

A FEMINIST DISABILITY THEORY APPROACH TO  
REPRESENTATIONS OF MENTAL ILLNESS IN FOUR  
POST-1990 PLAY SCRIPTS

By

SUNSHINE ANNE STEVENS

Bachelor of Science in Liberal Studies

Eastern Oregon University

La Grande, OR

2007

Submitted to the Faculty of the  
Graduate College of the  
Oklahoma State University  
in partial fulfillment of  
the requirements for  
the Degree of  
MASTER OF ARTS  
December, 2011

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Thesis Approved:

Dr. Maria C. Beach

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Thesis Adviser

Prof. Peter Westerhoff

---

Prof. Kevin Doolen

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Dr. Sheryl A. Tucker

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Dean of the Graduate College

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## CHAPTER I

### INTRODUCTION AND REVIEW OF LITERATURE

The world of theatre has a rich history of providing its audiences information which goes beyond simple entertainment. Arguably the world's oldest vehicle for social change, theatre has been banned, persecuted, or lauded by political powers in efforts to promote and standardize social norms, values, and thought, or to reinvent societal viewpoints. Revolutionaries have used theatre as a literal stage to demonstrate issues of social injustice, giving audiences a taste of the outside other which no amount of reasoned discussion could produce. There are times, however, when theatre perpetuates a stigmatized status quo, reinforcing negative beliefs with which audiences are comfortable and familiar. It is the task of this thesis then to glean from contemporary dramatic literature beliefs about a social justice issue whose entrenched stigma remains, whose philosophical underpinnings reach so far back that efforts to reduce its stigma have been only moderately successful. That issue is the disability of mental illness, and addressing current attitudes means examining the stories Western culture tells itself. Through the lens of feminist disability theory, lauded by feminist and disability scholars alike, the following chapters examine contemporary representations of one of the most enduring themes within dramatic literature.

In the spirit of Michel Foucault, who used literary evidence to examine centuries of developing social thought and philosophy towards mental illness in his 1965 *Madness and Civilization*, this thesis utilizes post-1990 dramatic literature to explore representations of mental illness. Most importantly, it examines how those representations uphold or challenge current beliefs about the disability of mental illness. Of all disabilities, mental illness experiences

relatively unchanged levels of stigmatization and has the greatest amount of representation within theatre (Hinshaw and Stier 372). Assistant Professor Kirsty Johnston at the University of British Columbia, whose current research includes disability and theatre in Canada, noted that “few figures, tropes and themes are as ubiquitous in world drama as those involving mental illness” (756). Mental illness is a “ubiquitous” theme because without conflict there is no drama, and the device of mental illness creates an “other” which provides substantial means to create the dramatic tension theatre requires. Theatre thus holds significant promise for both evaluating current beliefs about mental illness and challenging them.

To do so, however, it is important to understand the role of stigma which supports and maintains current beliefs of mental illness sufferers as undesired “other.” The term “stigma” is readily bandied about, yet the historical weight it carries underscores a particular significance when attributed to mental illness, and helps to explain why it resists efforts at eradication. Additionally, the terms “disability” and “mental illness” are frequently presupposed as understood, so for the purpose of clarification working definitions are offered below. The definitions of mental illness and disability vary as widely as the purposes for which those terms are used; hence a detailed discussion of each is necessary.

### **Definitions and Discussion of Terms**

Like Michel Foucault’s work on the history of madness, Erving Goffman’s 1963 groundbreaking book *Stigma: Notes on the Management of Spoiled Identity*, reaches back to ancient times to contextualize his subject matter. Goffman notes that the term “stigma” arose from the Greeks who used it “to refer to bodily signs designed to expose something unusual and bad about the moral status of the signifier” (*Stigma* 1). The bodily signs, “cut or burnt into the body” was a silent but significant indicator “that the bearer was slave, a criminal, or a traitor—a blemished person, ritually polluted, to be avoided” (1). Although Goffman points out that the precise original meaning of the Greek term has shifted, its shame remains. Additionally, an

individual with a stigma is “a tainted, discounted one,” which can also indicate “a failing, a shortcoming, a handicap.” Due to its deeply “discrediting” (3) nature this “undesired differentness” (5) relegates the stigmatized to a “not quite human” status, “imput[ing] a wide range of imperfections on the basis of the original one.” To justify this “we construct a stigma-theory, an ideology to explain his inferiority and account for the danger he represents” (5). As the review of literature will demonstrate, contemporary society’s ideology upholds the medical model as a rationale for explaining the biological-based, and thus indisputable, “differentness” that the stigma of mental illness imputes.

Distinguishing the difference in meanings between disability and impairment are key to a fuller understanding of mental illness. Rather than turn to the slippery meanings rampant in popular culture, two key sources are utilized here. The first is the definition utilized by the United Nations, written by the Director of the World Institute on Disability. She states:

Impairment: Any loss or abnormality of psychological or anatomical structure or function.

Disability: Any restriction or lack (resulting from an impairment) of ability to perform an activity in the manner or within the range considered normal for a human being.

Handicap: A disadvantage for a given individual, resulting from an impairment or disability, that limits or prevents the fulfillment of a role that is normal, depending on age, sex, social and cultural factors, for that individual (Kaplan).

In short, disabled people are those who “have long-term physical, mental, intellectual or sensory impairments which, in interaction with various attitudinal and environmental barriers, hinders their full and effective participation in society on an equal basis with others.” The UN website further notes that “disability resides in the society not in the person.” This definition for obvious reasons is, as noted by Susan Wendell “favoured by disability activists and other advocates” (13). It is positive in that it illustrates a disability might be invisible and includes the social limitations placed on the individual as well as the constraints of a “physical, mental, intellectual or sensory

impairment.” Confusion between impairment and disability are rampant. Are they the same thing? Does one result in the other? Snyder and Mitchell contend that “impairment is both human variation encountering environmental obstacles and socially mediated differences that lends group identity and phenomenological perspective” (10). It could be said disability is the social and medical label while the impairment is the way that label limits the individual, whether those limitations are due to discrimination or a bodily-contained “difference.” For example, a wheelchair-bound individual may be impaired by their inability to walk upstairs, or may experience discomfort or embarrassment when they cannot see the receptionist over the check-in counter, and the annoyed receptionist leans over the counter in order to be seen.

No one definition being perfect or all-encompassing, the second source is Section 902 of the Americans with Disabilities Amendments Act of 2008. Their website states that disability is “a physical or mental impairment that substantially limits one or more of the major life activities of such individual; (B) a record of such an impairment; or (C) being regarded as having such an impairment” (EEOC). The website elaborates its explanation by stating

A person has a disability only if his/her limitations are, were, or are regarded as being the result of an impairment. It is essential, therefore, to distinguish between conditions that are impairments and those that are not impairments. Not everything that restricts a person's major life activities is an impairment. For example, a person may be having financial problems that significantly restrict what that person does in life.

By these definitions, it can be concluded that someone with an undisclosed mental illness may not be impaired by society's response (or lack of it) to their invisible condition, behavioral issues notwithstanding, and thus not considered disabled. On the other hand, an outspoken individual who is biologically healthy may be viewed as a threat and deemed mentally ill by society should their views and behavior not mesh with social norms. There is no blood test for mental illness, and thus it becomes a largely subjective category in the hands of an establishment which benefits from the maintenance of an idea society likes to call “normal.” Interestingly, modern use of the



word “normal” arose from the discipline of statistics, which was at the heart of the eugenics movement, as we shall see later on (Snyder and Mitchell 5).

It is important to understand that, just as an individual can become disabled, the categories of “disability” and “impairment” are not rigid. Deb Hamilton, a disability studies scholar at the University of Chicago, states that “impairment is an unstable category imbued by the prevailing social climate” (643) and reminds us “whether impairments are physically produced, socially constructed or continually sustained by society, they are sensitive measurements of hidden social mechanism . . . in perpetual motion in every imaginable social environment” (649). In short, someone who is not considered disabled could become so, and vice versa, whether or not anything in their physical body or condition had actually changed.

The final definition, “mental illness,” necessarily entails a biological description given the widespread belief of illness as a physiological departure from “normal.” The medical model has dictated social comprehension of mental illness to such a degree that its stigma becomes justifiable given contemporary understanding that it is scientifically regarded to be the result of physical defect. Neuroscientist Joseph LeDoux, who writes “biological psychiatry was founded on, and still largely adheres to, the assumption that mental disorders are due to chemical imbalances in the brain,” thus “the key issue is not whether mental illness is really neural in nature. It is instead the nature of the neural changes that underlie mental problems, and the manner in which treatment should proceed” (261). It is of note that there is no question as to whether or not “treatment should proceed.” The aberration from all things good and normal necessitates “fixing.” As disability theorist Tobin Siebers reminds us, “the first response to disability is always to treat it,” (*Disability Theory* 60) to make it go away, because “the human ego does not easily accept the disabled body” (60). There is no room in LeDoux’s framework to view mental illness in any light other than a biological error, a medical situation requiring medical intervention. The difference of a mental “disorder” cannot be tolerated in the paradigm he has accepted. The instant response evident in LeDoux’s theoretical approach to mental illness

is “let’s fix it,” demonstrating the common cultural belief that the biological difference must be wrong. As a result, the inherent presumption in LeDoux’s sweeping statement is that treatment goes without saying, thus “taking from the supposed sufferer control over their own medical decisions and turning them into, by virtue of their mental problems, a subject of difference under the authority of the medical establishment” (Szasz). This difference-making and infantilizing or dehumanizing is characteristic of modern psychiatry.

Unfortunately, a baseline for “normal” goes without definition, thus bringing a hugely subjective quality to the diagnosis and treatment of what may, or may not be, mental illness. While some may be quick to point out that diseases such as schizophrenia, bipolar disorder, and borderline personality disorder are obvious ‘mental illnesses,’ the question remains regarding the subjective nature of diagnosis and the absence of clinical data suggesting a baseline of normal which takes into account the wide range of biological variety.

Despite LeDoux’s popularity in scientific, academic and social contexts, not everyone agrees with his definition of mental illness as a biological or chemical imbalance. Noted and controversial psychiatrist Thomas Szasz states “there is no evidence for a chemical imbalance causing mental illness” (24). Though biology is a frequent mention amongst psychiatrists and consumers alike, it is not a test of biology which brings about diagnosis of mental disorder, but rather the subjective observations of a mental health care individual, often supplemented with the self-report of the individual in question and family members. Disability scholars have noted further that the term mental illness is utilized when a subject’s behavior departs from socially acceptable norms.

Given the premise of this thesis is based upon belief in the social construct of a difference termed “disability,” disability theorist Tobin Siebers, perhaps one of the most important scholars in the field of disability studies, provides the working definition of disability, since most other definitions are based upon the medical model which, as Siebers states, “defines disability as an individual defect lodged in the person, a defect that must be cured or eliminated if the person it to

achieve full capacity as a human being” (*Disability Theory* 3). Instead of a defect, the aim of this paper is to give support to an ideology which sees “value [in] disability as a form of diversity.”

Rather than a personal “flaw, lack or excess” which feminist disability scholar Rosemarie Garland-Thomson notes society presumes to be characteristic of mental illness, the position of this paper is that disability is a matter of “social injustice, one that requires not the cure or elimination of the defective person but significant changes in the social and built environment” (3). This leads to the conclusion that “disability is not a physical or mental defect but a cultural and minority identity,” meaning that “it is not a biological or natural property but an elastic social category both subject to social control and capable of effecting social change” (4). Siebers’ exploration of disability definitions includes a look at the “ideology of ability,” noting, as do Snyder and Mitchell, that society’s “preference for able-bodiedness” (8) sets

the measure of body and mind that gives or denies human status to individual persons. It affects nearly all of our judgments, definitions, and values about human beings, but because it is discriminatory and exclusionary, it creates social locations outside of and critical of its purview . . . disability defines the invisible center around which our contradictory ideology about human ability revolves. For the ideology of ability makes us fear disability (8-9).

Siebers notes further that “the sharp difference between disability and ability may be grasped superficially in the idea that disability is essentially a ‘medical matter,’ while ability concerns natural gifts, talents, intelligence, creativity . . . in brief, the essence of the human spirit” (9).

Given mental illness does not necessarily come to mind when one thinks of what constitutes a disability, it behooves the purpose of this paper to state that due to the impairment implied by society’s response to a perceived difference in those with a recognized mental illness, the term falls under the category of disabilities, as much as any obvious physical impairment might.

Mental illness constitutes a disability because of imbedded social responses as well as the long history of social and legal impairment associated with madness. The “unquestioned, unremarked upon state [of able-bodiedness] which only becomes notable in its absence . . . to become disabled is to be relegated to a marginalized status in society and brings into high relief for the disabled person the advantages accorded those who inhabit the unacknowledged ‘centre’” (Gavin 149). Despite scholarly recognition of mental illness as a disability, and despite society’s belief that the disabled have rights, the belief in such rights “does not extend to people with mental disabilities” (*Disability Theory* 78). Borrowing Foucault’s term, Siebers asserts that “the ‘feeble-minded’ hold rights of citizenship nowhere, and few people in the mainstream believe this fact should be changed. Behind the idea that physical disability may be cured by acts of will or the imagination is a model of political rationality that oppresses people with mental disabilities” (78). Even under the umbrella of “disabled,” mental illness carries such a stigma that there has been no full integration with the mentally ill into the social or political activism of the physically disabled.

The mentally ill remain the pariahs of our culture, as evidenced by the continuing belief that physical disabilities could and should be overcome with enough effort, and that failure to do so constitutes a “mental defect,” implying “a caste system that ranks people with physical disabilities as superior to those with mental ones,” and Siebers goes on to say that this caste system “encourages the vicious treatment of people with mental disabilities in most societies. Its influence is fully apparent in models of political citizenship, the history of civil and human rights, structures of legal practice, the politics of institutionalization, employment history, and the organization of the disability community itself” (*Disability Theory* 78). These significant social structures which maintain a cultural atmosphere of discrimination view and interpret the behaviors of the mentally ill through a different lens than what would be used with anyone else, disabled or not, and thus to be labeled mentally ill in modern Western culture constitutes the acquirement of a disability, whether a biological basis exists for the diagnosis or not.

This paper does not seek to argue against the existence of biological disturbances in the human brain, as many within the field of medicine make some interesting claims regarding chemical imbalances as a possible cause. However, biological difference alone is not fully accepted here as the sole source for creating a stigmatizing disability such as ‘mental illness’ is wont to do. Due to the episodic, ambiguous nature of an invisible disability like mental illness, “research has consistently shown that there is a great deal more prejudice and stigma associated” with it than other disabilities, such as blindness (Smart 144), which are consistent and “run a stable course” (144). Biology alone as the source for mental illness thus cannot fully account for the centuries of stigma and discrimination with which it is associated. Finally, biological diversity abounds in the natural world of any one species, but nowhere is diversity less tolerated by human beings than in human beings. In a culture which thrives on images of youthful beauty and power, an invisible impairment which is believed to result in socially unacceptable or even dangerous behavior, thought, or appearance is a threat to a culture built on independence and the social capital of physical beauty.

### **Review of Literature**

A cursory glance over centuries of literature reveals mental illness as a long-standing dramatic device to create difference and make an example of poor leaders, unrequited love, and immorality. Students of theatre history will recognize mental illness in the mad characters of Shakespeare and Cervantes, though certainly madness was not a new literary topic even then. Greco-Roman myths include Dionysus and Hercules who were respectively responsible for either causing or being given to temporary madness, and the curse of madness was a common punishment for violating the will of the gods. Mad characters were separated by their difference from society, though the meaning imparted to madness shifted over time. Writers before Shakespeare treated madness as a possibility dormant in the hearts of all men and the mad fools of Shakespeare’s time were often devices used to reveal truth, whereas in the past two centuries

mental illness evidenced a moral failing associated with the refusal to work at the dawn of the Industrial Revolution, as Michel Foucault demonstrated in *Madness and Civilization: History of Insanity in the Age of Reason* (1965). Importantly, the Age of Reason brought with it a scientific slant to the social issue of mental illness, already rife with centuries of negative moral undertones. The belief in mental illness as a defect or weakness, either of moral or physical origin, was a source of fuel for the philosophies which drove the eugenics movement of the late nineteenth and early twentieth centuries, a movement whose framework continues to shape modern views and theories of mental illness and disability.

