterns of psychosis in speech to high usage of determiners and a possible reduction in verbosity. We will not look to understand Alan's speech through these findings, as they are not predominant throughout the play. Moreover, I argue that it is important to denote the decay of Alan's quality and clarity of language as the play progresses, as it is a compelling condition associated with the illness. As the focus of Alan's retelling of affairs concentrates on the most traumatic events (e.g. his first meeting with a horse, his father taking the picture of Jesus down, the blinding of the horses, etc.), his speech gains an erratic manner, which contrasts heavily with the calm, reserved nature of the first sections of speech. The idea that Alan is in control is somehow lost. As described in the play, his first meeting with a horse at the beach becomes an important turning point in his life. Alan has a vivid memory of this. As he recounts the memory back to Dysart, he quickly loses focus and his speech becomes entangled with different ideas from the mistreatment of horses to his wish to be an orphan cowboy, because it would give him the freedom he craved. Alan is sharing the information without any tricks to hide his inner feelings from Dysart. As cited in Shaffer (2006, Act I: 49):

> **Alan:** Even the most broken down old nag has got its life! To put a bowler on it is filthy ...Putting them through their paces! Bloody gymkhanas!... No one understands!...Except cowboys. They do. I wish I was a cowboy. They're free. They just swing up and then it's miles of grass...I bet all cowboys are orphans!...I bet they are!

Moreover, Alan's speech is completely disembodied once he is faced with the memories of the dreadful night. There are many instances throughout the play where the audience is made aware that there is something affecting him. His mental illness is recognized as a product of variable factors, from his dichotomous upbringing to constant visual and auditory hallucinations, nonetheless it is as he recounts the events of the night of the crime that the audience gets, through Alan's own words, a true insight into his unsettled mind. The audience hears him talk as Alan and talk as Equus. He is being possessed by this god figure, which transforms his speech. It becomes longer and less cohesive as he moves along. In the following excerpt, Shaffer shows the way Alan panics at the notion of never truly learning how to rightfully worship his god. I argue that the main issue is Alan's feeling that he wouldn't be left to rest while he did not fully give himself over to the vanities of this entity. His freedom was held in shackles until he fully committed to his god. As quoted in *Equus* (2006, Act II: 105):

> **Alan** [in terror]: "Eyes!...White eyes – never closed! Eyes like flames – coming – coming!...God seest! God seest!...NO!

There are accounts of visual and auditory hallucinations of the god Equus prior to the fatal night. Nonetheless, the feeling of paranoia, which is often associated with psychosis, and which Alan describes, reaches its peak during the night at the stables. Shaffer writes (2005, Act II: 105):

> **Alan** [...] I see you. I see you. Always! Everywhere! Forever!
> **Dysart** Kiss anyone and I will see?
> **Alan** *[to Dysart]* Yes!
> **Dysart** Lie with anyone and I will see?
> **Alan** *[to Dysart]* Yes!

Alan is paranoid over the thought of being fully controlled by Equus. He has grown up in a toxic household, where both his parents have tried to impose their own distinctive morals on him. The day he first met a horse at the beach was the first taste of actual freedom he felt. Upon the realization that this new-found god is controlling him and watching him with the same pitiful eyes he had tried to escape from,

Alan is led into a state of both anger and despair. When Alan relayed his first experience with a horse to Dysart, he mentioned the thrilling feeling of having the power to choose where you go. He had a ride on the horse's back until his father came along and pushed him off the horse. His father works as a symbolic figure for the oppression Alan feels. The power he had on the horse's back was a power he never found again within his family or societal settings. This recurrent idea of holding some degree of power is something Alan associates with being on or around horses. His first experience is also enhanced by his first known auditory hallucination, as he asks the horse whether the chain in his mouth hurt and the horse supposedly answers him back, although Alan never really states what the horse has told him. The symbolism attached to horses is only magnified as the image of Jesus in Alan's bedroom gets replaced with an image of a horse, whose head is completely centred, making its eyes look enormous. As explained by Shaffer (2006, Act I: 44/45):

> **Dora** Well, do you remember that photograph I mentioned to you. The one Mr. Strang gave Alan to decorate his bedroom a few years ago?
>
> **Dysart** Yes. A horse looking over a gate, wasn't it?
>
> **Dora** That's right. Well, actually, it took the place of another kind of picture altogether.
>
> **Dysart** What kind?
>
> **Dora** It was a reproduction of Our Lord on his way to Calvary.
>
> [...]
>
> **Dysart** Could you describe that photograph of the horse in a little more detail for me? I presume it's still in his bedroom?
>
> **Dora** Oh, yes. It's a most remarkable picture, really. You very rarely see a horse taken from that angle - absolutely head on. That's what makes it so interesting.
>
> **Dysart** Why? What does it look like?
>
> **Dora** Well, it's most extraordinary. It comes out all eyes.