Foucault's first book, *Madness and Civilization*, was a product of his graduate school studies. The work explores the birth of the stigma attached to mental illness by examining the worldview different historical ages have held. Madness has been seen as a form of intense grief, religious delirium, or demon possession, and became an especial point of scorn during the Industrial Age. The able-bodied were needed to run the technology that had exploded onto the world scene, and those incapable of doing so were looked down upon as leeches. Madness had already taken on the stigma of leprosy when that disease, according to Foucault, became manageable in the Middle Ages. For the most part, a religious view of the world kept outright hostility in check. However, once the mad were viewed as financial drains on community resources and the age of reason was ushered in via science to replace now-scorned religion, societal forces ensured that the sufferers were viewed as less than fully human (hence the popularity of eugenics), whose lack of economic contribution equaled a secondary class of citizen, and viewed mental illness as physical or psychological brokenness or defect. To that end, the notion of "overcoming" mental illness or physical disability continues to perpetuate itself in contemporary thought, which has done the pharmaceutical companies a world of financial good as their medications offer hope for "normalization."

The entrance of science introduced to Western thought the philosophy of mental illness as a biologically-based difference. From science the medical model of disability was thus

created, resulting in a form of social control through the medical establishment which is outside the jurisdiction of those under its treatment. Society, conditioned to accept answers of science, is dependent on promises of a cure or normalization through treatment via its need to strengthen and uphold cultural beliefs in a heritage of pursuing and achieving idealistic norms. Whether the “defect” is of body or mind, the medical model encourages the view that something is wrong which is necessary to overcome to achieve normalcy. Moreover, the creation of a “difference” which established the need for cure or treatment administered by machinations of society has unfortunate consequences for those who are unresponsive to its “cures.” Failure to overcome what is believed to be a biologically-based, correctible difference or imbalance proves existence of personal or moral defect on the part of the individual because they do not wish to be well. Society is now justified in marginalizing further through involuntary hospitalization or other treatment deemed necessary for the individual’s own good and the protection of humanity.

Few if any works exist which so succinctly and accurately trace the philosophical roots of discriminatory thought. Foucault’s short, thorough, and well-regarded work also, and importantly, sets the stage for understanding the emergence of the eugenics movement, which continues to shape every aspect of modern thinking about difference as well as the social outcomes for those diagnosed with or thought to have a disability, including mental illness. Foucault’s work is in many ways the historical backdrop for Garland-Thomson’s feminist disability theory, which will be explored in detail later on. Foucault’s excellent history on the negative associations attached to mental illness is the foundation for this thesis, upon which the theoretical lineage of the eugenics movement and disability studies rest. It is believed by many that eugenics was short-lived, that disability theory has no real history, and that mental illness is a biologically-based flaw.

Foucault’s work has brought us to the mid- to late-nineteenth century, a time when the firmly planted set of social expectations, governed administrative processes, and the acceptance and construction of physical spaces for the mentally ill, inside which physical spaces the outcasts would be treated by an emerging group of specialists, met with the need for standardization

brought upon by the economic realities of the Industrial Age. Upon this stage all has been prepared for what in retrospect seems inevitable—the start of the eugenics movement which sought social control through the premise of physical normalcy, an arbitrary social idealism which, as will be demonstrated, was constructed with the help of the medical field, psychiatry, and statistics. As the next source demonstrates, this philosophy continues shaping Western thought and theory about mental illness and disability. While the term “eugenics” is relegated to an unfortunate hiccup in history, it is the root of current social beliefs about normalcy and defective human biology as the source of at least some social ills – mental illness and disability most prominently.

Sharon L. Snyder and David T. Mitchell’s *Cultural Locations of Disability* (2006) “seek[s] not to fill in an alternative “positive” content of disability experience, for that would merely replace one form of historical simplification with another, but rather to destabilize our dominant ways of knowing disability” (4). The first goal of their text is to “demonstrate how these institutional, and largely scientific, ways of knowing disability can be challenged from a historical perspective” (4). Their second goal is to “undermine the presumption that U.S. culture has produced an “objective” discourse about disabled bodies” (4). Thus Snyder and Mitchell successfully characterize beliefs about disability within a historical framework, incorporating the theoretical predecessors of modern thought and unique historical events in a way that disability studies, sociological viewpoints and even feminism have largely ignored or overlooked, eugenics being a key point.

In their research on eugenics literature as the basis for framing disability within the U.S., Snyder and Mitchell recall

we came to understand that the categorization of disability as a pathological deviance was not an excursion from normalcy rather its ultimate product. Many in disability studies – from Lennard Davis to Rosemarie Garland Thomson to Henri-Jacques Stiker – had argued various versions . . . but eugenics gave the theory a substance that it had never



quite achieved before in our minds. . . . struck us as “not over.” Instead it lurked like a social phantasm just below the surface, determining the standards, manner and parameters of our cultural, political, and intellectual debate about embodied differences”(x).

Snyder and Mitchell address modern locations of disability from the cultural history viewpoint, a discovery of “locales [which] represents a saturation point of content about disability that has been produced by those who share certain beliefs about disability as an aspect of human differences” to just before the eugenics movement, since that is “when disability began to be construed as an undesirable deviation from normative existence.” They found within the “cultural spaces that have been set out exclusively on behalf of disabled citizens” from “nineteenth-century charity systems; institutions for the feebleminded during the eugenics period . . . international disability research industry . . . current academic research trends” in which “disabled people find themselves deposited, often against their will.” The authors’ introduction notes that “even in the face of benign rhetoric about disabled people’s best interests, these locations of disability have resulted in treatment, both in the medical and cultural sense, that has proven detrimental to their meaningful participation in the invention of culture itself” (3). In other words, a philosophy of flawed physiology as the basis for human deviation and social ills attributed to biological difference has created places in modern society where the disabled lose power over their own lives compared with their “normal” counterparts, lose legitimacy of voice, and are stripped of society’s privileges in venues ranging from political power to academia to art as noted in multiple sources (Hillyer; Longmore; Siebers; Titchkosky).

The reason behind the deep infiltration of philosophy about the body into cultural thinking has to do with the wholesale acceptance of the truth and legitimacy of science, whose teachings replaced the cultural location of religion, and gave a reasoned explanation to a social ill. The social triumph of science and reason over religion was a major cultural shift, and this turning point permitted the entrance of new explanations into every aspect of Western life and culture.

Eugenics “adopted a largely biological analysis of poverty and other social inequalities as a product of human deficiencies . . . unemployment, alcoholism, social unrest, prostitution, indigence, and sexual deviances, could largely be attributed to human ‘defects’ causing the degeneration” (Snyder and Mitchell 69). The social ills of that time period have been retained in this, with a high statistical correlation between poverty, mental illness, unemployment and that assorted addictions and criminal activities that are, in the mind of society, tied to these modern plagues.

Tobin Siebers writes “that social attitudes and institutions determine far greater than biological fact the representation of the body’s reality” (*Social Constructionism* 737), meaning that “disability offers a challenge to the representation of the body” (*Social Constructionism* 737). Because of the debilitating ways in which disability, physical or psychological, is viewed by modern society, breaking out of the barriers of belief is especially difficult. To turn the tide of modern thought Siebers states we must “pierce false ideologies” by “overturning the dominant image of people with disabilities as isolated victims of disease or misfortune . . . it means opposing the belief that people with disabilities are needy, selfish, and resentful – and will consequently take more than their fair share of resources from society as a whole” (750). We are a culture taken up with the idea of “normal,” “average,” and Lennard J. Davis, a professor and prolific author on disability issues, writes a notable caveat in the introduction to one of the first disability studies readers, “I will assume, perhaps problematically, an agreement on the fact that not one of us is, or can be, normal, nor can anyone describe what a normal person is” (6). Ours is not an easy heritage to dismiss. The whole of our Western society has been built with borrowed structures of a European past which contain ideologies of discrimination, the disqualifying of the weak, the different, the “feeble-minded.”

Siebers’ masterful exploration of artistic representations of difference in *Disability and Aesthetics*, he writes “disability now serves as the master trope of human disqualification . . . in disability oppression, the physical and mental properties of the body are socially constructed as

disqualifying defects” (26), and that this system of oppression “occludes in each case the fact that the disqualified identity is socially constructed, a mere convention, representing signs of incompetence, weakness, or inferiority as undeniable facts of nature” (37). These successfully oppressive structures continue in part because “it has been extraordinarily difficult to separate disability from the naturalist fallacy that conceives of it as a biological defect more or less resistant to social or cultural intervention. In the modern era, of course, eugenics embodies this fallacy” which “has been of signal importance to oppression because eugenics weds medical science to a disgust with mental and physical variation, but eugenics is not a new trend, only an exacerbation of old trends that invoke disease, inferiority, impairment, and deformity to disqualify” (27). Here is the history of eugenics philosophy, bearing full fruit in all its discriminatory, damning glory.

As demonstrated by Siebers, Snyder and Mitchell, eugenics allowed the medical establishment to organize the formation of psychiatry and its permeation into every aspect of our culture. Their work mentions Foucault and all have a point of agreement with Foucault’s historical treatment of “bodily based inferiority rationales” (12) that came to a head with the eugenics movement, which introduced to Western thought the belief in biologically-based defects. Here there is significant overlap with feminist Susan Wendell, who finds modern “cultural practices [which] foster demands to control our bodies and to attempt to perfect them, which in turn create rejection, shame, and fear in relation to both failures to control the body and deviations from body ideals” (85). Here again is a direct tie-in with the historical development of norms and a carrying-forward of the legitimacy of an ideal standard below which something is wrong.

One of Snyder and Mitchell’s major arguments is that “disability has been historically fashioned as if it were a denotative designation of biologically based deficits” (16), detrimental to the view of disabilities in general as within the range of human difference. They state that

the cultural locations of disability form the foundation . . . of efforts to classify and

pathologize human differences (known today as disabilities) and then manage them through various institutional locations . . . they accomplish their debilitating effects through taxonomies of naming, the statistical calculation of average and nonstandard bodies, restrictive public policy implementation, and especially participation in a normative science of eugenic origin. The eugenics period provided the tools and rationale for a hygienic drive toward the valorization of perfection and normalization” (4-5).

Then and now, the voices of the mentally ill were discounted as the scientifically reasonable, authoritative voice of the doctor had taken control. This created a taint upon those labeled mentally ill that remains, with the related guilt still upon the shoulders of the offending party, the “person’s culpability for the possession of a discordant biology and as the origin of personal and social dysfunction” (72). This view of difference as a matter of biological deviance (Davis 10; Wendell 85) is also found in feminism.

Feminism has long fought against the perception of the female form as defective by virtue of its difference from the male body. But dependence on strength and a simultaneous claim of disability has, as Kim Hall illustrates, not been in the best interest of either feminism or disability studies. Hall explains

the conception that women are disabled by patriarchal oppression actually works against feminist efforts to resist and end patriarchal oppression because it is shaped by norms of embodiment that have been used to justify the oppression of those marked different. Indeed, as some feminist disability scholars have demonstrated, feminist conceptions of patriarchy as disabling have at various moments actively contributed to efforts to institutionalize disabled women. Feminist attempts to measure the harms of sexism by the extent to which it disables women furthers an ableist perception of disability as a despised condition that should be prevented or eliminated, a perception that continues to have harmful consequences in the lives of disabled people (x).

Susan Wendell's text philosophizing feminism and disability came just before the emergence of Rosemarie Garland-Thomson's solidified feminist disability theory. In Wendell's *The Rejected Body: Feminist Philosophical Reflections on Disability* (1996), she shares the experience of becoming disabled as a feminist, a professional, and the questions it raised that had been pondered by few before her. Through this she became what Snyder and Mitchell might term a "victim" of her "own tragic embodiment" (105). Wendell wrote this early and important work from both the personal experience of becoming disabled and through the lens of an academic who had trained as a feminist. Wendell details the difficulties of defining disability, its medical and social challenges, through which she engages the important topic of "idealization of the body is related in complex ways to the economic processes of a consumer society," (86) an echo of Foucault, Snyder and Mitchell, and Siebers who find the emergence of disgust towards 'dis'ability a by-product of the Industrial Revolution and the capitalist values our culture embraces.

### **The Gap**

Feminist scholars including Wendell, Hillyer, Silvers, and Hall have a united voice in expressing wonder that feminism, which has long drawn on the strength of women, a physical and intellectual strength equal to men, bottoms out in the face of disability. If a disabled woman cannot measure her equality to men or humanity by the strength of her body or mind, then it discredits her claim to legitimacy as a human being, as a voice with anything worthwhile to say. Anita Silvers furthers compares the normalization of discriminatory practice by pointing out that like "women as a group, disabled people as a group have been denied and displaced because they do not comply with biological or social paradigms and therefore are dismissed as nothing more than anomalies" (132). Garland-Thomson received immediate response with the articulation of her feminist disability theory, and Kim Q. Hall remarked that "feminist disability studies provides a theoretical framework for expanding an understanding of historical and ideological connections

between marginalized embodiments” (viii). Hall goes on to state that Garland-Thomson “articulates how both femaleness and disability have been marked as deviations from “normal human” embodiment, deviations that must be contained or eliminated to maintain the perception of existing social hierarchies as natural and inevitable” (viii). Feminism rooted in normative bodies leaves vulnerable others who might claim shelter under their claims for equality.

Rosemarie Garland-Thomson writes that “feminist theories all too often do not recognize disability in their litanies of identities that inflect the category of woman,” (*Integrating Disability* 2), which is unfortunate because “feminist theory can offer profound insights, methods, and perspectives that would deepen disability studies” (2). The two fields – feminism and disability studies – answer the gap within each other. The historical gap in feminism has been the reliance on strength and normative minds and bodies, whilst the gap within disability studies is, as Garland-Thomson writes

much of current disability studies does a great deal of wheel reinventing... largely because many disability studies scholars simply do not know either feminist theory or the institutional history of Women’s Studies. All too often, the pronouncements in disability studies of what we need to start addressing are precisely issues that feminist theory has been grappling with for years (1).

Garland-Thomson cautions not all feminist theory can simply be “transferred wholly and intact over to the study of disability,” but that the two have a tremendous amount in common. Both groups have felt the impact of discrimination so deeply ingrained into society that questioning it threatened to disrupt major social structures. Kim Q. Hall finds “feminist disability studies interrogates the complex web of institutionalized techniques of normalization that sustain patriarchy” (vii). Those structures, discussed in Foucault’s earlier work, frame the production of societal norms and behaviors. This suggests that contemporary conceptions of mental illness require vigorous challenge to reimagine a society where differences are no longer negative. Garland-Thomson finds a feminist approach to disability studies will argue against

tired stereotypes about people with disabilities. It seeks to challenge our dominant assumptions about living with a disability. It situates the disability experience in the context of rights and exclusions. It aspires to retrieve dismissed voices and misrepresented experiences. It helps us understand the intricate relation between bodies and selves. It illuminates the social processes of identity formation. It aims to denaturalize disability. In short, feminist disability studies reimagines disability (*Feminist Disability* 1557).

This reinvention, however, challenges the very core of contemporary social understanding about mental illness. This disability and the stigma surrounding it are social constructions utilizing a medical model framework over a hundred years old. The process of construction “lead[s] directly to the achievement of disability as an ‘abnormal’ condition, as an ‘affliction,’ as bodies, minds, and senses ‘gone wrong’” (Michalko 65). Such thinking is not easy to eradicate, because it is part of the process which constructs the worldview of individuals. However, Garland-Thomson’s theory provides an objective way to discourse about the topic, focusing the new lens through which to view the difference that is the social construction of mental illness.

The basis for this thesis is the premise that the disability of mental illness is largely a socially constructed difference weighted with moral and philosophical meanings of historical significance which continue to shape modern perceptions and direct representations of a long-marginalized population. Observed through the lens of feminist disability theory, “which questions our assumptions that disability is a flaw, lack or excess” (Garland-Thomson, *Feminist Disability* 1557), this paper seeks to examine the portrayal of mentally ill characters in modern dramatic literature as demonstrations of difference. This difference is noted using textual examples which highlight the negative outcomes of refusals to cooperate with social norms. In short, the stigma of mental illness equates a loss of power revealed tellingly in the dramatic literature of our day which exposes the life outcomes, limited choices, and untenable

circumstances which are brought upon characters who are considered mentally ill or are on intimate terms with the mentally ill.