This replacement implies that Alan has now replaced one god with the other. His father is not a fan of his wife's religious fanaticism, and, during an argument on religion he rips the image of Jesus from Alan's wall. Frank, his father, offers him the picture of the horse, which comes to replace that first picture. The picture is described as being all eyes. Eyes acquire an importance within the play, as they are also the vessels to Alan's own visual hallucinations. The theme of eyes, particularly of rolling eyes as a source of mental illness, has roots in the Ancient Greek dramatic tradition. In Euridipes' *Heracles* (416 B.C.), the

Messenger comes and describes to audiences the way Heracles' face and eyes suddenly changed at the moment of his family's murder (apud. Oyebode, 2012: 11) "His face had changed; his eyeballs rolled unnaturally". The rolling of the eyes is not a behaviour performed by Alan, but it is resonant with the way he perceives Equus. He relates the way his god had looked at the moment of the blinding with the following words, as Shaffer writes, (2006, Act II: 105): "**Alan** [to Dysart: whispering]: "Mine!...You're mine!...I am yours and you are mine!"... *Then I see his eyes. They are rolling*[64]". Later, as Alan finishes the process of blinding the horses, he is described to (2006, Act II: 105) "collapse on the ground – stabbing at his own eyes with the invisible pick", which plays similarly with Oedipus' great tale, he who blinded himself after knowing the truth about the murder of his father and his sexual union with his mother. These comparisons serve to underline the premise that signs and symbols are essential in theatre to convey specific messages to audiences. No matter how accurate these signs may generally be, the truth is that they are understood as references to what the playwright wishes to convey.

The degeneration of Alan and the erratic manner with which he expresses the night's events point to a major trauma, and give audiences the final pieces left to build a full representation of a mentally unstable young man. The representation of Alan in *Equus* follows most of the basis of Ancient Greek tragic heroes. Audiences are meant to fear him due to his action, but also to pity him as they learn his story. He is possessed by an evil entity who, combined with situational issues, leads him into a state of pure delusion. Alan is thus portrayed as a young boy who is lost in a belief of a freedom that does not exist.

8.2.4. Alan's influence on Dysart: the other side of the coin.

In *Equus*, Dysart is introduced as a professional doctor whose job is to restore Alan to a normalized state, which will allow him to safely return to a life in society. In the previous example of Kane's *4.48 Psychosis*, the condescending and patronizing manner with which the secondary voice conducted dialogue with the primary voice became the main source of information regarding the relationship between patient/doctor. In *Equus*, this relationship is more intimately connected. Dysart begins as Alan's doctor, who stops at nothing to extract the truth out of him (there are mentions of specific therapies and drugs). Moreover, as the play unfolds Dysart begins to develop an admiration towards Alan's way of living life. In Kane's *4.48 Psychosis*, the primary voice is quoted as saying, (2001: 233)

[64] These are my own italics.

"**(P.V.)** 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. / And I am your proselyte[65] to sanity". These sentences fit within the concept of Alan and Dysart's relationship. Dysart is a broken man, who is not happy with the current status of his life. He is bored, in a failed marriage, and has one recurring dream. In the dream, he is officiating at a sacrifice of a group of children. The children are killed by being thrown against the stones. His job is to carve them with images and patterns. As the ritual continues, he feels himself becoming sick while his mask continuously falls. Dysart reveals clear signs of a possible mental illness or at least a growing obsession. As he meets Alan, a boy with a purpose in life and a way of living that is so much greater than his, he becomes aware of how much of himself he has lost due to the societal pressures of his time. In his eyes, the mental patient he is caring for is more alive than himself. I consider this throws Dysart into a loop, where he is not capable of understanding how someone who performed such a hideous act could somehow live a more fulfilling life than he does, a successful doctor. Dysart views Alan as his own proselyte to sanity, a hope that by understanding his patient's illness, he will be capable of understanding his own. There are specific moments where an imbalance of power is perceivable between both characters, however this imbalance shifts from scene to scene. Dylan holds the power as he uses hypnosis and placebos to control Alan's truth, and Alan holds the power of knowing that Dysart is desperate for the same thrilling feeling he had felt upon the worship of Equus. On page 60, Dysart finally realizes that his intelligence is nothing when compared to Alan's. As cited in *Equus* (2006, Act I: 60):

> **Dysart:** Wicked little bastard – he knew exactly what questions to try. He'd actually marched himself round the hospital, making enquiries about my wife. Wicked and – of course perceptive.

As Alan continues to ask questions, Dysart slowly descends into a mental space, which is not appropriate for his profession. He begins to question the concept of normality as it is known. Dysart asks Hesther about this, getting an answer that does not satisfy him due to its lightness and easiness. As quoted in *Equus* (2006, Act I: 62/63):

> **Dysart**: What am I trying to do to him?

[65] A person who has converted from one opinion, religion, or party to another.

Hesther: Restore him, surely?

Dysart: To what?

Hesther: To a normal life.

Dysart: Normal?

[...]

You mean a normal boy has one head: a normal head has two ears?

Hesther: You know I don't.

Dysart: Then what else?

[...]

[to himself - or to the audience]: Normal!...Normal!

The concept of normality as a human established norm is explored. Hesther gives audiences the professional view of normality in medicine, claiming that their only job is to ensure Alan is well enough to return to society. Nonetheless, Dysart is not convinced by such belief. It is towards the end of the play that he turns to audiences and utters the word "normal". Dysart's final monologue is filled with important questions on the way medicine is incapable of fully understanding mental illness. Ensuring that a patient is normal enough to fit in with society is, in his opinion, to disregard all of the complexities that make up his/her illness. Dysart argues that, as quoted in *Equus,* (2006, Act II: 108) "**Dysart** Passion, you see, can be destroyed by a doctor. It cannot be created". It is with this final monologue that audiences become aware of how out of depth Dysart actually is. He is clearly experiencing a case of delusion, triggered by his life experiences and an unhealthy, growing obsession towards Alan and his views. He does not wish to restore Alan back into a version of normality their society will accept, due to his own selfish beliefs that doing such will claim his passion for life. Normality is thus associated with a lack of passion, which asserts the idea that Dysart is jealous of Alan's condition. Towards the ending, Dysart finally accepts Equus as his god. His speech, much like Alan's, is erratic and disembodied. Shaffer writes (2006, Act II: 108):

Dysart And now for me it never stops: that voice of Equus out of the cave – "Why me?...Why me? Account for me!...Alright - I surrender! I say it!...In an ultimate sense I cannot know what I do – yet I do essential things.