### **Methodology**

Four contemporary plays were selected for analysis largely based on the significance of mental illness in the lives of the characters. The prominence of mental illness was clearly a necessary focus in order to be able to fully explore the various issues which arise when examining representations of mental illness. The second-most important consideration was the quality of plays themselves. Good writing, strong story lines, and the adequacy of character development helped ensure rich material from which to draw relevant conclusions. Although three of the four plays represent mental illness in stereotypical ways using the medical model or similar frameworks, this does not necessarily undermine the legitimacy of the work itself. Therefore, to illustrate how contemporary playscripts reflect negative cultural viewpoints about mental illness required scripts which were well-written and preferably well-known. Doubtless there are many approaches to analyzing even the representation of mental illness within dramatic literature, so it is important the reader keep in mind these plays were selected with the understanding the analytical framework would consist of Garland-Thomson's feminist disability theory.

The first three plays analyzed exemplify particular aspects of negative cultural beliefs. For example, the first play, Tracy Letts' 2005 *Bug*, contains many of the stereotypes attributed to the mentally ill. These stereotypes include the scary but charming seducer, the frail and easily-influenced female victim, and themes of drug use, violence, and isolation. The marginalization represented in this play occurs in significant ways which dramatically impact the opportunities and outcomes for each character. The play upholds popular conceptions of the mentally ill as being dangerous, unable to protect themselves or, in the case of the male character, out to seduce and harm. In doing so, it utilizes nearly all stereotypes and demonstrates the validity of Garland-Thomson's argument that modern society continues to view disability as a flaw, lack or excess.



A surprising piece by Tom Kitt and Brian Yorkey sets the theme of mental illness to music in their award-winning show, *Next to Normal*. It is a frank examination of a wife and mother suffering from bipolar disorder. To write a faithful representation of what this disorder inflicts upon individuals and families, Kitt and Yorkey conducted considerable research and were lauded for their insightful representation. However, the play was researched, written and performed within the confines of the medical model of disability. The musical fully supports the contention that outside the medical establishment there is no hope or cure, only damaging behavior and degradation. In other words, it does nothing to challenge the conception of mental illness as a biologically-based flaw which requires fixing.

The third play selected is the only piece in which the main character is arguably not mentally ill. David Auburn's *Proof* demonstrates the secondary stigma attributed to caregivers of the mentally ill, particularly family members. Research in the fields of sociology and psychology are utilized to examine the depiction of Catherine, the mentally ill character's daughter who has chosen to care for her father at home. Erving Goffman's sociological work on stigma becomes important in understanding the way in which Catherine is portrayed and how her older sister, who has been away, interacts with her.

The final play was chosen for its radical approach to representing mental illness on stage. The formatting of the script itself presents a visual picture of the main character's break with reality, and the logic the individual maintains throughout. The play, Sarah Kane's *4.48 Psychosis*, importantly demonstrates the reasoned thought behind self-injury and the wish to end one's life. It also details the dehumanizing effect of standard mental health care, side effects of medication, and challenges the popular notion that mentally ill people who hurt themselves simply do not know what they are doing. Given the play's contrast from the others, this chapter also lays out the context and theatrical movement in which the playwright worked.

The chapters which follow treat mental illness as a byproduct of the interactions between individuals and culture. Believing the arts to contain rich reflections of social thought and trends,

the lens of feminist disability theory applied to theatrical representations of mental illness and the ideologies which thus reveal themselves contains significant promise for analysis. Through the lens of feminist disability theory, portrayals of mental illness are viewed as a social construction of difference directed by cultural values. Thus, mental illness is not located within the individual and their biology, nor is it a 'problem' to be cured or normalized. Rather, mental illness is created through a process of deviation from cultural norms and expectations. Rosemarie Garland-Thomson's challenge that cultural presumptions view disability as a "flaw, lack, or excess" (*Feminist Disability* 1557) will be a significant part of the framework for evaluating the mentally ill character in each play. In particular, character traits, circumstances and outcomes as demonstrations of deviant difference which create the perception of mental illness will be examined in detail.

## CHAPTER II

### BUGGED OUT: STEREOTYPES OF PSYCHOSIS

Pulitzer Prize and Tony Award-winning playwright Tracy Letts, a native of Oklahoma, is no stranger to theatre with strong shock-values. Using stigmatized characters on the edge both socially and psychologically, his plays contain mature themes, graphic portrayals of violence, and emotionally disturbing content. Despite these elements, or perhaps because they reflect so well the negative mainstream attitudes and beliefs about psychological deviance, Letts' creations have been heralded in mainstream theatre as must-see work from the likes of *Variety*, *CurtainUp*, and *The New York Times*. *Bug* premiered at the Gates Theatre in London September 1996, and its creepy premise of two social misfits who end their drug addiction in flames was well-received. From the perspective of theatre as a reflection of mainstream thought, the play provides interesting material for case study. An overview of the play's story within a disability feminist framework is followed by a brief examination of *Bug*'s critical reception. Finally, this chapter will explore the flaw, lack and excess of the main character Agnes in relation to Peter, who accelerates her life to an unexpected end.

Through characters on the edge of society in significant ways, *Bug* demonstrates portrayals of difference which speak to the flaw, lack, and excess of Rosemarie Garland-Thomson's theory that society views those characteristics as inherent components of disability. A diagnosis of mental illness is mentioned outright in Letts' play, and by the end of the piece there

is little doubt as to the unstable and dangerous psychological state of two questionable individuals. Although well-written and unquestionably deserving of its laurels, the piece unfortunately uses its power to repeatedly reaffirm, rather than challenge, stereotypes pervasive in Western culture.

It is no accident that Letts has placed his characters on the literal fringe of a city in a seedy motel. In doing so he creates a setting which speaks to the instability of impermanence and puts the main character, Agnes, in a physical location which may be unconsciously associated with prostitution. In addition to the physical location rife with unspoken cultural associations, Agnes is depicted as a cocaine-addicted waitress not yet recovered from an abusive marriage or her young son's mysterious disappearance almost a decade prior. Alone and vulnerable, she succumbs to Peter, a charming and possibly AWOL military man seventeen years her junior who introduces her to the world of conspiracy theories. Whether Agnes suffers from mental illness or is simply a drug addict traumatized by domestic abuse is unclear; but as the tale unfolds, she is sucked into Peter's paranoia and hallucinations with devastating consequences. Both her emotional vulnerability from a traumatic, fragmented past and the impairments brought on by drug and alcohol use contribute to her eventual decline into a delusional, paranoid state in which she decides to take her life. Critics loved it.

### **Critical Reception**

Head theatre critic at The New York Times, Ben Brantley, was enthralled with Letts' piece and extolled his playwriting ability. In a 2004 review of Greenwich Village's Barrow Street Theatre production, Brantley writes "'Bug' has a subtlety and sureness of composition that testifies to top-flight craftsmanship. Mr. Letts, in other words, is much more than a shock artist." Brantley praises in particular the development of Peter, whose paranoia and conspiracy theories make him an instant representation of the untrustworthy psycho, and "initiates Agnes into his perspective so gently, that by the time they have crossed the boundaries of sanity, neither she nor

the audience knows quite what's happened.” Brantley notes that even if the audience is not seduced intellectually into Peter’s conspiracy theories, his skewed and paranoid perspective of the world rings true on a “gut” level. He gushed *Bug* was “an obscenely exciting play” with a “visceral wallop likely to come as a shock” even to fans of Letts’ other and equally “nasty” work.

Elyse Sommer of *CurtainUp* wrote Letts offers “a close-up of life in the lower depths of society” noting that from the moment of Peter’s appearance on stage, his bad-guy role in the storyline is clear. With a degree of admiration Sommer calls the piece “sleazy and violent,” mistaking the cocaine-induced psychosis of bug-oriented hallucination for a “sci-fi element” which adds a degree of “manic excitement.” Sommer steers her readers away from thoughtful play analysis, encouraging future audience members not to “scratch that itch to look for deep meanings but just grab the edge of your seat and indulge the guilty pleasure of following” Letts’ masterful storytelling which “gleefully pile incredibility upon incredibility for a final crescendo of kitschy theatricality.” This unfortunate and all-too-common reaction to treating theatre as entertainment fodder misses the opportunity to the inner door of the social psyche theatre offers.

In this case, what *Bug* offers, unbeknownst perhaps even to Letts himself, is a widespread representation of social beliefs and attitudes about mental illness. Audiences are presented with and encouraged to unquestionably accept the stereotypes and socially accepted beliefs within *Bug* as they “indulge the guilty pleasure” of mindless consumption. As a psychological thriller, or even escapist fiction, the play script definitely does its job. But the message it sends the audience reinforces common stereotypical beliefs about the dangerous delusions of those with mental illness. Audience members may leave the theatre shuddering with squeamish delight at the fiery ending, but they also come away with an affirmation of socially accepted representations of individuals outside societal norms.

The stigmatizing differences attributed to Agnes and Peter pave the way for Letts to reveal a mental illness diagnosis near the end of the piece. The characters’ fringe social standing, dysfunctional relationship, and life-threatening behavior are stereotypical representations of

mental illness, and interpreted here as a reflection of the negative beliefs society ascribes to mentally ill individuals. As will be shown, elements of danger to self and others, illegal activity, seemingly inexplicable behavior, and presence on the wrong side of social institutions reinforces the image of the mentally ill as unstable, unpredictable, and irrevocably damaged.

Framing Agnes within Garland-Thomson's assertion that society views disability as a flaw, lack or excess, three corresponding themes emerge. Agnes' flaw is the inability or unwillingness to protect herself. Social connectedness is the lack that increases her vulnerability; and excess the drug and alcohol abuse which provides the key to Peter's success as the catalyst for Agnes' destruction. Significantly, Peter and Agnes are presented as dangerous to others and themselves. The road leading to their tragic end is a series of events which an otherwise psychologically healthy person would presumably find a way to escape. Yet Letts gives them no such out. There is no redeeming trait within either person which allows them to save each other. Agnes and Peter are set up from the beginning as individuals whose character is wanting in some way, and both characters individually have some sort of stigma, which when brought together, results in catastrophe. This speaks to the social belief that those with mental illness are dangerous, wanting, in need of oversight, irreparably flawed. Whatever progress has been made in the politically correct language use of society, contemporary Western entertainment continues to demonstrate the negative view of mental illness whose associations with illegal activity, shifty characters, unpredictable behavior and economic or social worthlessness are unchanged.

### **Part One: Flaw**

Arthur Miller, in an essay he wrote shortly after *Death of a Salesman*, said that tragedy "always reveals what has been called [the protagonist's] 'tragic flaw,' a failing that is not peculiar to grand or elevated characters" (3). Certainly a character who waitresses for a living and resides in a seedy motel could be considered neither "grand" nor "elevated." And, as Miller presumed true of tragedy, *Bug* reveals Agnes' greatest flaw: her inability to protect herself. Although the

majority of the play revolves around her relationship with Peter, and it is through this relationship that she essentially commits suicide, her lack of self-protectiveness is best illustrated by the relationship with her ex-husband Jerry. The play opens with her answering the phone and the monologue that results when the caller refuses to speak (Letts 7-8). Despite believing Jerry is her silent caller, she answers the phone a second time after hanging up. This indicates both to Jerry and the audience that Agnes, despite her fear, will not cut off contact with him. Though he has been in jail for domestic abuse, which presumably required Agnes' testimony, Letts does not give her the power to tell Jerry no. Instead, Agnes talks to him, the first indication that she can or will not protect herself. She insists that if "You're gonna call me, you might as well talk. All you do this way is freak me out" (7-8). She swears at him, threatens to call the police, and finally says "I got a gun," but in "hanging up quickly" (8) per the stage directions, it is clear that her threats are empty.

She awakes the next morning to freshly made coffee and Jerry strolling out of the bathroom. Agnes, "speechless" at his unexpected presence, listens to him compliment her before she says "get out" (17). Her command ignored, she responds in short fearful sentences to Jerry as he struts around the room. When Agnes refuses his advances, Jerry hits her so hard she is knocked to the ground, and then she takes the blame for getting hit. Just in time, Peter appears, and his casual response to Jerry prevents the situation from escalating. This second encounter illustrates the real danger of Jerry and his intention to reconnect with her romantically. Having spoken with him on the phone earlier, this second encounter underscores Agnes' inability to stop or leave a situation she knows will result in her physical harm.

A couple weeks later, Jerry returns, belligerent as ever, picking the lock to get into Agnes' room. In the presence of both Peter and her best friend, R.C., Agnes feels safe enough to make him leave. However, once the door closes, it is R.C., not Agnes, who picks up the phone to call the police. Before R. C. can report Jerry's parole violation, Peter grabs the phone out of her hand and slams it down. R.C. reminds Agnes that by coming around Jerry "violated his parole,

his restrainin' order . . . Have him put away, don't mess around with him." But Agnes begs off with "It just ain't that easy" (34). Letts paints Agnes as an almost willing victim through her helplessness even in the face of support from her best friend and the obvious threat Jerry continues to represent.

Agnes' flawed, ineffectual efforts speak to the social belief that the victim is ultimately the one to blame, and that a lack of social connectedness or personal determination were factors in the play's outcome. After all, one might argue, Agnes could have changed her phone number. Agnes could have left town, gone to trade school, made new friends, changed her last name. Presumably, Agnes could have started a new life instead of slinking away to live in a grungy motel on the edge of town, wasting her life doing drugs and waitressing. And she certainly does not have to answer the phone, or stay on the line when she believes it is Jerry, a person who has done her physical and emotional harm. Society through the legal system granted a restraining order, put Jerry in jail. But Agnes continues to interact with him not only by answering the phone, but by carrying on a one-way conversation with him which reveals her fear and inadequacy.

Unable to protect herself from or evade her ex-husband, Agnes demonstrates the stereotype of the mentally weak, ineffective, injured female. This portrayal illuminates the Foucauldian concept in which childish attributes were assigned to the mentally ill—individuals unable or unwilling to protect themselves— and thus in need of oversight. Because of Agnes' lack of social connection, which is the topic of concern for the following section, she is without the social layers of protection family and healthy friends purportedly provide. As it is, she is alone and vulnerable, and though her best friend may be sincere, Agnes' flaw takes on new significance when Peter enters the picture with characteristics of protectiveness, though not in ways which improve Agnes' outcome.



## **Part Two: Lack**

The relationships society values typically include family and friends. It is a way in which people define themselves, and in dramatic literature, characters are purposefully placed in particular relational roles as a way of indicating status. Letts has written Agnes with a best friend ultimately unable to help her, an ex-husband with a restraining order who tried to kill her; and a new acquaintance who succeeds in doing so. The normative family connections Western society uses to place and define self are, in Agnes' case, corrupt, broken, or missing.

So far removed from normative relationships, Agnes finds herself beyond the reach of social institutions, and conversation with R.C. reveals that her best friend has become her only friend. The only mention of parents is her mother, now deceased (14). Agnes' child is missing and likely dead (22), and she fears her ex-husband will kill her eventually. The corrupt relationship with R.C., her best friend who also appears to be her cocaine provider, the broken relationship with her ex-husband, and the missing family connections of her mother and her son paint a bleak social picture. The social lack brings meaning to the quick attachment created with Peter, and speaks volumes about the belief that abnormal or missing socialization leads to affection-starved vulnerability for a woman the audience already knows is unable to protect herself.