Shaffer proves to be quite clever in the way he shapes the entire relationship between Alan and Dysart. The audience is so fixed on Alan's illness that many may fail to recognize a similar emotional turmoil in Dysart until the later part of the play. His envy towards Alan leads him into trying to search for this god, Equus, as a catalyst for achieving the same amount of passion towards something. Nevertheless, the way he utters (2006, Act II: 108) "Why me?" indicates that Dysart is aware of the wrongness of his choice. All in all, he proves to be a problematic doctor for Alan as he stops him reconnecting with other characters, and focuses his main attention on his own beliefs and needs. This could be the sole portrayal of medicine in *Equus* if not for the character of Hesther, who grants audiences with the other perspective. Her belief is that there is a chance of returning Alan to normality. She is straightforward with what she knows. In her mind, her job as a mental carer is limited to this naive view on a complex issue. As long as Alan is accepted as normal within his own society, everything within him will be well as what human beings crave for is acceptance.

Thus, Alan becomes someone who changes Dysart's life, more so than the other way around, which somehow defies the stereotypes most people have of mental institutions and the relationships between doctors and patients. The complexity of the influence Alan has on Dysart is what turns *Equus* into a very interesting piece of drama.

8.3. *BLUE/ORANGE.*

8.3.1. Brief introduction.

The action in *Blue/Orange* (2001) begins near the end of a patient's prescribed twenty-eight days within a mental institution. Christopher has been assigned to the facility after the occurrence of a brief public psychotic episode. While there, Christopher becomes the target of two different diagnoses, which seem to vary according to each doctor's perceptions and intentions. The doctors are Bruce, who has followed Christopher since the beginning of his stay at the institution, and Robert, a Senior Consultant who is invited to meet Christopher right before he leaves. The audience is told of both diagnoses within the first act of the play. Bruce diagnoses Christopher with schizophrenia, claiming that (2001, Act 1: 27) "**Bruce** He's a Type I Schizophrenic with Positive Symptoms including Paranoid Tendencies. Probably Thought Disorder as well". Upon meeting him, Robert argues that Christopher isn't particularly ill, but is rather suffering from (2001, Act 1: 27), "**Robert** a brief Psychotic Episode associated with BPD". Borderline Personality Disorder is also a mental illness; nonetheless it is not as serious as schizophrenia,

meaning that its diagnosis wouldn't imply a longer stay at the institution. If Christopher is to be diagnosed with schizophrenia, he would need to stay at the mental facility for a longer period of time, which has two main drawbacks according to Robert. The first is that Christopher would most likely forget how to live within a proper, organized society. This concept has been briefly discussed in the previous sections on the way mental institutions operate. Inhabiting these institutions for a long period of time would not allow patients to experience a normal, social environment. Another issue is the stigma of schizophrenia. Christopher as a human being would be lost within the weight of such a grave diagnosis, which comes with an array of predetermined stigmas. The second major drawback, and one of Robert's main concerns, is the lack of beds. This is a more superficial, financial concern, nevertheless it is consistently brought up by Robert.

The plot revolves around conversations Christopher holds with both doctors, as they try to prove their own personal point by using Christopher as a pawn. Many issues of race and society arise around the discussion of mental illness within the play, gaining a greater focus in the later acts. The truth is that audiences may believe which diagnosis they wish, but as the play utilizes the observational method, audiences do not get much insight into the mind of Christopher himself. The point is not to establish Christopher's illness, but to understand the way his illness is treated within the mental institution. For that reason, the only way to try and understand his condition is to consider the worst case scenario and try to understand how likely that scenario is to be true. Thus, the way Christopher is presented as a physical entity will be the focus of this chapter together with his language and behaviour, which will be analyzed using Bruce's schizophrenia diagnosis.

8.3.2. The schizophrenic patient: language and behaviour.

Schizophrenia has often been portrayed in works of art. The mental patient who hears voices in his/her head and performs impulsive acts has come close to becoming a poster picture for the illness. Nonetheless, this thesis will look to perceive schizophrenia in a more scientific manner, with the goal of understanding its studied complexities. Later, the scientific knowledge would be projected onto the analysis of Joe Penhall's *Blue/Orange*.

The first source of information regarding language in schizophrenia comes from Gina R. Kuperberg's 2010 essay named *Language in schizophrenia Part 1: an Introduction*[66]. From the start Kuperberg presents all of the scientific symptoms associated with schizophrenia, grouping them into two

[66] Kuperberg, Gina R. (2010), *"Language in schizophrenia Part 1: an Introduction"*. Lang Linguist Compass. 576–589. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2950318/

different notions: positive and negative symptoms. Kuperberg explains that (2010: 1) "Symptoms of schizophrenia reflect abnormalities in multiple aspects of human thought, language, and communication". With this, the author goes on to list the most understood symptoms of the illness. Kuperberg writes (2010: 1):

> problems in distinguishing between verbalized thought and external speech (verbal auditory hallucinations), in perceiving and interpreting the world around us (delusions), in social interactions and motivation (negative symptoms), and in expressing thoughts through language (thought disorder).