Agnes' lack of social connections marks her from the first few pages of the script as an outside other. The negative difference she represents is one of isolation. When Agnes reflects in an early conversation with R.C. that she "used to have a party myself ever' now and again," R.C. reminds Agnes that "this is the way you wanted it. You're the one hermitized yourself" (9). The purposeful exclusion speaks to a negative difference. Outside normative social relationships, Agnes becomes more vulnerable to Peter than she might have otherwise. Due to the fact of her isolation, the relationship with Peter takes on an almost exaggerated importance. And Peter himself has an unusual background. Peter was homeschooled because his preacher "father didn't believe in school" (26) and is now AWOL from the military. Peter's history dating back to

childhood is one of social marginalization. Not only does Letts write negatively of homeschooling by placing it in the context of someone who “didn’t believe in school,” but the outcome of the adult character with that background may be said to have a skewed sense of morality (he stays with Agnes the day they first meet) and is bereft of understanding his obligation as a United States citizen and member of the military (i.e. he embraces conspiracy theories as reality and went AWOL). Lack of education, lack of socialization, a parent who disagreed with a mainstream idea created a dangerous sociopath of an adult.

Peter’s paranoid perspective is established quickly. While insisting there’s “hidden stuff” (14) in the motel painting hanging on the wall of Agnes’ room, they both hear the cricket-like chirp of a bug which they discover together is a low battery in the smoke detector, a device which he says with all seriousness contains “a radioactive element” (15). Agnes believes him. This mutual search and discovery legitimizes Peter’s line of thinking while creating rapport. It also lends tangible support to later conclusions that bugs have invaded their space and bodies, and by this point Agnes is beyond saving. Letts sends R.C. to the rescue for a conversation which demonstrates just how lost Agnes has become. Agnes has someone to love, to care for, and is not about to let go.

R.C. physically tries to remove Agnes from the motel room, reinforcing the childlike attributes Letts has written into Agnes’ character. Peter cares for her when Jerry roughs her up, R.C. demonstrates alarm when Peter’s infected sores are displayed towards the end of the play, and Agnes gets a turn at caretaking when she defends her relationship with Peter to R.C. “Who do you think you are” she screams at R.C. as she covers Peter with a blanket, “You come in here and try to take away the only thing in the world I have, that’s mine. Why can’t I have one thing? Why can’t you leave me with one thing?” (39). Even in the midst of possible cocaine-induced psychosis or emotional evidence of post-traumatic stress, Agnes’ question makes sense. Her life has been one of abuse, loss, isolation, despair. To give up Peter would be to surrender the only

apparent hope life has offered. R.C., unable to “disconnect” Agnes from the connection created with Peter, and is shunned as Peter makes a final move to completely isolate the troubled woman.

Mental illness as social disease, an observation made by Foucault, is important to the framework for understanding the lack of Agnes’ social connections as a marker for both her psychological vulnerability and the hidden, dangerous psychopath Peter represents. Their fringe position in society as outcasts and misfits is compounded by illegal drug use, a social indicator of likelihood for criminal activity, and creates an aura of the darker, unsavory layers of American society. The circumstances of these two characters represent the rampant social beliefs that mental illness is a form of social deviance, evidenced by idleness (Peter is unemployed), lower-status employment, drug use, domestic abuse, attraction of a dangerous individual recently released from prison, poor citizenship (Peter is AWOL), near-squalor living quarters, psychosis endangering self and others - all on in seedy conditions on the outskirts of a city.

Letts has, as Rosemarie Garland-Thomson wrote in her 2005 article examining society’s categorization process of disabilities, taken “a wide range of physical, mental, and emotional differences [which] are collectively imagined as defective and excluded from an equal place in the social order” (*Feminist Disability Studies* 1558). In the final consummation of a relationship based in misplaced desire and beliefs, this combustible twosome seeks to eradicate from themselves the flaw, lack, and excess a complicit society has bestowed. They are literally consumed by desire to escape from the confines of their lives, whether or not they are sane is of little importance. Their final act tells the audience that of course they are insane, and thus perhaps deserving of such a horrific fate.

*Bug* captures major elements of stereotyped, discriminatory beliefs mainstream society upholds about mental illness. While not necessarily directly related to mental illness, drug use can induce a state of dangerous psychosis and is associated with criminal activity as a socially recognized marker of danger. It is therefore an important component of the psychosis both

characters experience. When applied to Agnes and Peter, it has considerable weight in the excess factor discussed by Garland-Thomson.

### **Part Three: Excess**

While drug use puts Agnes and Peter in a particular social category, it also has major implications for the psychological state of both characters and ultimately the outcome of the play. Though it was misrecognized by Elyse Sommer for a science-fiction element, the infestation the characters believe in are not of the Ray Bradbury genre, but rather known to medical science as a side-effect. In addition to bug hallucinations, paranoia amongst users is recognized as part of a chemically-induced psychological state. Research on cocaine use reveals that “the transient paranoid state appears to be a common feature of cocaine dependence and does not seem to be simply a result of exceeding a threshold of use . . . affected individuals might possess a predisposition to this drug-induced state” (*Cocaine and Paranoia*). In other words, Agnes’ shared delusion with Peter is to be expected. Add the factors of her life circumstances, the fear she feels towards her abusive ex-husband now back in contact, and her complete social isolation from mainstream society, Agnes is a disaster waiting to happen. As the play unfolds, she becomes more a pawn of Peter’s manipulation and schizophrenic-like psychosis, succumbing to symptoms of cocaine psychosis very much like that described by medical doctors and authors Weiss, Mirin and Bartel in their 2002 book *Cocaine*:

Cocaine psychosis is typically preceded by a transitional period that is characterized by increased suspiciousness, compulsive behavior, and dysphoric mood. Users also become increasingly irritable, fault finding and eventually quite paranoid. Some psychotic individuals experience visual and/or auditory hallucinations, with persecutory “voices” commonly heard. They also may feel that they are being followed by the police or that others are persecuting them. Everyday events may be interpreted in a way that supports these paranoid beliefs. When coupled with irritability and hyperactivity, cocaine-induced

paranoia may lead to violent behavior as a means of “self-defense” against imagined persecutors. Individuals with cocaine psychosis may also experience tactile hallucinations. Some users, for instance, develop the belief that they have parasites (“cocaine bugs”) crawling under their skin. These individuals may pick constantly at their skin and produce open sores (66).

Events in the play unfold predictably then in the light of cocaine psychosis. The description of feeling bugs “crawling under the skin” and picking “constantly at their skin” with the result of “open sores” is precisely what happens in the second half of the play. However, from the opening scene onward Agnes is ingesting cocaine and may already be experiencing chemical psychosis according to the pattern of use presented in the play and the medical description noted above. At the very least, her decision-making ability is impaired. She compulsively wavers between whether or not to answer the phone even though she has every reason to believe it is her ex-husband, against whom she has been successful in obtaining a protective order. Peter’s ongoing presence after a scene in which he becomes hysterical about “bugs” underscores Agnes’ inability to make decisions regarding her own welfare.

Through the drug-induced veil of the pipe, the manipulative Peter also communicates a frailty, a humanity, which to Agnes must seem a sainted contrast from that of her ex. The connection is understandable as Peter makes every effort to be believable and gentle while he creates a rapport of common values through an excess of shared drug and alcohol abuse. He lures her in from the get-go with compliments and an attempt to establish camaraderie. “You’re very beautiful” he tells her (Letts 11), and then apologizes for making her uncomfortable. “I’m just trying to start something different” he claims after R.C. leaves unexpectedly. “I don’t mean to freak you out, I’m just trying to make a connection, or whatever” (13), and make the connection he does. Despite her initial unease Agnes is quickly putty in his practiced hands, offering from the first meeting for him to stay with her, which he does.

Peter manages to create a mysterious aura with vague references to his past. Agnes, who in a sense is locked away from the rest of the world, has no basis of reality against which to check his claims or “check back in” with a more solid version of healthy existence. In a drug-induced fog, compounded by previously discussed factors of her flaw and lack, Agnes is easy prey. Peter’s sham demonstration of emotional strength as a misunderstood bad boy (a vet on the run recovering from evil-doing bad guys and shady military experiments) draws Agnes ever-further into his paranoia that people are after him. After all, she can relate as she’s had to run both physically and emotionally from her ex, though it has been in many ways a losing battle. Peter’s manipulations are considerable distraction and he plays a game of pretending to not want to share certain types of information or physical experiences (not interested in women, an uncertain place to stay, classified military experience) which of course fascinates Agnes to the point that she will not hear of him leaving and shuns the help of her best friend.

Peter clearly manipulates each situation to his advantage, playing a winning hand as he separates Agnes and R.C... “I’m . . . stunned . . . that you think I would try to stop Agnes from going with you” he says to R.C. as she tries to help Agnes leave the motel room. “I don’t stay where I’m not wanted, and I certainly wouldn’t attempt to keep someone where they didn’t want to be. Agnes is an adult. She’s free to do as she pleases” (38). Though the manipulation is arguably obvious to R.C. and the audience, it is lost on Agnes, who in Peter sees redemption. She cannot see reason, and slips beyond reach of the one friend trying to help her. The dangerous combination of Agnes’ frailty, Peter’s paranoia, and their shared drug use which escalates into delusional thinking become a maelstrom from which neither escapes alive. The drug-induced delusions of bugs and paranoia have a significant link to a specific and well-known mental illness: schizophrenia.

The similarities between cocaine psychosis as described by Weiss et. al. and schizophrenia are remarkable. Rigby and Alexander describe schizophrenia as a form of thought disorder, noting that “delusional thinking is one of the most common disturbances in thought

content. Here, the individual holds beliefs that are perceived to be contrary to objective evidence, and which are not commonly held in the context of the person's culture" (50). This last distinction is particularly important, because what may be everyday common sense in one culture could very well be viewed as superstition in another. However, this distinction is also problematic in that it assumes mainstream thought in one culture is inherently organized and sane.

Paranoid, grandiose, and somatic thoughts are common in schizophrenic patients and show up in Peter's delusional and complicated explanations for the events connecting his life to Agnes. Like Weiss et. al. postulated with their explanation as to those who may be most vulnerable to cocaine psychosis, Rigby and Alexander raise the issue of vulnerability to schizophrenia through stress and other social-environmental factors (52). This theme is present in the Weiss text as well, where the authors contend "stressful life circumstances" (68) may be a contributing factor in determining those individuals most likely to succumb. In Agnes, Letts created a character whose "stressful life circumstances" are outside the social norms of expectations, and also indicates her questionable state of sanity.

The social stigma mental illness carries includes "attributes of . . . degeneration, immorality, and social ineptitude" (Fabrega 590), all of which are themes within the lives of Peter and Agnes. The collision course Peter and Agnes are on unfolds in a sequence which starts with the premise that both characters are odd or ineffective in some way. They have an abundance of lack, an excess of problems, and character flaws which make the most trivial circumstance tragic. Even more damning, they appear largely oblivious to the fact that their lives are lacking normal relationships, material possessions and culturally recognized symbols of worth or value.

As Erving Goffman wrote the negative difference represented by stigma results in belief that such a person "is not quite human. On this assumption . . . we effectively, if often unthinkingly, reduce his life chances" (205). It may be argued that Letts' representation of mental

illness is written in such a way as to uphold the discriminatory attitudes and beliefs prevalent in contemporary culture.

Letts writes Agnes as a social outcast and marked in several ways with negative differences. Physically, socially and emotionally, Agnes is a misfit. From the expectations Western society has of an adult woman, Agnes is a failure. She is unable to protect herself or develop even remotely healthy friendships, unable to take advantage of the reprieve society granted her when Jerry went to jail and unable to rise above a low-paying job. Agnes maintains a perpetually vulnerable state, and it is not clear what she is living for. Her past provides the rationale for the escapism drugs and alcohol provide, but until Peter's arrival, her life is one without any forward motion. The aura of stigma Letts creates with this character sets her up for failure from the beginning. She is stigmatized in every possible way. She is a woman whose speech usage reflect lack of education, a woman who married an abuser and had her young son inexplicably disappear; a woman who in every way is on the fringe. And there she teeters without purpose, resolution or forward movement until Peter comes along to propel her into a future over which she has already relinquished control by virtue of the circumstances of her victim status. And now Letts can now permit the axe to fall on a woman whose world will easily unravel given that so little holds it together.

Society's treatment of disability as a flaw, lack, or excess is demonstrably evident in characters through whom representation of a socially obvious mental illness are present. This is compounded by the revelation that Peter has schizophrenic tendencies and escaped a military hospital. An ending in which both characters, high on drugs and alcohol, commit suicide by lighting themselves on fire to kill a legion of rapidly producing bugs for which their bodies are host, leaves little room for doubt in the mind of the audience that the characters were "crazy" in some fashion. Further, Agnes and Peter are without redeeming qualities, disposable. This unfortunate and stigma-ridden representation perpetuates stereotypes of mental illness, reinforcing the most negative aspects of social difference.



## CHAPTER III

### ALMOST NORMAL: MENTAL ILLNESS INSIDE THE MEDICAL MODEL

Of the four plays selected for their portrayal of mental illness, Brian Yorkey and Tom Kitt's Pulitzer-Prize winning *Next to Normal* is the only musical of the group. While musicals have a reputation for being uplifting or providing the obligatory happily-ever-after ending, not all celebrate the brighter side of life. A handful, including *Sweeney Todd*, *Carousel*, and *La Strada* demonstrate this genre is fully capable of using song to successfully address darker themes. In Kitt and Yorkey's creation that theme is mental illness. Their bold approach unapologetically puts mental illness at the center of the stage. *Next to Normal* unveils life with bipolar disorder and the effect it has on a woman and her family. Diana, married for more than sixteen years to an ever-faithful and patient husband, Dan, has been diagnosed with and seeks answers for her manic depressive episodes. As the plot unfolds, the audience learns Diana and Dan married due to her pregnancy, and that the child subsequently died. Diana's unresolved grief and the couple's inability to face the loss together haunt their married life and keep her distanced from their second child, Natalie, with Dan the go-between and peace-maker.

The strength of *Next to Normal* comes from Diana's devotion to her family. Even at her most depressed or most manic, Diana's actions represent deep commitment to her roles as wife and homemaker. Her continuous efforts to stabilize her mood through medication and therapy, her willingness to go so far as electric shock therapy when other modalities fail indicates this is no slovenly housewife. Rather, her job is her family. And it is one she takes seriously.

Diana cleans the house, prepares meals, and waltzes through a variety of moods and medication. Though emotionally estranged from her teenaged daughter due to long years of illness, Diana fights for mental health and stabilization. By the end of the piece she has reconnected with Natalie and the two are actively working at communicating.

Diana does not give up on any project or undertaking easily; the only time she quits is when the side effects of medication become such that she no longer recognizes herself. At that point, the pills are literally flushed down the toilet, and she cycles immediately back into her highs and lows. Throughout every painful or exhilarating turn, her husband supports her. Dan drives her to doctor's appointments, soothes things over with Natalie, and never once causes Diana to feel that somehow she has failed. *Next to Normal* illustrates the powerful role of love without softening the heartache mental illness can mean for family members. Critics responded enthusiastically.

### **Critical Reception**

*Next to Normal* debuted February 2008 at Off-Broadway's Second Stage. Critical reception was positive, with varying amounts of emphasis on the show's subject matter. In February 2011 Misha Berson, theatre critic for *The Seattle Times*, addressed the musical's theme. "Embodiments of destructive and creative derangement are plentiful," she noted of staged depictions of mental illness, but "more varied and authentic visions of mental illness are starting to emerge," counting the touring New York production among the latter. Berson believes the show avoids "criminalizing and stigmatizing the mentally disturbed, or romanticizing them." Certainly nothing about Diana could be viewed as criminal, though the depiction of a mentally ill character suffering from unresolved grief could be viewed as tinged with romanticism.

Berson's review demonstrates that contemporary society as a whole still views mental illness in a negative, stigmatized light, and that view is reflected in the way disabilities are talked about. The very fact that mental illness is, as Berson wrote, only now "starting to emerge" in

“authentic” theatrical portrayals alludes to an entrenched stigma. Despite Berson’s effort to give the musical and the issue of mental illness their due, her word choice indicates a negative difference of categorization that has meaningful social consequences (Link and Phelan 367). Though she lauds the play for its breaking with tired old tropes, Berson attributes to Diana a negative difference by virtue of her descriptive word choice. Researchers Robey, Beckley, and Kirschner (2006) have found that language use about disabilities demonstrates an “implicit level” of thinking which in turn reinforces social beliefs and opinions (451). This is not to say that Berson herself views mental illness in a negative light, but the way she presents the character of Diana alludes to a socially significant and highly stigmatized category. Put another way, “participants [in research studies] tended to associate words related to disability with negatively connoted words” (452). This finding is supported through Berson’s choice of the word “disturbed” to reference Diana’s mental state, a word which has solely negative connotations.

Rather than emphasize Diana’s natural response to the death of a child, which unaddressed has become an exaggerated form of grief, Berson’s word choice draws attention to Diana’s lack. It indicates to her readers that Diana is set apart from what society holds to be a normative mental state. Interestingly, Berson presents the show as an “authentic” representation, strengthening social perspectives and norms *Next to Normal* leaves unchallenged. As this chapter will illustrate, the musical portrays its mentally ill character going from one doctor and one prescription to another. This supports rather than challenges mainstream expectations that mental illness is a biological flaw requiring treatment within a medical paradigm.

*New York Times* head theatre critic, Ben Brantley, wrote “no show on Broadway right now makes as direct a grab for the heart” and called it a “brave, breathtaking musical” in his April 2009 review. He warns that the story line is not for the faint of heart and departs from qualities the general public might attribute to the genre. It “does not, in other words, qualify as your standard feel-good musical. Instead this portrait of a manic-depressive mother and the people she loves and damages is something much more: a feel-everything musical.” Brantley,

perhaps inadvertently, provides an interesting comparison between Diana's damaging love for her family and the effect of the show on audiences. Similar to Berson's assessment of Diana which employed words with negative connotations, Brantley's description states the mentally ill "damage" family members. Although he acknowledges Diana loves her family, even this comes across as not being in anyone's best interest through Brantley's connecting the "love" with the "damaging." The implication in Brantley's review is that because Diana—a mentally ill woman—loves her family, she damages them. This promotes the stereotypical belief that even emotions or actions which have positive connotations in society at large are twisted in the behaviors or motivations of the mentally ill. Love of family, a strong cultural value, is belittled when held by one with a diagnosed illness.

Brantley's tantalizing description of the show, a "direct grab for the heart" demonstrates that portrayals of mental illness can open up audiences to an uncomfortable excess of feeling. This might be seen as parallel to Diana's love for her family, a love which makes all vulnerable to the pain she inflicts through the symptoms of her illness. The audience identifies then not with Diana, but with the hurting family members. This dehumanizes Diana, making her a conduit through which her family members, and the audience by association, experience the emotional rollercoaster of her disorder. Diana, inseparable from her symptoms, thus signifies mental illness itself and becomes unredeemable. Because the character represents not a human being but a stigmatized illness, positive character traits go unacknowledged, as seen in both Brantley and Berson's reviews.

Both reviews, chosen as a representative sample from dozens, discuss Kitt and Yorkey's onstage depiction of mental illness as realistic. Berson found it an "authentic" telling, true to the real life experiences of the mentally ill, and Brantley made similar comment when he declared the "production assesses the losses that occur when wounded people are anesthetized." Here he does not refer to the main character as mentally ill, but wounded. Interestingly, no inherent biological flaw or lack is indicated, rather the choice of the word "wounded" speaks to an acquired pain.

Despite this term, which does not necessarily speak to an inherent biological error within Diana, it remains a negative term, further illustrating Robey, Beckley, and Kirschner's findings about the implicit negative connotations associated with disabilities (452).

Since *Next to Normal* illustrates characters seeking answers and treatment within the mainstream medical paradigm, reviewers' comments reinforce the belief that mentally ill people need the psychiatric oversight and treatment provided through the medical model. The next section defines both the medical model, which treats disability as a biological problem, and social constructionism, which recognizes the tremendous influence of social forces in bodily-based discourses of power. Unfortunately, the medical model continues to treat those forces as insignificant in issues of disability.

### **Medical Model & Social Constructionism**

The medical model views negative physical or psychological difference as needing treatment, requiring afflicted individuals to overcome in order to achieve normalization and thus social acceptance. It "views disability as an individual problem in need of medical and rehabilitation intervention" (Michalko 65) rather than an individual challenge greatly exacerbated by current social discourses. Contemporary society puts a good deal of emphasis on normative bodies, and though it gives some acknowledgment of power structures, for the most part stigmatized populations remain solely responsible for their plight. "The medical model situates disability exclusively in individual bodies and strives to cure them by particular treatment, isolating the patient as diseased or defective" (Siebers, *Social Constructionism* 738). In this way, the patient alone is responsible for their condition, and social forces are not considered as part of the equation. Moreover, this view of disability also permits current stigma to go unchallenged. This view of the isolated body is rampant within society, the medical establishment, and representations of mental illness.

Tobin Siebers, considered one of the founding fathers of disability studies, writes “social attitudes and institutions determine far greater than biological fact the representation of the body’s reality” (*Social Constructionism* 737). In other words, the medical model alone cannot account for the stigmatizing attributes and marginalization that those with disabilities experience. Rod Michalko agrees. “The troubling thing about disability” he ponders in a 2009 article, “is that it comes to us, enters our lives, as an indication or as a sign of something ‘gone wrong’” (66). Of course, a mind or body not functioning as it was designed to is indeed a sign of something ‘wrong.’ However, as Michalko elaborates, the experience “of the what-has-gone-wrong story has been claimed by, and given to, the realm of medicine. Medicine has emerged as the self-proclaimed storyteller of the human body” (66), creating diagnosis with which society cannot argue. He then narrates on the difference between a “problem” with the human body and the “trouble” associated with that problem. Everyone has problems, he notes (67), but this paper and others argue that when those problems become trouble, negative stigma creates a sense of fear which leads to dependence on the self-proclaimed authority of the medical establishment. Michalko argues that “the only option to the removal of the difference that disability makes and to privileging personhood over disability is to conceive of disability” (69) as a problem which happens, separating the person from their disability. This retains their humanity and “holds that disability is not who we are, but is something we have” (69). However, the medical model finds it unacceptable to include disabilities as a variation of a normative body or mind. Instead, the medical model seeks cure.

The medical model, and the social use of language which mirrors the thinking of that model, believes that “rehabilitation, or the act of restoration . . . to a previous normative order” (70) should be the goal of those with disabilities. The language used to discuss the restoration through which integration occurs happens under the auspices of “the rhetoric of inclusion” (70), which despite its politically correct appearance continues to marginalize and differentiate those with disabilities. That marginalization happens through insistence of adherence to standards of

normative bodies and minds. For example, psychological problems can be alleviated through the normalizing effects of psychotropic medication. Therefore, a mentally ill individual can be seen as making appropriate efforts towards restoration by taking the appropriate medicine. To do otherwise flies in the face of conventional wisdom, which has fully put its trust in the medical establishment, and this rejection of social norms and standards is viewed with fear, hostility, and treated as evidence that the individual does not wish to be well. Since the disabled person will not adhere to social standards of what it means to be normal, or make good effort towards that goal, they are viewed with suspicion. The medical model does not allow for disabled people who find that there is a “life worth living” outside “the paramount reality” (70) of idealized normative bodies and minds.

*Next to Normal* was researched and subsequently written within the framework of the medical model. According to Berson, Kitt and Yorkey’s research for the show included “input from mental-health consultants,” namely New York psychiatrist Anthony Pietropinto and Nancy Elman, a psychologist. Their input, which included information about how long it can take to get a diagnosis, the frequency with which mental health patients change both doctors and medication, meant incorporating current medical beliefs about mental illness, which became an integral part of the story. As is to be expected of a production whose representation of mental illness upholds mainstream values, no alternate modalities of treatment were sought or presented in the character’s search for healing. Rather, “a recurring motif has a frustrated Diana visiting numerous specialists, in search of a definitive diagnosis and cure for her condition” (Berson 2011). The presentation of a mentally ill character who spends two hours on stage alternating between living in dysfunction at home and spending time in a doctor’s office reinforces stereotypes and social expectations that, eventually, the right doctor or the right pill will bring an answer, if not a cure. Although Diana finds no cure, the whole of the script has her searching for one. This sends the message that so long as she does not give up on modern medicine, she is making a good faith effort at overcoming the psychological problems which are, as Brantley

stated, “damaging” herself and her family. The medicalized view of mental illness then does not place negative difference upon society’s reaction, but upon the individual and whether or not they fit into a normative model.

Clearly the medical model, applied here to the analysis of dramatic literature, has significant drawbacks and limitations in the perceptions of disability to which it adheres. The negative differences it creates and the stigma or discrimination which results necessitated a theoretical approach which took into account social factors. That approach is social constructionism. The field of disability studies has utilized this theory because, as Siebers asserts, it enables the view of “disability as the effect of an environment hostile to some bodies and not to others, requiring advances in social justice rather than medicine” (*Social Constructionism* 738). Essentially, social constructionism holds “that the dominant ideas, attitudes, and customs of a society influence the perception of bodies,” and “tries to advance a commonsense approach to thinking about how people victimize individuals unlike them” (*Social Constructionism* 738). In other words, how bodies are thought of and subsequently responded to is a social construction; expectations of what they can and should do are upheld by the power of social discourse. This straightforward concept serves as a foil in understanding the medical model as a view which prevents necessary social reforms by reinforcing the belief that disabilities are inherently a flaw, lack or excess rooted within the afflicted individual.

However, one important critique of social constructionism is its insufficiency addressing the realities of the disabled; yes, beliefs about normative bodies and negative difference are socially constructed, but the reality is not all bodies and minds are capable of every task which might be expected of an individual in any given culture. Bodies exist outside of social perception. For example, a person requiring the use of a wheelchair for mobility is no less able to walk when not observed in a social context. Therefore, negative difference is not a matter of ability or disability, but the value society places on what it perceives as non-normative.



What can be gleaned from social constructionism then is the impact of social discourse on perceptions of disabilities as an unwanted difference. Although this theory also has its shortcomings, it redresses the marked inadequacies of the medical model, calls into account social forces beyond an individual's control, and provides a merge point for feminist disability studies. Social constructionism has been criticized for ascribing too much power to society and ignoring the corporeal reality of disabilities, thus Garland-Thomson's feminist disability theory provides the bridge and balance between these two competing ideologies. Given social constructionism's emphasis on discourses of power intersecting with bodies and norms, it has attracted no little amount of attention from feminist scholars. Siebers notes

the women's movement radicalized interpretation theory to the point where repressive constructions of the female form are more universally recognized . . . disability studies has embraced many of these theories because they provide a powerful alternative to the medical model of disability. The medical model situates disability exclusively in individual bodies and strives to cure them by particular treatment, isolating the patient as diseased or defective . . . thanks to the insight that the body is socially constructed, it is now more difficult to justify prejudices based on physical appearance and ability, permitting a more flexible definition of human beings in general (*Social Constructionism* 738).

This exemplifies Garland-Thomson's assertion that feminism could have major implications for disability theory, one which "offers a particularly trenchant analysis. . . both women and the disabled have been imagined as medically abnormal . . . Sickness is gendered feminine" (*Integrating Disability* 10) and women suffering from mental illness who seek treatment may arguably be treated differently than their male counterparts. Certainly the character Diana, who has been diagnosed as a "bipolar depressive with delusional episodes" (Kitt and Yorkey 18), is the "quintessential" image of none other than the hysterical housewife who simply needs the right medication and a firm hand. While *Next to Normal* has been lauded for its fearless portrayal of

mental illness, particularly within a family setting, Kitt and Yorkey chose the injured woman as the individual seeking treatment. In this way, their representation of a mentally ill character is doubly stigmatizing. The caretaking Diana requires in being driven to doctor's appointments, watched over in performing routine household tasks, and finally hospitalized when no efforts are enough to prevent a suicide attempt, this representation of mental illness upholds the childlike attributes often given to female mental patients.

Unfortunately, the story written by Yorkey and Kitt has a mentally ill individual whose answers are dependent upon a fully medicalized view of the body and illness. Outside psychiatry, outside medication, outside even the controversial electroshock therapy, there is no life. "I don't feel like myself. I mean, I don't feel anything" Diana complains to her doctor. She wants to feel something, but since she is cooperating with the dictates of standardized medicine her complaint goes unheard. "Hmpf. Patient stable" is the response (22). As noted by Wendell above, Diana's situation does not allow her to have "knowledge about how to live with" the pain and suffering. The answers offered by the medical establishment are pills and therapy, neither of which addresses the deeper psychological issues of grief. Taking matters into her own hands, Diana decides to give up the medication.

What follows reinforces the social expectation discussed in the introduction: stepping outside mainstream norms have negative, even dangerous, consequences. The instances where Diana goes off her medication are embarrassing or life-threatening. The first situation arises when she tires of the mind-numbing effects of her psychotropic medication. A medicated Diana sings "I miss the mountains. I miss the dizzying heights. All the manic, magic days. And the dark, depressing nights," as "she goes to her medicine cabinet and begins to take out a passel of pill bottles," dumping them down the toilet she continues her song, "Everything is balanced here and on an even keel. Everything is perfect—Nothing's real . . . Nothing's real" (26). In a phone call with Dan immediately following this scene, Diana's mania has returned as she bubbles "Hello? Oh, hi! Everything's great here, sweetie. Fantastic. I disinfected the entire house,

rewired the computer, and did some decoupage. Okay. Buh-bye,” she says and hangs up the phone, then declares “Next. I think I’ll retille the roof!” (28). Mania is still raging when Natalie’s boyfriend Henry comes over, and Diana has made a birthday cake. “Whose birthday is it?” Henry asks quietly. With a “small pause” Natalie responds “my brother’s.” After which she must explain, embarrassed, that the brother “died before I was born” (31). While this quiet exchange occurs, Diana’s crash back down from mania has begun.

Holding the cake she asks “What? What is it?” and the script states that in the silence following her question “Dan goes to Diana” (31). Diana has stepped outside the safety of psychopharmacological intervention. She has refused to follow the norm of what society, and her doctor, have deemed are best for her body. In the midst of mania, gripped with knowledge of the death of her son, an unmedicated Diana expresses grief outside of what society deems appropriate, and then must be gently handled as one would a frightened child. In throwing away the medicine that normalizes her, Diana exhibits behavior deeply embarrassing to her already-estranged teenaged daughter.

The visit to the doctor which follows this episode has Dan hanging on to hope. He speaks to Diana in the waiting room, but it sounds more like a pep-talk for himself. “Let’s not get discouraged. We’ll find a doctor who’ll treat you without the drugs. There’s someone out there for you—in the depression chatrooms, they say it’s like dating, you have to keep going until you find the right match” (38). But the new doctor, Dr. Madden, gives up on talk therapy with Diana after one month, suggesting hypnotherapy (44) during which he tells her subconscious “make up your mind to be well” (45). Though the audience knows Diana does not consciously hear this statement, the point is that they do, they are on the receiving end of this medical view of mental illness.

The second situation illustrating negative consequences occurs after Diana has cycled through mania and efforts at therapy fail. She attempts suicide. “Unresolved loss can lead to depression” (49) Dr. Madden has told her, and the depression outweighs her own will to live.

Although the script does not indicate who finds her, Diana is discovered at home, unconscious, with “multiple razor wounds to wrists and forearms” (53). The character Diana, this “authentic” representation of mental illness, finds answers provided by the medical model insufficient or unsatisfactory. As a result, she is unable to normalize via medication or be rehabilitated through conventional therapy. Her suicide attempt introduces an extreme alternative, yet still safely within the medical model. During her stay in the hospital, Dr. Madden tells Dan that the time has come to consider electric shock therapy. Exhausted and emotionally overwrought, her husband agrees to the procedure.

The research undertaken by Kitt and Yorkey created a character who cannot escape the confines of standardized mental health care, because that is the source of their information. Professional opinion in the medical model provide precisely the stigmatized characterization Kitt and Yorkey’s musical illustrates. Therefore, the staged struggles of Diana and her family reveal the entrenched cultural stigmatization of mental illness by disallowing dialogue outside medicalization. The musical’s authors by default support what society deems normative, reinforcing the belief that there is no other legitimate approach to the disability of mental illness. As a result, rather than addressing the cultural factors at work, the responsibility is solely on the character patient, and no wider social constructs are explored. Thus the manic and depressive episodes Diana experiences uphold mental illness as a personal failing or biological flaw.