Positive symptoms include hallucinations (most often auditory, visual, and verbal), delusions[67] and positive thought disorder[68], while negative symptoms are not exclusive to a mental illness and do not manifest themselves in schizophrenic patients. These can often affect healthy individuals and may include as Kuperberg affirms, (2010: 1) "lack of voluntary behaviour or lack of motivation (*avolition, amotivation*), apathy, flat or inappropriate affect and "negative thought disorder"[69]". Although schizophrenia can and should only be clinically diagnosed, it is possible through these symptoms to understand the way the illness might manifest itself in some individuals. Focusing on language, Kuperberg explains how a difficulty in verbalization may only be comprehended as a symptom, and may not be manifested in all schizophrenic individuals. Those who do suffer from language impairment can be placed under the category of "thought disorder", which in turn can be positive or negative. Positive thought disorder, as previously explained, entails that (2010: 2) "several different phenomena that lead to discourse which is disorganized and difficult to follow". If the patient suffers from positive thought disorder, his/her speech will be disorganized, deranged and difficult for anyone else to follow. Patient behaviour may vary from delusions, which lead the patient into holding onto beliefs against common sense, and hallucinations.

Our focus for the analysis of Christopher's behaviour in *Blue/Orange* will then focus on positive symptoms. The goal will be to verify how much these symptoms correlate with the character that Penhall presents to his audiences.

8.3.3. Christopher's diagnosed schizophrenia.

[67] (2010: 1) "Fixed false beliefs, out of keeping with cultural norms, and held against all evidence to the contrary".

[68] (2010: 1) "Disorganized language output".

[69] (2010: 1) "Poverty of speech and language".

Christopher's language is colloquial. It is colloquial in the sense that Christopher doesn't shy away from using shortened versions of expressions or phrases, and maintains an informal style throughout the play as he speaks with people in higher position of authority. I argue that Penhall intentionally places Christopher's way of speaking against the formal style of both Bruce and Robert in order to personify the immediate forces of imbalance between the characters. The truth is that while Christopher is the main character of the play, Bruce and Robert are the ones in control of his fate. I argue that Penhall has chosen to portray Christopher as a black man to demonstrate that power imbalance even more forcefully. History has had several episodes in which Caucasians had the power of decision over the lives of Black people. Certain stigmas and feelings of superiority are still recurrent in a society where fascism and other forms of racism are slowly gaining more traction. Obviously, I cannot claim that this was Penhall's goal, however it gives the play a more socially charged feeling. If an individual is to read the transcript of the play without watching a specific actor of colour portraying Christopher, one would immediately be aware of his race through the way he speaks. The following excerpt exemplifies this belief, as quoted in Penhall (2001, Act 1: 9):

> **Christopher** [..] what have I got in my doctor's bag, gimme some smack, where's some smack? Where's the Tamazie Party? This bad nigga patient I got. This bad nigga dude I know. My God! I Can't Take The Pressure!" Innit? [...] Go home to the old lady - "Aw I can't take the pressure. Oh no. I can't calm down. Oh no - yes - no - I can't shag until you gimme the smack, darling!

This more colloquial manner of speech, or *patois*, is often popularly associated with a lack of education. There are many recurrent stigmas within societies, which are linked to the way individuals express themselves through speech. People with strong accents or a more informal style of speech are often labelled as uncultured. The fact that Christopher is black only adds to this stigma. We have previously discussed the reason why the mental illness percentages of African and African-American populations are higher than those found within Caucasian individuals. Degrading social conditions and scarce resources within the African community can often be causes for this. That is not to generalize the issue, but to understand that there is a reality in the way both race and class may perform a crucial role in the understanding of Christopher's illness. Both his race and social class are indicated through his manner of speech and the way the character appears in front of audiences. Could we assume that both doctors are aware and actively engaging in these stigmas as they analyze Christopher? It seems clear

that they are somewhat aware of such issues. Bruce is careful from the beginning in the usage of the right terms, as quoted in *Blue/Orange* (2001, Act 1: 12):

> **Bruce** OK, look...there are things we...there are terms we use which people used to use all the time, terms which used to inoffensive but things are a bit different now. Certain words.
>
> **Christopher** Certain words, what words?
>
> **Bruce** Just...terms which aren't even that offensive but -

Even though Bruce is discussing the usage of terms associated with mental illness, we may argue that there is a subtle notion that racial terms are also something to be careful about. Towards the end of the play, in Act 3, Bruce is confronted with a complaint reported by Christopher after the patient enters into contact with Robert. One of the accusations has to do with racism. Questions of race are brought up by the playwright as a possible cause for the way each doctor treats Christopher. At first, Bruce treats him carefully, as he is afraid of somehow saying the wrong thing. Once he realizes that all his efforts were in vain his demeanour towards Christopher changes, proving that this extreme concern had more to do with Bruce's professional career, as opposed to Christopher's own feelings. By the end of the play, Bruce yells at Christopher using all types of derogatory terms, which he would never have used at the beginning of the play. Penhall writes, (2001, Act 3: 111) "[...] **Bruce** You you you *moron*. You stupid *fool*. Are you *retarded*?". It is clear that once Bruce realizes his job is at risk, he does not care to be politically correct regarding Christopher, releasing all that he really thinks about him. In turn, Robert looks at Christopher as nothing more than a case study for his research. He is not shy to describe his intentions in finding the cure to black psychosis in the early stages of the play. The whole dialogue he has with Christopher in Act 2 shows nothing more than patronizing actions, as Robert believes he is capable of influencing Christopher into doing what he wishes him to do, as exemplified in the following excerpt quoted in *Blue/Orange* (2001, Act 2: 70):