The question remains, however, how might feminist disability theory interpret the character of Diana? What does it mean that she makes no financial contribution to her household, and that even in staying home, she presents a burden to her husband and is an embarrassment to her daughter? Garland-Thomson wrote that within the ever-broadening scope of feminist disability studies, the theory offers a “reimagining” (*Feminist Disability* 1568) of what disability means. This invites exploration of possibilities for the character Diana outside the medical model because, as Garland-Thomson challenged

seldom do we see disability presented as an integral part of one's embodiment, character, life, and way of relating to the world. Even less often do we see disability presented as part of the spectrum of human variation, the particularization of individual bodies, or the materialization of an individual body's history. Instead we learn to understand disability as something that is wrong with someone, as an exceptional and escapable calamity rather than as what is perhaps the most universal of human experiences. After all, if we live long enough, we will all become disabled. A feminist disability perspective suggests that we are better off learning to accommodate disabilities, appreciate disabled lives, and create a more equitable environment than trying to eliminate disability (*Feminist Disability* 1568).

Applying Garland-Thomson's theory to the character and story of Diana means accepting that the unaddressed grief is being expressed the only way permitted by society. Rather than encouraging Diana to process grief, Dr. Madden urges her to simply let go. To a long-grieving mother this doubtless comes across as threatening. All Diana has are a few baby items from her son's infancy, and she is being asked to let them go or face the consequences of never achieving the normalcy society expects. Diana embodies the concept of "next to normal," the medical model can accept her within its framework if she will cooperate. Diana wishes to, for the sake of her family, but not at the cost of her grief which has already been denied and medicated for almost two decades. Diana and her family are constantly fighting with the mood swings, the highs, the lows, the unexpected and sudden turns of emotion. The mental illness, which Diana embodies, is fought at every turn. What would it mean for the character and her family to allow the old grief to be processed? Not in hopes of effecting an overnight cure, but in allowing Diana to come to grips with her loss and figure out where she wants to go from there.

Garland-Thomson's theory further illustrates that the medical model, and the social norms it represents, have failed but put the blame on the problem of Diana. Sixteen years of inadequate answers go without accountability, and the audience observes the couple continuing

without ever discovering the help they seek. Medication, therapy, hypnosis, electric shock therapy—all are preferred over simply allowing Diana to mourn the loss of her long-dead child and discover her own way of relating to the world. Kitt and Yorkey write her as incapable of relating to the world or her family in a productive way when she is off medication, and indicate she hurts her family and herself when refusing the emotionally deadening side effects. The character is expected to uphold social beliefs without regard to her own feelings, grief included. Kitt and Yorkey's representation of mental illness then communicates only helplessness and inadequacy resulting from a rejection of the answers provided by the medical model. What does not get communicated to audiences are the ways in which Diana, on her own terms, might find a way to cope. Diana does not represent the ideal, she represents the isolated body of a disease. Susan Wendell, whose groundbreaking research in feminism is quoted widely by disability scholars and feminists alike, writes

the idealization of the body, the myth of control, and the marginalization of people with illnesses and disabilities mean that much knowledge about how to live with limited and suffering bodies is not transmitted in cultures where these influences are powerful (109).

Concepts of strength, independence, and acquiring skills to cope with the mood swings are nowhere to be found as Diana crashes from one crisis to the next. At very few points in *Next to Normal* is Diana viewed in a positive light. She has become her illness; both family members—and thus the audience—relate to her through the lens of bipolar disorder. The stigma of mental illness that Diana represents is one of flawed functioning. The medical model has taken independence and the ability to make the choices our society affords adults, turning her into the equivalent of a child, or at the very least, a woman who is not fully human. Not surprisingly, studies in sociology recognize the lack of adult human characteristics attributed to the stigmatized, mental illness included.

In 1963 Erving Goffman wrote one of the first major texts on stigma, noting that the stigmatized person is believed “not quite human” (*Stigma* 5) and “an ideology to explain his

inferiority and account for the danger he represents” becomes necessary. This can be seen definitively in the character of Diana, whose every flaw, lack or excess is attributed to the ideology of her mental illness as the characters around her struggle to see the woman behind it. One song has Dan singing “And I loved a wife so alive, but now I believe I would settle for one who can drive” (17). Diana’s illness has come to define their marriage and the beliefs about her abilities and limitations in each role she occupies. Feminist disability theory sees a woman whose grief has been acknowledged in a limited fashion, treated as abnormal rather than unprocessed.

During one therapy session Dr. Madden says “wouldn’t you like to be free from all that? Finally? Wouldn’t you like to go home, clear out his room . . . maybe spend some time with your daughter? And let your son go, at last?” (50). Unfortunately, for Dr. Madden the concept of grief processing is limited to simply making an intellectual decision. It ignores Diana’s heart and the emotional attachment she had to her son. Dr. Madden is supposed to be helping her; he is the expert, the one in the trusted white coat. When Diana refuses to take medication, and talk therapy fails, the message is “make up your mind to be well.” Wendell asserts that “the pernicious myth that it is possible to avoid almost all pain by controlling the body gives the fear of pain greater power than it should have and blames the victims of unavoidable pain” (109). Though Wendell refers primarily to physically painful disabilities, her assertion is certainly applicable to the pain of mental illness as well. Diana cannot control her mood swings within the constructs society offers, and after several painful episodes detailing the finer points of bipolar disorder, Diana leaves her family.

“So anyway I’m leaving” (Kitt and Yorkey 97) Diana sings to her husband, “I thought you’d like to know. You’re faithful come what may, but clearly I can’t stay, we’d both go mad that way” (97). Despite the departure, *Next to Normal* offers some hope for its characters. Leaving is the closest Diana comes to stepping outside the medical model. She is not on medication, nor is she going to a hospital. Diana goes home to her parents (102), singing that “you find some way to survive. And you find out you don’t have to be happy at all to be happy

you're alive" (101). Perhaps on her own, she will find the answers she has persevered in seeking, and in doing so will discover that, as noted by Wendell earlier, control is a myth.

There are no perfect bodies or minds; they exist only in the collective imagination of society. It might be argued that the only thing "wrong" with Diana is that she has been duped by society into believing a medicalized view of her grief is the only approach to resolving the loss. Wendell critiques Western social constructs for the lack of information about how to live with the pain of limited bodies, and the truthfulness of that critique echoes throughout *Next to Normal*. Diana for sixteen years has been unsuccessful in gleaning answers about how to live with her loss, and at the end Kitt and Yorkey write a somewhat hopeful ending that may hint at a life for Diana in which she incorporates a new way of approaching what has tormented her.

Garland-Thomson argues that feminist disability theory supports accommodation of disabilities as opposed to the view that those with disabling characteristics should be normalized. Diana's departure from her family may indicate that she is seeking the alternative Garland-Thomson describes, a life in which she can live with her symptoms and not allow them to destroy her. This new way of relating offers her a different perspective from the medicalized view of herself she has so long accepted. Diana's way of relating to the world has changed dramatically, and though it requires at least a temporary departure from her family, the end of the musical hints a happier ending in store. "There will be light" she sings with her family at the end, "there will be light" (104).



## CHAPTER IV

### *PROOF: CINDERELLA'S HEIR APPARENT*

The third play this thesis will examine is perhaps the most realistic of the four. Unlike the other three, which portray the negative difference of mental illness through near-melodramatic methods, David Auburn's Pulitzer Prize winning play *Proof* is in some respects the simple story of a father and daughter. Auburn does not rely on big, flashy scenes or demonstrations of spectacle. He does not wow the audience with special effects or larger-than-life song and dance numbers. The setting is realistic—the back porch of a home in an older Chicago neighborhood—and the characters themselves seem to be everyday people.

In the opening scene, Catherine talks to her father, Robert, who was a noted mathematician and professor at the University of Chicago, exceedingly gifted but struggled with mental illness starting in his twenties. Eventually he was unable to work as the dementia took hold. Catherine, the younger of his two daughters, surrendered a college education to care for her ailing father at home. Abandoned by friends and family to a large extent, Catherine and her father are shown in flashback scenes negotiating the halls of his illness, made terrifying by unmarked descents into breaks from reality. In one particularly moving scene, Catherine, taking courses at a nearby university, is unable to reach Robert by telephone. Concerned, she drives home to find him out in the freezing cold with no coat, excited over a proof he has started. His behavior is not that of a raging, dangerous psychotic, but a mind adrift in a sea of ideas, unable to comprehend that the new work he has begun writing is not a thrilling discovery, but a strange

thread of sentences with a convoluted Mother Goose-type feeling. As Catherine silently reads the first page, the audience shares in her palpable horror at the realization her father has gone over the edge again. Robert's excitement fades, and Catherine gently leads him into the house.

The play opens on her birthday, and an expository conversation ensues which reveals her isolation and her fears. Alone with Robert, drinking cheap champagne from the bottle, Catherine wonders aloud at the possibility of going mad. Thus it is established from the opening scene of the play Catherine fears she has inherited both Robert's madness along with the remarkable intellectual gift they both know she possesses.

But just as the admission is made that Robert died a week prior to this scene, Catherine is interrupted by Hal, Robert's former student, who has been upstairs going through dozens of notebooks to try and locate any work of value Robert may have done in his final days. There are a few touching moments where Hal attempts to get Catherine to come hear his band, distracting the audience with humor in a scene that could otherwise immediately indicate Catherine must be crazy since she is having conversations with her dead father. The clumsy Hal, obviously smitten with Catherine, ends up leaving the house alone, though not before Catherine has phoned the police when the discovery is made that Hal has stolen a notebook. Hal's thievery reveals itself as an effort to show Catherine Robert's note regarding his longstanding gratitude at being able to remain home even during the worst of his illness. The remainder of the play focuses on Catherine's inner battle over sharing her secret mathematical proof with Hal, and the surprise of Claire's intention to both sell their childhood home and have Catherine return with her to New York for psychiatric care (Auburn 39). As with historical heroines, Catherine is faced with an antagonistic older sister.

At the heart of its simplicity is *Proof's* standing in the literary line of succession to the Cinderella story. As the youngest daughter, Catherine resembles a long line of plucky, intelligent females who are their father's favorite and scorned or overlooked by the older sibling(s). Auburn's choice to gender Catherine feminine places her as the literary descendant to heroines

who, though underestimated, prove their doting fathers correct despite the doubts, misgivings, or cruel tendencies of their older sisters. For example, Cinderella, Belle of *Beauty and the Beast*, Ariel of *The Little Mermaid*, and a host of other young ladies were alternately abused, scorned, or thought of little import until their principles resulted in obvious and positive changes. This theme will be reflected upon following examination of the play's critical reception and a scholarly critique which, though viewing Catherine as a type of Cinderella, considers Auburn's depiction as strictly anti-feminist.

### **Critical Reception**

*Proof* debuted on Broadway in October of 2000. In addition to the Pulitzer for Drama, the play also earned the Drama Desk Award and Tony for Best Play. Its critical reception was largely positive, though the straightforward story line and lack of spectacle did not impress every critic. A 2002 review in the *UK Guardian* criticized the play because "we never know what the crucial [mathematical] theory is" (Billington), and this "intellectual evasion" cannot be repaired even by the outstanding cast, which included Gwyneth Paltrow as Catherine in the UK production. Billington writes Catherine's "love for her father . . . is the key to her character," praising the acting while finding the character "depressive . . . moody, withdrawn." Billington makes no connection between the possibility of Catherine's emotional burnout and her "depressive" appearance, leaving readers to speculate the character may have inherited her father's mental illness in addition to his mathematical genius.

John Simon of *New York Magazine* wrote in 2000 that Catherine is "mathematically brilliant but too-depressed-to-work" and is "barely living." In Simon's description of Catherine's older sister Claire trying to save her from impending madness by whisking Catherine off to New York, humor demonstrates to readers that Catherine may not be mad after all. However, Simon's negative opinion of Catherine's choice to sacrifice and care for Robert at home reflects the stigma of mental illness which can attach itself to those in close relationship with the mentally ill.

Though secondary stigma typically refers to the way in which caregivers view themselves, it is argued here that such stigma can also be placed upon the caretakers by society (Mak and Cheung 532). Secondary stigma discredits Catherine's choice and thus calls into question her ability to make wise decisions, similar to the way in which Robert's decisions might be discredited by those aware of his diagnosis. "Catherine," Simon writes, "who gave up a potentially great mathematical career to look after him and, in the process, let herself run down, perhaps irreversibly," has made a choice which is devalued by society. Similar to Billington's review, Simon establishes no connection between Catherine's depression and the toll caretaking has exacted from her. Michael Feingold of *The Village Voice* did comment briefly on Catherine's "self-sacrifice" in his May 2000 review, but treated the play overall as more fluff than substance, damning with faint praise its "acceptance of its own shallowness" which translated into a kind of saving grace.

Dave Bayer, a mathematics professor at Columbia, wrote *Proof* offered "a rare treat to see the romance of a mathematical proof take center stage in a popular work that teases with our preconceptions without succumbing to stereotype" (1082). Finally, in 2005, still popular, it was made into a film directed by John Madden, starring Gwyneth Paltrow, Anthony Hopkins, Jake Gyllenhaal, and Hope Davis. The success was surprising considering it was only the second full-length play Auburn had written.

One scholarly critique of *Proof* came from Carol Schaefer, Associate Professor of Theatre and Women's Studies at Pennsylvania State. The value of her article, *Auburn's Proof: Taming Cinderella*, is its use in demonstrating the concepts of secondary stigma and the social reverence for normative bodies. Her article focused on the ways in which the story upholds patriarchal values, but her points were made at the cost of addressing major themes in the piece which provide alternative explanations as to Catherine's character. Schaefer's article illustrates what Mairian Corker discussed as the "constraints on how we theorize the relationship between disability, impairment, and normativism" in utilizing a strength-based feminism that does take

into account a more “universalizing” (35) approach to discussing disabilities. Schaefer upholds mainstream patriarchal values of normative bodies and minds, scolding Catherine for valuing her father’s stability and happiness above her own education. Sacrifice is acknowledged, but Catherine’s character discredited. Schaefer’s analysis downplays or ignores aspects of Catherine which can be attributed to issues surrounding mental illness, a topic she only briefly mentions.

Therefore, revisiting the issue of stigma sets the stage for analyzing Catherine in the context of a family member taking care of a mentally ill parent at home. Doing so demonstrates the shortcomings in a reliance upon feminist theory alone while acknowledging the relevant points regarding representations of female characters through the lens of feminist disability theory. Schaefer’s argument does make sense to a degree, but her critique of Catherine’s appearance and the laziness attributed to that appearance rests on normative bodies. “Feminists have always criticized the idealization and objectification of women’s bodies” Susan Wendell writes, “yet feminist movements have expressed their own body ideals, often insisting on women’s strength and overlooking the fact that many women’s bodies are not strong” (92).

Although Catherine is not presented as a character with a physical disability, Auburn has written her as depressed and exhausted. Schaefer, ignoring Catherine’s context, expects the character to live up to the mathematical gift she inherited as though she had not spent five years focused on solely the needs of her father. This comes across as the strongest criticism of Catherine, the character’s refusal to step out and embrace the world her gift could open for her. Interestingly, Wendell connects the concept of idealized bodies with a consumer mentality (86), and it may be that Schaefer’s desire to see a productive Catherine has just as much to do with the character proving her economic worth as it does with the physical appearance and demeaning tasks caregiving requires. But, as Wendell insists,

until feminists criticize our own body ideals and confront the weak, suffering, and uncontrollable body in our theorizing and practice, women with disabilities and illnesses are likely to feel that we are embarrassments to feminism (93).

As Schaefer's 2005 article illustrates, even in contemporary feminism there is a tendency to treat disability issues as insignificant in a wider cultural context and associate non-normative behavior and appearance with weakness, defiance, or deviance. The remainder of the chapter will focus concepts of normative bodies, stigma and the application of feminist disability theory to Auburn's *Proof*. Suffice to note that Garland-Thomson's assertion disability studies and feminism can broaden the depth and scope of one another is most certainly underscored by Schaefer's analysis of the play. The aspects of feminism that have worked against the movement of equality—i.e. dependence on normative bodies as the basis for gender equality—thus providing evidence for Rosemarie Garland-Thomson's argument that disability studies and feminism have much to offer one another. Schaefer's critique of Catherine as a male construction of injured, self-debasing femininity supports Garland-Thomson's contention that "sickness is gendered feminine" (*Integrating Disability* 10).