> **Christopher** Cos I wanted to get out of this place.
>
> **Robert** Aha! "The truth will out". You "wanted to get out of this place". You did. It's true.
>
> **Christopher** But now I don't.
>
> **Robert** Yes you do.
>
> **Christopher** No I don't.
>
> **Robert** I think you do.

Christopher is an easy target for Robert. I argue that this perceived ease can be an effect of both his illness and his race, at least in Robert's mind. Both doctors never really see Christopher as a normal patient. He is not just an individual who is possibly suffering from schizophrenia and should stay longer at the mental facility. He is someone that scares Bruce, as he does not want to offend him by using incorrect words, and that fascinates Robert, as his race makes him the ideal prototype for his research. One can then argue that both doctors are filled with certain concepts, prejudices, agendas, and stigmas attached to Christopher as an individual. It is due to these predetermined concepts that Christopher's identity seems to dissolve as his encounters with both doctors increase.

Christopher does present some signs of suffering from a grave mental illness. We return to Kuperberg's essay on schizophrenia to understand the way in which Christopher's mental illness may be manifested. Positive thought disorder, which is a symptom of schizophrenia, entails that the patient may utter disorganized speech with possible sudden outbursts. Christopher's speech is not so much a constant array of sentences without link or meaning. His speech is quite understandable to the audience at large, and at times quite clever. When I aim to find examples of schizophrenic language within Christopher's manner of speech, I am not claiming that his speech constantly lacks meaning, but that there are some instances in which these confusing outbursts come through in the middle of his sentences. For example, as Bruce explains to him the importance of using the right terms for his illness, and tells him that he is unsure if the first diagnosis he made of him is correct, Christopher shouts the following, as quoted in Penhall (2001, Act 1: 13):

Bruce [...] This term, this label, and what it means, because the thing is, I'm beginning to think, now...it's...well, it's a little inaccurate -

Christopher YOU'VE MADE YOUR POINT I SAID I'M SORRY WHAT DO YOU WANT - BLOOD?

The lines that come prior to this are all spoken in a calm, normal tone. Christopher shows signs of being confused and annoyed at the realization that Bruce may want to keep him at the mental institution, nonetheless at no time does he seem angry. The sentence in itself does not make sense within the rest of the dialogue. Obviously, one may argue that while he does not show physical signs of it,

previous to this outburst, he may feel anger at a possible treatment which he considers to be biased. Christopher previously apologizes for not understanding why "crazy" wasn't a good term to use to describe people, so it is understandable that he would go back to his apology as Bruce is keeping within the topic. Nonetheless, Bruce is now talking about Christopher himself. He is in the middle of telling him of the inaccuracy of his first diagnosis when Christopher shouts at him, telling him he is sorry. He then moves on to ask Bruce if he wants blood, which is not understandable within the context of the scene and the dialogue preceding it, unless the reader makes a connection with Bruce sucking the blood out of Christopher by wanting to keep him at the institution. His discourse is incoherent, but could have a context of a social nature if the audience perceives Christopher as being angry at having to be kept at the institution for a longer period of time. One may argue Christopher feels he is being kept there for no understandable reason, which in turn, might result in a belief that his race is the main reason. In Act 2, Christopher's fear becomes an apparent reality as Robert claims that much of the treatment is based on the colour of his skin, going so far as to state that the colour of his skin might be the reason why he is there in the first place. Penhall writes (2001, Act 2: 78):

> **Robert** [...] I think he has a very real fear that...our response to you is weighted by our response to your colour. I personally feel that should be the case; it should be a factor in your treatment. [...]
> You are sectioned and locked up when you shouldn't be. *(Beat.)* Because you're "black".
> **Christopher** I'm being punished?
> **Robert** Maybe that's too strong a term but but but-
> **Christopher** Because I'm black?

Audiences are made aware of the overall importance of race in the play. Christopher's fear becomes a reality, and he becomes aware of his powerlessness against the diagnosis of the doctors. It is with this fear that he reports Bruce, as he believes that by doing so, Bruce won't be able to keep him at the mental institution.

Christopher's behaviour is marked with a hint of paranoia and delusional thoughts, which are in accordance to Kuperberg's findings. In Act 2, Christopher tells Robert that he is being followed and persecuted by skinheads in his neighbourhood (2001, Act 2: 65):

> **Christopher** I am being harassed. I'm in fear of my life. I live in fear. They Know Who I Am.

[...]

I see him at night. He bangs on my door. Says he's coming to get me. He says he'll do me and nobody would even notice and I believe him.