Garland-Thomson's introduction to the idea of a feminist disability studies invites a broader, deeper perspective of what society considers normal. By stepping outside a dependence upon physical (including mental) health, ability or appearance to promote the concept of equality, feminist disability theory enables a view that "aspires to retrieve dismissed voices and misrepresented experiences" (*Feminist Disability* 1557) which adds a unique, inclusive and holistic component to scholarly discussions about disability issues. For example, when applied to the analysis of dramatic literature, feminist disability theory bridges the gaps left by a feminism which historically relied upon an ideology of strength and self-sufficiency. This makes room for the growing contemporary view which sees imperfections and differences as acceptable (Linton; Corker; Hall). The inclusive tone of feminist disability theory incorporates those ignored or dismissed by strength-based feminism which had the effect of downplaying or dismissing the imperfect, the different, the feeble.

The unique perspective offered by feminist disability theory creates new insights into cultural conceptions of mental illness, whether those reflections are found in current dramatic

literature or the critics who apply strength-based feminism to analyze the characters therein. Thus, applying Garland-Thomson's feminist disability studies brings an inclusive approach to the feminism utilized by Schaefer in her disregard of mental illness as a primary topic of *Proof*.

The flaw, lack, and excess discussed by Garland-Thomson include corresponding definitions of "inherent inferiority, pathology to cure, and undesirable trait" (*Feminist Disability* 1557) which will guide the analysis of Catherine's character comparing it to the predominantly negative view of her which would be indicated by social norms. In particular, this chapter will address Catherine two primary issues: that of the stigma which Catherine has inherited by virtue of her close relationship with Robert and an exploration of Catherine in light of raised by Schaefer: Catherine's willful self-"debasement" (2), and the "abandonment" of future and education via her caretaking of Robert (4). Schaefer offers an analysis of *Proof* through the lens of gender, but as demonstrated here and in the introduction, feminism alone does not sufficiently take into account issues pertaining to disability. To clearly understand the character of Catherine within the framework offered by Garland-Thomson, this chapter will explore issues of stigma and the impact of caregiving for mentally ill family members through research in the fields of psychology and sociology. Caregivers undergo both social and emotional changes in the framework of the most highly stigmatized illness in Western society. Thus, the theoretical groundwork begins with the individual who many consider to have written the essential text on stigma, Erving Goffman.

Goffman has influenced fields such as sociology, psychology, and cognitive studies. His text, *Stigma: Notes on the Management of Spoiled Identity*, sets the framework for understanding the nature of stigma. Goffman's work explores in-depth issues of social identity, information control, group alignment, deviation, and reality. Importantly, not everyone lauds his premise. Criticized by feminist disability scholar Wendell, who claimed Goffman "repeatedly fails to appreciate the possibility that having at least some disabilities may be . . . as good as or better than 'normality'" (59), he "misses the importance of the specific symbolic meanings people with

disabilities have for others in society” (58) and that the concept of “genuinely felt group pride” (59) could only be interpreted as a coping mechanism among the stigmatized rather than an empowering sense of unity. However, what these criticisms do not fully take into account is that, with the possible exception of the Deaf community, group solidarity amongst the disabled is a relatively new concept.

When Goffman’s book was published in 1963, the very fact he was writing about stigma in relation to identity and society was groundbreaking. At that point in history, the existence of disabilities had horrific implications for individuals and families, no legal protection, and depending on the specific impairment, outcomes included institutionalization or exclusion from public education. Goffman’s work challenged the status quo, serves as the basis for ongoing scholarship, and continues to provide a thought-provoking lens through which to contemplate issues of stigma and the social creation of identity.

In addition to Goffman’s framework for applying the issue of stigma to Auburn’s *Proof*, a 2008 study by sociologists Mak and Cheung from The Chinese University of Hong Kong explores the issue of secondary stigma attributed to caretakers of the mentally ill. Secondary stigma has great significance to the character of Catherine, and this chapter demonstrates how the negative difference of her father’s mental health has implications for the way in which Catherine views herself. Expounding on the theme of family members caring for their mentally ill relatives, Karp and Tanarugsachock’s research on the emotional lifecycle of such individuals provides additional insights into the emotional life of Auburn’s Catherine. Evidence of caretaker burnout and the stigma surrounding mental Catherine as a character who has debased herself, performing “menial” tasks, and refusing to maintain a certain level of hygiene (2).

It is important to acknowledge the question raised by psychologists Hinshaw and Stier, who asked “why the stigmatization of mental illness continues to be so pervasive and persistent” (373). In the wider social context of contemporary Western society, one can take into account the cultural values working beneath even scholarly examination of power structures and the thinking



which maintains norms. The perhaps oversimplified answer from Hinshaw and Stier is that “individuals with mental illness—who are prone to act in socially deviant ways—receive stereotypes and stigmatization in automatic fashion” (373). Recalling from Foucault, Snyder and Mitchell, and Goffman that the stigma attached to mental illness has deep historical roots in social thought, it is evident that this “negative form of stereotyping” (Galvin 155) is imbedded even in how mental illness is thought about. In other words, the very basic concept of mental illness in Western thinking has inescapably negative connotations. Therefore, stigmatization is automatic through ingrained cognitive processes which create categories of social groups and related attributes (Hinshaw and Stier 373). Though the character of Catherine is not mentally ill, the question of her genetic inheritance does raise the issue, and she receives by proximity the stigma of mental illness attached to her father.

Goffman asserted in his masterful work that social settings routinely determine norms (2) and that individuals who appear or behave differently than expected are marked as an other. Such an individual “is thus reduced in our minds from a whole and usual person to a tainted, discounted one.” Aligning with Garland-Thomson’s flaw, lack, and excess, Goffman wrote that stigma can “also [be] called a failing, a shortcoming, a handicap.” This “deeply discrediting” (3) attribute of stigma has such a level of “undesired differentness” that “we believe the person with a stigma is not quite human” (5) and thus further marginalization is justified without requiring much thought. Importantly, Goffman also found that “a wide range of imperfections” (5) may suddenly be attributed to the stigmatized individual which have nothing to do with the initial discovery of the negative difference. Speaking of the “courtesy card” (97), a situation in which a stigmatized individual has in their close confidence someone who passes as normal, Goffman wrote that

it should be added that intimates . . . can in fact serve as a protective circle, allowing him to think he is more fully accepted as a normal person than in fact is the case. They will therefore be more alive to his differentness and its problems than he will himself. Here,

certainly, the notion that stigma management only concerns the stigmatized individual and strangers is inadequate (97).

This has implications for Catherine's caretaking of her father, perhaps granting insight as to part of the character's motive to stay home. A lifetime of watching people react to Robert's illness combined with Claire's departure to seek a life of her own may have prompted within Catherine the desire to protect Robert from the social consequences of his illness. Catherine, who knows her father better than anyone else, is in a position to react to him in positive ways. Particularly since a form of dementia seems to be part of Robert's illness, Catherine's lack of reaction to the great proof he thinks he's writing which is actually gibberish, reinforces the protective walls of being cared for at home. Keeping Robert insulated in this way may also have intensified what Mak and Cheung term "the internalization of stigma" (532) known to result from being "closely affiliated" with a stigmatized individual.

Mak and Cheung reference the "courtesy stigma", so termed by Goffman, in their introduction to a discussion of what they have coined the effect of "affiliate stigma" (532) of caregivers for the mentally ill. Mak and Cheung argue that this secondary stigma is different from Goffman's use of similar terminology in that it addresses the perception associated individuals have of themselves, a "negative influence" (533) resulting from the close relationship. They note that in

the caregiving context, caregivers with affiliate stigma may perceive a greater sense of burden and strain in their caregiving because stigma might have distorted their views towards the care-recipients and affect their relationships (533).

Catherine's relationships have been deeply affected by her decision to care for her father at home. Though it is unclear that they were ever close, the relationship with her older sister Claire is strained, and in the opening scene the conversation with Robert reveals Catherine has no friends. "High levels of affiliate stigma" Mak and Cheung claim, may result in "a sense of shame and inferiority" (542), feelings which can arguably be attributed to Catherine. She questions her

sanity and, as Schaefer points out, Catherine's initial hygiene and appearance leave much to be desired. This raises an issue addressed by Karp and Tanarugsachock: the emotional response of those caring for mentally ill family members, and the ways in which mental illness is different from other, recoverable illnesses.

Karp and Tanarugsachock bring attention to the "feelings of obligation, responsibility, and duty" (6) in the context of individuals with mentally ill family. Importantly, they acknowledge that unlike illnesses from which individuals physically and socially recover

mentally ill people often cannot abide by the usual rules of social settings, may engage in behaviors considered socially repugnant, sometimes deny that they are ill, and frequently treat their caregivers with hostility instead of gratitude (7).

Auburn's *Proof* exemplifies Karp and Tanarusachock's findings. Robert's employment at the University was sporadic, his emotional swings sudden and unpredictable, and he rarely if ever acknowledges Catherine's sacrifice. The development and worsening of Robert's illness meant that she "not only radically revise[d] downward their expectations for the ill person but also that they ratchet down their own life expectations" (17). In Auburn's scene mentioned in the introduction, Catherine comes home in freezing weather to find Robert outside, without a coat, working. He appears rational, logical as he explains that his gift, what he called "machinery" is working again. Catherine is thrilled. But one glance at the work Robert hands her, and Catherine understands Robert's excitement unwarranted. The machinery is not working, it never will be again. Catherine covers her deep disappointment, and as Robert stands shivering and exhausted from the excited emotional outburst, Catherine quietly takes him inside. Her father is not the math genius he once was; his mind has been corrupted by illness, she cannot expect greatness of him any longer. In addition to her disappointment over Robert's downward turn, Catherine now must also shift her "own life expectations" as Karp and Tanarugsachock state. If she is to care for him the way she wants to, staying in college is not an option for her.

Auburn's choice to write the character of Catherine as female could be interpreted as anti-feminist, per Schaefer's assertion. However, research from the psychologists and sociologists mentioned above broaden the analytical scope. Catherine's life choices were not limited because she is female; they are limited because she wants to keep Robert at home, as that is where she believes him most happy. She has the opportunity for a college education, and Auburn indicates Catherine continues researching and working even while caring for Robert. The limitations Catherine faces are of her own making, they are not solely attributable to social constructs regarding gender. Schaefer, however, writes of Catherine as a woman who made choices based on gender roles and social expectations. It raises the question of how Schaefer's response to the play would have been different if Catherine had been written as the younger brother. All things being equal, such a choice on Auburn's part would have resulted in a female Hal. How might those gender dynamics have influenced a feminist interpretation?

Perhaps the brief emergence from an untidy appearance makes more frustrating to a strength-based feminism Catherine's later breakdown. The mathematical proof Catherine wrote during Robert's illness, safely sequestered in his upstairs desk, comes to the surface when she decides to share the information with his student Hal, who has since graduated and is now teaching at the University of Chicago. Hal's romantic interest in Catherine is long-standing, and the eloquent proof she has written comes between them when Claire expresses her disbelief that such sophisticated work could belong to her younger sister. A shouting match ensues, years of isolation, frustration and rage come pouring out as Catherine's very sanity is questioned by her now-sophisticated New York sister who hopes to introduce her to the type of caretaking facility Claire wanted for their father.

The realization that Claire doubts her sanity, and Hal her mathematical ability, breaks open Catherine's fear that she has also possibly inherited Robert's mental instability. The shock results in a breakdown, during which an exhausted Catherine stops speaking to her sister. Karp and Tanarugsachock note that in a society which values independence, "bounded by a history of

Protestant ethic ideologies and a cultural ethos of individualistic achievement, empathy is especially accorded to those who show a willingness to pull themselves up by their bootstraps” (18), attributes which Catherine fails to demonstrate by mainstream standards. Karp and Tanarugsachock describe “the intense emotions that surround efforts to honor a commitment to care for a family member with a major mental illness” (6) and that every “person interviewed felt the emotions of fear, confusion, hope, compassion, sympathy, love, frustration, sadness, grief, anger, resentment, and guilt” (7) as the illness of their loved one progressed. Auburn’s Catherine reacts predictably and realistically to the illness and death of her father, with concern for her own genetic fate, and grief compounded by the father figure she lost to illness long before the occurrence of physical death.

In the context of intense emotions and grief, Catherine’s failure—her lack—to keep up with hygiene immediately following Robert’s death is understandable. The deep-seated fear of being like him not only in terms of mathematical giftedness but what that may portend for her psychological future has emotional consequences as well. The context in which Auburn places her then is not that of a rebellious young woman fighting patriarchy but a grief-stricken daughter, misunderstood by her sister and isolated by the requirements of caring for Robert at home. Not only is Catherine experiencing normal, predictable reactions, she shares the taint of mental illness with Robert.

Much has been written about the secondary stigma attributed to those with relatives or close friends diagnosed with mental illness. Cheung and Mak found mental illness related “stigma affects not only the public and the discredited individuals” but includes those “who are associated with the targeted individuals (e.g. family members, caregivers, friends, service providers)” (532). Catherine fits this description as both family member and caregiver, “personally affected by public stigma that prevails in the society” (532). Choosing to stay at home with Robert, which meant giving up at least temporarily her education; Catherine shared in her father’s isolation.

There is no mention of visiting friends or colleagues, no respite provided by concerned neighbors or even a hired home nurse. What Robert could not do for himself, Catherine did. This meant that instead of continuing her education or finding paid employment, she was removed from the world of work in a society which values economic productivity. Refraining from the socially valued activity of gainful work, and the implications of well-being and independence attached to it, Catherine increased her stigmatized position. As Foucault explains in *Madness and Civilization*, the stigma attached to lack of economic contribution dates back to the industrial revolution, which required the labor of every able-bodied individual for success. Those not considered able-bodied bore societal scorn for their feeble-mindedness or a non-normative body which prevented their ability to contribute financially to the success of a growing nation in an increasingly competitive, technologically advancing world. What potentially makes the tasks unpalatable is the illness which necessitates their completion.

Society might view Catherine's apparent weakness as a tribute to patriarchal oppression or victory rather than the expression of grief experienced by the daughter of a recently-deceased mentally ill parent for whom considerable sacrifice was made in accordance with Catherine's own values. Mainstream interpretation of Catherine's situation would thus rob Catherine of her voice, turning her into a mealy-mouthed, tantrum-throwing woman of adolescent maturity without the good sense to live up to the mathematical gift genetics granted. In other words, a strictly feminist reading of Catherine might indicate that she is refusing to live her own life or grow up. The idea that Catherine is somehow running away from her mathematical gift, hiding behind her famous, ill father for fear of eclipsing him demonstrates contemporary misunderstandings about the role of family caretakers in the lives of the mentally ill.

Social norms would decry Catherine's level of caretaking, which included bathing Robert. This serves as evidence Catherine has crossed the line in what social norms define as a healthy, familial relationship. What society might decry as signs of co-dependency are surely rampant in Auburn's play, and though Schaefer does not specifically use the term, her view of

Catherine's over-dependence and need to be rescued is clear. Noting the effect of wider social beliefs about co-dependency, which many see as an illness, Karp and Tanarugsachock found family member caretakers of the mentally ill struggle with "decisions about how to draw boundaries" because "over involvement with dependent people might properly be considered a disease" (19) in mainstream social networks. Additionally, the nature of mental illness isolates caretakers even as they struggle with questions of boundaries. The choice to provide in-home care seems directly linked to a level of isolation because mentally ill people often cannot abide by the usual rules of social settings, may engage in behaviors considered socially repugnant, sometimes deny that they are ill, and frequently treat their caregivers with hostility instead of gratitude.

Furthermore, if ordinary social interaction requires that people take each other's roles, efforts at meaningful communication with the mentally ill are often short-circuited. After all, they have been identified as mentally ill because they inhabit phenomenological worlds that are inaccessible and incomprehensible to healthy people. In this way, mentally ill people threaten both the concrete routines of daily life and, more significantly, the implicit symbolic order on which such routines are premised. Their behaviors are especially disturbing because they upset the most sacred of all social things: the coherence of everyday life (Karp and Tanarugsachock 7).