This feeling of paranoia holds similarities to Alan's own with Equus. Christopher senses a loss of freedom, as he is not allowed to be in his own neighbourhood for the fear that these zombie-like individuals will do something bad to him. Again, one may wonder if any past event or meeting with such skinheads has led into this fear, or whether the paranoia is created as a direct effect of Christopher's illness. It is quite probable that these threats may have been a real part of Christopher's life. Although, Robert reaches the conclusion that the skinheads are just football hooligans, Christopher's race is always an impending question, and could have been a cathartic factor for possible racist comments, which Christopher takes as threats. Adding to this paranoia, he experiences delusions and is at times out of focus with reality. The famous scene with the oranges is both a prime example of the experience of a visual hallucination and of the impending pressure of normalization. Christopher is pressured by Bruce to tell Robert the colour of the oranges. Bruce wants him to say bright blue, so he can prove to Robert that Christopher is in grave condition. Christopher, despite not being aware that the problem stems from him, is pressured into giving an answer, which may trigger a more accented disconnection with reality. This is called delusion, and it is one of the effects of schizophrenia and other mental illnesses. Christopher's delusional behaviour is strengthened by his claims that a former Ugandan President, Idi Amin, is his father. The claim first comes in Act 1, as cited in *Blue/Orange* (2001, Act 1: 42/43):

Christopher You don't believe me, do you?

Robert When was this?

Christopher 1974. Before I was born.

Robert Before you were born?

Christopher I was conceived. That's why she had to go. He couldn't father a foreigner. It's obvious.

Christopher presents both the doctors and the audience with colloquial evidence that points at the possibility of the story being true. He shows Robert a page of a newspaper talking about the secret fifth wife of Idi Amin, who supposedly lives in Feltham, Christopher's home area. Nonetheless Bruce

immediately refutes any of Christopher's claims when he states that, as Penhall writes (2001, Act 3: 100):

> **Bruce** What makes me uncomfortable is that this morning he told me his father was Muhammad Ali. He'd seen him on breakfast television winning Sports Personality of the Century.

This situation proves that Christopher is suffering from a serious lack of contact with reality. This lack of distinction between dreams and reality ultimately lead him into being diagnosed with schizophrenia. Schizophrenia itself often leads to paranoia or the fear of things outside of the person's control, which is also revealed as a reality in Christopher's life in the later stages of the play.

8.3.4. Bruce and Robert's own hidden agendas.

In *Blue/Orange*, the imbalance of power between the doctors and Christopher is noticeable throughout the play. This imbalance doesn't stem only from the way Christopher is dependent on them to leave the institution, but it also has much to do with Christopher's race. As I have previously argued, Penhall seems to have wanted social concerns to be the focus of *Blue/Orange*. The focus isn't given so much to Christopher's illness and factors leading to it, aside from the constant mentions of his visual hallucinations and delusional thoughts, but rather to the way he is treated by the doctors. There is a constant implied racism throughout the play. This raises a very crucial question. Doctors treating mental patients should be impartial with their individuals, in the sense that, they are meant to treat them without certain prejudiced thoughts they might harbour about them as individuals. Nonetheless, it is hard for someone to be completely unbiased as we live in a society where we come into direct contact with a number of different stigmas, ideas and concepts. That is why Christopher's race becomes such an important point of discussion, as it creates this imbalance of power and serves to show the way stereotypes and stigmas are still present in the medical field and society

At the beginning of the play, Bruce and Christopher have a conversation about the reason why Christopher is at the mental facility. As quoted in *Blue/Orange* (2001, Act 1: 10):

Bruce Why do you think that is? If you'd just wanted drugs you wouldn't really be here, would you? You'd be out there. Scoring off somebody and...going home. Wouldn't you?

There are no indications that Christopher is a drug addict. The only reference to drugs come when he imitates Bruce's manner of speaking a few lines before, but other than that there are no reasons for audiences to regard Christopher as a drug addict. No arguments are presented to support this belief throughout the rest of the play either. So, one can assume that the mention of drugs here stems from a prejudiced thought Bruce maintains about Christopher. This treatment proves to be recurrent as Christopher feels that Bruce believes that he does certain things due to his race. Penhall writes (2001, Act 1: 18):

Christopher No one, man, I just did it. I just (no, you stay there), I put my pyjamas in a bag and my toothbrush in on top. (Don't move). Took a whole five minutes. Shoot me. What, you think I "pinched the towels" and some stationery?

[...]

Because I'm a Brother?

Bruce seemingly lets some of his own prejudices affect the way he behaves and talks to Christopher. Christopher himself feels persecuted and punished by his race. Towards the end of the play, the relationship between Bruce and Christopher takes on a different tone. No matter what prejudiced thoughts Bruce may have had about Christopher due to his race, at the end his goal was to help Christopher to be properly diagnosed so he wouldn't suffer more that he should. However, the way he goes about connecting to Christopher is debatable. From the very beginning, there is the question of identity. Christopher is unsure about his identity due to a lack of communication with reality. Bruce is continually telling him how he should and shouldn't act or what he should and shouldn't say, according to specific notions associated with his condition. There is a point where Christopher ironically says (2001,

Act 1: 20) "Now you're telling me who I am", which suggests that Bruce expects Christopher to act in a certain manner according to the way he believes he is meant to behave as a product of his illness. When Christopher finishes talking to Robert, he is convinced Bruce has been putting thoughts into his

head. Robert convinces Christopher that he doesn't want to stay in the institution; Bruce is the one who had placed his own thoughts in Christopher's head to convince him to stay. This leads Christopher to a psychotic breakdown where he faces up to Bruce in the final act. The climax of Christopher's crisis of identity is as described by Penhall (2001, Act 3: 104):

> **Christopher** And now I don't, I don't, I don't know what to think! I don't know what to think any more. When I do think, it's not my thoughts, it's not my voice when I talk. You tell me who I am. Who I'm not. I don't know who I am anymore! I don't know who I am!

Christopher and Bruce's relationship functions on different levels. They start by being polite with each other, despite Bruce's own prejudices. Nonetheless, Christopher's conversation with Robert is what eventually brings out some of Bruce's true intentions towards Christopher. Towards the end and with the threat that Christopher may complain about his work, Bruce states that, as quoted in *Blue/Orange* (2001, Act 3: 106):

> **Bruce** [...] I could possibly be sacked in the first month of my training! It isn't your fault. And I am not taking that personally. But what I would like to point out to you is that, that could well affect both our personal, private lives in a, in a terrible, disastrous way. OK? Do you understand now?
>
> **Christopher** Don't patronize me.

Although Bruce wishes to help Christopher, many of his worries revolve around his own job and what could possibly happen to him if Christopher is to complain. This shows that medical and social reputation continue to play key roles in the way doctors connect with patients. At the beginning of the play, Robert mentions that if Bruce insists too much on diagnosing Christopher, he might be judged by his own medical community as being ill himself. This gives a brief indication of the way the medical community is organized. This thought is recurrent in Kane's *4.48 Psychosis*, as the primary voice denounces the way the doctors treat their patients by, much as Christopher believes, putting words into their mouths and filling their bodies with pills. Kane attacks the medical community by writing (2001: 209):

> **(P.V.)** 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 anguish and cover each other's arses.

This description can be suitable for both Bruce and Robert. Bruce and Robert are in constant conflict throughout the play. Nonetheless, they share some views on Christopher which stem from racial and social prejudices. With Robert, a racial prejudice may not be as easily perceivable, as the doctor recognizes the importance of Christopher's race to his study. Robert's entire character revolves around the premise of him becoming the cure to black psychosis, which would raise him to a god-like status within the medical field. In one of his last sections of dialogue, Robert asserts that, as quoted in *Blue/Orange* (2001, Act 3: 117):

> **Robert** You see, sick people come to me.
>
> All creeds and colours.
>
> They are suffering.
>
> They go away and they no longer suffer.
>
> Because of me.

To which Bruce responds by asking him (2001, Act 3: 117): "Who do you think you are? God?", which Robert doesn't deny. Robert's own ego overpowers his sense of understanding Christopher's illness. He wishes him to not be diagnosed with schizophrenia for many reasons, but mainly because schizophrenia isn't as easily cured by human hands. His ego blossoms from the knowledge that if he was to find a cure for black psychosis, everyone in society would perceive him as a God, who can perform miracles. Robert initiates an argument on normality and the value society places on it to justify his actions and beliefs, moreover his attempt at discourse only amounts to a concern for his own self. He claims that Christopher's illness stems from the way mankind is naturally insane or the way society turns them insane. In a dialogue, Robert even defends a belief that Christopher might actually be saner than either him or Bruce, which correlates with Dysart's discoveries in Shaffer's *Equus*. Dysart began to perceive Alan as a better human than him, due to his overflowing passion towards something. To him, normality was what he perceived in Alan, even if such perception did not correlate with the common argument held

by society. Robert's case is somehow different, as he does not admire Christopher. His whole argument on normality, although interesting, serves only as a means to achieve a specific goal. Penhall writes (2001, Act I: 33):

> **Robert** [...] But maybe, just maybe he's a right to be angry and paranoid and depressed and unstable. Maybe it's the only suitable response to the human condition.
>
> **Bruce** What?
>
> **Robert** The human species is the only species which is innately insane.

R. D. Laing explains how the process of connecting a patient to an analyst works through the view of the analyst. He argues that, (1964: 34) "[...] the therapist must have the plasticity to transpose himself into another strange and even alien view of the world. In this act, he draws on his own psychotic possibilities, without forgoing his sanity". This is where Dysart fails, as he loses his own sanity within the process. To him, Alan becomes a figure of what it means to be a human being. Robert doesn't lose this focus, as his speech on normality doesn't present the same threatening notions as Dysart's. His entire relationship with Christopher is based on power imbalance, and on the advantage Robert has over a mentally-weak Christopher, who is slowly starting to lose his reasoning and belief in a coherent identity. Robert moulds him into fitting with the individual he needs him to be.

Christopher is assigned two doctors with two different agendas. Bruce's agenda implies that he wishes to help Christopher, but his own stigmas and preconceived notions about him create a barrier between them, which doesn't allow him to reach out as deeply as he might have wanted to. Robert has a professional agenda in mind. He wishes Christopher to be diagnosed with a treatable illness, which he can claim to cure without forcing him to stay in the mental institution. Penhall's focus throughout the play is the social issues that stem from the mistreatment of Christopher due to his race. His race is at the centre of Bruce's stigmas and Robert's professional interest. His mental illness is left in the background, leaving audiences to despair as they watch Christopher's illness being progressively ignored.

9. CONCLUSION: SOME FINAL THOUGHTS ON THE IMPORTANCE OF THEATRE.

In his book *Scenes of Madness: a psychiatrist at the theatre* (2002), Derek Russell Davis claims that theatre-goers may learn much about mental health from the viewing of plays. Russell Davis writes (2002: 1):

> Plays when they portray madness put it into the context of the events and circumstances that have afflicted the person [...] The understanding plays give of madness is all the more vivid because the events are presented dramatically, feelings being evoked as well as intellectual curiosity.

As previously reported, plays place mental health into a context of events. The relationships maintained throughout an individual's life have an impact on the way their illness may be experienced and recognized. By placing mental health in context; into a sequence of events and life experiences, audiences are better prepared to understand it in a way that differs from the scientific knowledge they could have acquired through articles or other works. Theatre presents mental illness in a different manner from the way it is presented in psychology articles or other sources. Its array of representations gathers information extracted from science and personal experiences, completing it with social concerns and other essential notions for context. The playwright is free to discuss other issues within the topic of mental health; issues that are harder to fully convey through scientific findings. As opposed to other art forms, such as cinema and literature, theatre allows audiences to be more closely connected with the messages of the plays. Within this thesis we have explored three main examples of such. The three case studies show a variety of expression of other subjects or topics, which become important for the rising of discussion and breaking of stigmas. Penhall's *Blue/Orange* treats issues of race and social concerns on the way medical professionals conduct themselves within the presence of minorities. Shaffer's *Equus* presents a dramatic retelling of a real life event, which allows audiences to fully delve into a world of delusion and worship, signalling certain issues of personal relationships. Finally, Sarah Kane's *4.48 Psychosis* represents an intimate portrayal of an individual's inner turmoil. All in all, theatre's capacity of allowing these representations to exist within a contextual nature is essential for such taboo issues to be discussed within a safe environment. As was mentioned throughout this thesis, audiences are capable of more intensely connect to the characters being presented due to the blurriness of the lines separating stage and audience. This aesthetic distance allows the playwrights' messages to be presented without a feeling of personal and direct threat, as ideals regarding mental health and other social issues may be more easily understood by audiences. Theatre-goers are capable of exploring these ideals through a vast array of representations, which always differ from one another. Whether these representations are positive

or negative is another question, nonetheless their distinctiveness brings a new capacity of understanding the complexity of certain illnesses. Theatre's aid to a more educated and improved world is proved to be of great value and worth exploring as a possible catalyst for a better societal organization.

Education proves to be the greatest differentiating factor to the way society deals with mental health. Without proper education, which theatre can promote, public stigmas will prevail, which, in turn, may give place to the origin of self-stigmas. As explained in the following research conducted by Nicolas Rüsch, Patrick W. Corrigan, Andrew R. Todd,and Galen V. Bodenhausenc in 2012.[70]

> Persons with schizophrenia and other mental illnesses are often exposed to public prejudice, and they may consequently come to internalize negative attitudes about their own group, frequently leading to self-stigma (Brohan et al., 2010). Self-stigma is typically associated with low quality of life (Rüsch et al., 2006), can create enormous pain for persons with mental illness and may undermine vocational functioning (Yanos et al., 2010).

The creation of self-stigmas will often direct mentally-ill individuals into performing the role they are expected to. For example, in contemporary social media, it is often possible to find individual reports of depressed patients, who speak of the false expectations others have of them in accordance with their illness. Many expect to see cut wrists and for depressed individuals to be perpetually sad, which are stigmas based on little concern for reality. The target of theatre as an art form is to offer options of portrayals, which do not all abide by the same social stigmas. By showing a variety of portrayals, mentally-ill individuals may feel less restricted in the way they feel they should present themselves, and their illness to others. This may lessen the tendency to abide by public and self-stigmas. As I have been reinforcing throughout this thesis, the greatest solution for a more improved communication between individuals is education. Education through theatre is the best explanation for a blurring of the line that separates normality and abnormality. The dash that separated the colours blue and orange in Joe Penhall's work conveys the same feeling of separation, which exists between these two socially established groups. Education will allow the colours to be more naturally mixed together, thus allowing individuals to perceive the true traces of blue in orange.

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[70] Rüsch, Nicholas; Corrigan, Patrick W.; Todd, Andrew R. Bodenhausen, Galen V. (2011) *Automatic stereotyping against people with schizophrenia, schizoaffective and affective disorders.* Psychiatry Res. 2011 Mar 30; 186(1): 34–39. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3005008/

This thesis' topic was chosen for many different reasons. The first is that theatre is often neglected in the study of literature. As a literature student, I've always felt that the focus has been given to either narrative or poetry. Theatre has always been in the background of my academic journey. Aside from studying some Shakespeare and a few other plays, my knowledge of theatre has always been slim. It became more prominent when I began my Masters. I was given the chance to learn more about it, and to write my own play. This play was heavily-focused on mental health, which piqued my curiosity regarding this specific topic. All in all, my greatest reason for choosing to approach this topic in my thesis was to write something useful. I argue that the more resources there are to contribute to a better understanding of mental illness the better, because it not only helps "normal" individuals to understand the world and its complexities better, but it also gives outsiders a better prospect to live in a society where they will not be so promptly shunned. My hope is that this work helps to change certain perceptions and that it will work as a comfort to those who may be struggling with an illness they do not fully understand. I also hope that by demonstrating how vast the collection of portrayals of mental health in theatre is, people will be more aware of both the importance of theatre as a vehicle for education and the lack of rules to be followed when it comes to the way mentally ill individuals can and should be treated.

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