The "coherence of everyday life" and lack of it which Robert's illness has imposed upon the development of Auburn's characters, have brought about the changes discussed by Karp and Tanarugsachock. Catherine, coping daily with Robert's descents into a world of his own, with no outside social influences to condition her to "healthy" communication and norms, is misinterpreted by both Schaefer and Auburn's Claire. These changes in Catherine's life—most notably the isolation and depression—are interpreted as evidence for psychological frailty. Fearing the worst, Claire has plans to sell their father's house and whisk Catherine off to New York, whether she wants to go or not. Schaefer writes of Claire's "hopes to raise this Cinderella from the ashes" (4), clarified in the argument which transpires while debating the authorship of

the found proof. Schaefer insists Claire's verbal "abuse is really concern," (4) which any close reading of the play would dispute, but notes Catherine's refusal to be rescued by a feminine character. Catherine holds out, apparently, for prince charming, "since abandoning one's life for an unknown future" (4) in New York with her happily engaged sister is less desirable with no promised new love of her own. After five years alone with her father, Catherine's desire for companionship, whether viewed as the stereotypical negative Schaefer paints, is understandable. To fulfill Catherine's conviction that staying in his own home was in Robert's best interest, she has surrendered a great deal.

Not surprisingly, Karp and Tanarugsachock found that "a family member's enduring mental illness requires that caregivers not only radically revise downward their expectations for the ill person but also that they ratchet down their own life expectations" (17). As is the case with Catherine, "increasing isolation is surely one source of a caregiver's frustration. As their role extends for months or years beyond a family member's first episode, caregivers inhabit an increasingly constricted world dominated by the chronicity of mental illnesses, the often unreasonable demands placed on them, and the feeling that few people understand their own turmoil" (18). Though Claire is not unconcerned for her father, the emotional and geographical distance would have removed the sense of immediacy Catherine experienced in caring for their father. To Claire, whose career and relationship outcomes had not been negatively impacted by her ill father, the idea of putting him in a home would have appeared perfectly reasonable. To Catherine, upon whom the burden of care-taking fell when Claire went off to college, it is likely that her firsthand, ongoing, day-to-day interactions with Robert and the manner in which she was acquainted with his illness would make the concept of professional care in an institution unacceptable.

Auburn's depiction of the impact mental illness has upon a contemporary Western family is, in light of the research, realistic. Interestingly, however, the realistic characters and setting are created in such a way as to recall literary heroines who fight and overcome the challenges



presented by other family members and society at large. While Schaefer's critique engages the character of Catherine as a male's construction of femininity within the confines of patriarchy, consideration of Catherine as a Cinderella type has implications for examining the stigma of mental illness. The character Catherine knows full well from observing the progression of her father's illness that "to become disabled is to be relegated to a marginalized status in society" (Galvin 149). Claire's belief that her sister has "his [Robert's] tendency toward . . . instability" (Auburn 39) demonstrates this as she tries to help Catherine despite anything Catherine might wish for herself. In this way, it may be said that Catherine represents mental illness and Claire the helpful society who unknowingly debases and disempowers the mentally ill.

Bearing the stigma of mental illness originally attributed to the character Robert, Catherine is his heir apparent for both the mathematical gift and the mental illness. As the younger, self-sacrificing sister Catherine's position within the wider body of literature places her in the context of favorite child and delicate heroine. As a descendant of other literary heroines, Catherine retains the frail qualities of her gender. But inwardly, characteristics of strength and conviction propel her through negative circumstances and undue pressure from Claire. Catherine remains true to herself. Her refusal to give in to Claire's demands or submit herself to Hal's doubt about the proof's authorship is what directs the course of action, the play itself, and each character. As a result of Catherine's strength, her father lives out the remainder of his life where he is most happy, Claire's misguided efforts are thwarted, and Hal gains new respect for Catherine –not just respect for her intellectual ability, or love for her as a woman, but respect for the person. Catherine may be Cinderella, as Schaefer contends, but she is a Cinderella born from a long line of literary heroines whose strengths far outweigh the negative difference within her circumstances.

## CHAPTER V

### *4.48 Psychosis: “I don’t understand why you did that”*

Note: *4.48 Psychosis* was penned by a British author who used British punctuation in the title of her play. Out of respect to the author, this thesis will do the same.

#### **The Playwright and *4.48 Psychosis* in Context**

The fourth and final play this thesis analyzes is Sarah Kane’s *4.48 Psychosis*. Critical reception and scholarly analysis of the piece which followed its first production could well be summed up with a line from the play, quoted above: “I don’t understand why you did that” (Kane 216). The comfortable framework from which societal norms operate teaches that mental illness is a frightening, unpredictable, uncontrollable disease best left to doctors and therapists to medicate and somehow treat. Social norms tend not to recognize that even in the mind of the most desperately suicidal individual, a thread of reason may yet persist. What Kane so viscerally demonstrates in this powerful piece is the logic underlying an unraveling mind. In what appears to be a conversation with a psychiatrist, the main character presents logical, if morally challenging, reasons for wanting to die. Because the norms society uses as plumb line do not acknowledge that the wish to die could be remotely rational, Kane’s piece challenges contemporary perceptions of what it means to be mentally ill. Additionally, she does so using nontraditional play script formatting in an almost metaphorical representation of what is happening within the character. Due to Kane’s creative use of formatting to support an

unprecedented approach to emotionally disturbing subject matter, a closer look at the historical context which drove British theatre in the nineties is justified. Perhaps doing so will facilitate an answer to “why [she] did that.”

Sarah Kane was a British playwright whose higher education and first career steps took place in the midst of political and social upheaval. Britain was in poor economic shape and experiencing major political changes. Tony Blair replaced Margaret Thatcher, a conservative who had been in power for eighteen years, as the nation felt the effects of deep recession. And around the world ethnic cleansing and the reformation of geographic boundaries shocked the sensibilities of what people believed was possible. The younger generation of Britons grew restless, and found in theatre a way to express their rage.

British theatre found the soil for its resurgence in the turmoil, and no amount of conservatism could hold back the tide. Aleks Sierz, a Visiting Professor of Theatre at Rose Bruford College in London, is also a journalist and theatre critic. Sierz cites Arts Council “figures [which] show that new plays formed less than 10 percent of the repertoire” (17) at the end of the 1980s, a number which doubled by 1996. He also holds a “vital psychological change” in which critics went from moaning about the serious decline of new theatrical works to celebrating a host of emerging young playwrights who took the staid British theatre by storm. The emerging work “often critique[d] the conservative ideology that deems certain characters and subject matter unsuitable for art” in part to draw attention to a “media” which “looked on indifferently at atrocities occurring only a short plane ride away,” atrocities which consistently showed up in the themes and events of the newer work (Urban 39).

These new playwrights helped establish what Sierz coined in-yer-face theatre, which has three major characteristics. It is drama which “uses explicit scenes of sex and violence to explore the extremes of human emotion,” and in brutal, raw ways. Second, in-yer-face theatre broke taboos, “using the most vulgar language, sometimes blasphemy, sometimes pornography, and it shows deeply private acts in public.” Finally, it ranges in the experiential. “It can be so intense,”

wrote Sierz, “audiences feel – emotionally if not literally – that they have lived through the events shown on stage” (19). In-yer-face then is about emotion and testing boundaries in a manner which enraptures audiences and alters viewers’ perceptions about themes (violence, politics, frailty) and subject matter most wish to avoid or downplay. Despite the brutality new playwrights depicted, their contribution to British theatre meant that by the mid-90s, more new plays were being produced than the classics, including Shakespeare (17).

It was in this world that Sarah Kane’s emergence as a playwright took place. Kane graduated in 1992 from Bristol University, having studied Drama, and earned her M.A. at Birmingham University where she studied with playwright David Edgar. Kane penned her first piece to be produced, *Blasted*, while finishing her Master’s degree. Ken Urban, playwright and director of Rutgers University, wrote that it “was quickly recognized as one of the most important British plays of the decade” despite being “greeted with a maelstrom of abuse by critics when first produced by the Royal Court in 1995” (36). However, it also forced critics to “recognize changes occurring in British playwriting” (37). At twenty-eight Kane had seen four of her five plays and one short film produced. The popularity of her work from the first production of *Blasted* onward speaks to the connection she made between reader, audience and story. Their short, simple lines seem to leap off the page and demand attention. Not in order to save the characters, but to witness their pain, to acknowledge that some hurts go beyond what society in all its glory is able to cure. Wrestling her own demons, Kane gave voice to unspeakable depths of torment, that ‘dark night of the soul,’ and by reading or watching her stories, audiences bear witness to the life of a woman who could not find peace. The anguish of her short life is felt in every word of her exquisite writing, with glaring themes of sexual depravity, anguish, unrequited love and the bleakness of lost human souls. It is of course pure speculation as to whether or not Kane’s works were a kind of psychological or spiritual purge for the playwright, but given the hopelessness of her characters and their vocal rejection of a Christian God, it is safe to say that

she used the power of the written word to share, vent, expel or otherwise wield her pen as sword to bleed out the inescapably obvious pain of her existence.

By the second half of the 1990s, Kane, now an established playwright, was interviewed by Dan Reballato and his theatre students at Royal Holloway's University of London. The interview, believed to be her last, took place on November 3, 1998. Kane answered questions about her writing style, previous work, critical reception, and discussed the new play she had begun and what she hoped it would accomplish. In response to being asked what she was currently working on, she said, "It's about a psychotic breakdown" and "what happens to a person's mind" during a psychotic episode so that "you no longer know where you stop and the world starts." In terms of the play's format, she began a type of experiment in her previous work, *Crave*, which she sought "to carry on with making the form and the content one," though during the interview refused to state exactly how the form and content would be "one." Her choice of merging the story with the format itself presents a marked departure from standard play script formatting. It has no named characters or stage directions. No number of characters or setting is presented, just a series of lines, some of which have dashes in front of them, indicating in all likelihood a change in speaker.

Play scripts on any subject matter have a fairly standard format – dialogue, stage instructions, named characters of particular description. Time period, time of day and location are detailed, frequently including suggestions for music, sets and costumes. There are numbered acts and scenes. A script is more than a piece of dramatic action, it is the roadmap artists—such as directors, actors, scene and lighting designers, to name a few—go by to aid the development of their production. Yet *4.48 Psychosis* provides no such luxuries. There are no stage directions. There are no set designs in the back of the play, no time period or time of day supplied. There are no named or numbered characters, only a nod of turn-taking indicated. In short, there are none of the standard formulaic methods through which actors and directors are guided in their production efforts. Though there are widely thought to be three distinct characters - perhaps "voices" might

be a better term - it could just as easily be one person. Or a dozen. In breaking with traditional formatting and named characters, Kane provides a roadmap of a different variety, a representation of insanity that the audience can experience in unsettling ways. Before Kane's death she indicated there were three possible characters, and most productions to date have used three actors.

4.48 *Psychosis* is the story of an individual, presumably in-patient, told through conversations with their psychiatrist. It is the story of how someone labeled mentally ill is treated within the confines of an institution. Treatment modalities are listed, including medication and talk therapy utilized in an effort to help the person reach a state of mental health. *Psychosis* is also a story which tells the lie of mental illness and demonstrates the negative outcomes of being thought different. Despite the psychiatrist's contention that the patient is ill and unable to make reasonable judgments, it is the behavior which is in question; the attempts at suicide, the wish to die, and self-inflicted injury which the psychiatrist argues are evidence of illness. The character's feelings and behaviors run contrary to societal perception of normal, and so despite the character's logical rationale and reasoned justifications, the individual is thought and treated like a 'crazy' person.

The neatly framed boundaries through which ugly stories find their redemption are utterly shattered in this emotionally gory piece. Kane makes her audience and readers work for understanding, struggle to come alongside a devastated character and then realize, too late, that the audience has been called upon not to clap at the entertainment, but to witness a tale that is part autobiographical, part political and social commentary, and all art. Kane's extraordinary piece works because it breaks all the rules, and for her, "content was nothing without a form that best expressed such exploratory demands, and thus, each of her plays literally recasts dramatic form" (Urban 40). Forget what is known of play script formatting; of stories and pain too horrific to tell – she not only writes brazenly of mental health issues – she puts blood and bone and sinew where we are used to tentatively masquerading the issue as paper dolls. And it angered critics from her

first piece. “The element that most outrages those who seek to impose censorship is form,” Kane once said (Urban 40). Hers was a rare gift – the disregarded ‘rules’ of play script format are the frames for the story, the character, the human struggle she brought to the doorstep of theatre with an in your face feeling that leaves one with the realization that this is not just someone else’s story, but our own. Through words—or a lack of them—Kane’s piece is an invitation to witness not just her art and poignant life, but a pain somehow already known to humanity.

*Psychosis* delves into a mind tortured by the pain of being human. It does not bother with stereotypes of what ‘crazy’ should look like. It gives no balanced perspective to tell the audience where they as observers might fit in to the world it explores with fearless abandon. There is no hero for whom to cheer at the end, no deep sense of relief provided by the ending, no making the world right again. It leaves the audience hanging and in touch with a common pain.

Kane rejects limits of the socially acceptable, heart-warming play where a psychiatrist or the right medication can put the poor disturbed mind back in touch with a comfortable version of reality. Instead, in a poem-like spew of anguish, Kane unapologetically presents the brutal inner battle resulting from being a societal outsider, with no ounce of hope to help the audience find their way back to what they thought they knew before the play. Because of this, the audience can deeply identify with the character’s own hopelessness. Kane’s ability to give words to the unspeakable presents a challenge to perceptions of what should or should not be possible.

Providing a living picture of the mind is Kane’s gift to a society which continues to treat mental illness as ‘not normal’ and pats itself on the back for the progress of the past century. Kane’s words ignores placating sound-bites to present the reality that was her world, counteracting the oft-times simplistic solutions modern society prescribes to those society considers ‘other.’

Kane’s experiment to merge form and content was successful. As the form of the work disintegrates over the course of the play, words or even a list of numbers scattered across the page, reader and audience are brought into intimate proximity with a person whose inner world is collapsing. The mental anguish of the character leaps off the page with every scattered phrase as

she (or he) falls apart. Although Kane termed the character's experience a psychotic breakdown, during the process the character, however out of touch with reality society might consider him or her, does not fail to present logical reasons for their desire to die. The play was Kane's last. Mere weeks after its completion, on February 20, 1999, Sarah Kane committed suicide. Scotland Yard reported the death occurred in her home, when in actuality Ms. Kane took her life in a hospital where she was undergoing treatment for depression.

### **Production Overview & Critical Reception**

4.48 *Psychosis* premiered June 24, 2000 at the Royal Court Theatre. Directed by James McDonald, cast members of this production were Daniel Evans, Jo McInnes, and Madeleine Potter. From the first production onward enhancements such as mirrors and video screens have been utilized to disorient the audience as a way of introducing the story. Granted, the play script's lack of stage directions and named characters leave much room for interpretation, though Kane shortly before her death suggested there were three characters. Mirrors have been used on more than one occasion to catch the audience off balance from before the show begins, and multimedia, including video clips or projected still images, to create a world which embraces the audience, enveloping them into the story. Based on Sarah Kane's other works and the stark reality of her own experience with mental health issues, a production done with a realistic setting has the potential to highlight the psychological horror and redirect the audience's attention to the issues at hand, rather than dazzle or confuse them with spectacle. The truth of her words is enough – as she once said “just a word on the page and there is drama” (Kane 213). Critics agreed, but not always for the same reason.

Some critics and scholars, perhaps in an effort to keep at arms-length an uncomfortable topic, termed *Psychosis* her suicide note. Diagnosed with depression, Sarah Kane was both playwright and psychiatric patient, undergoing inpatient treatment for severe depression which ultimately failed. Sarah Kane's decision to take her life divided scholars and critics responding to



*Psychosis* into two distinct camps, those who see it as art, and those who see it as a suicide note. The latter, being of primary significance to the purpose of this paper, is the focus of the next paragraphs.

*New York Times* writer Ben Brantley in October 2004, described *Psychosis* as an “irrefutable suicide note of a play” and two months later added it was a “breathtakingly beautiful and ugly suicide note of a play” (December 2004) which was “written as a refutation of reasons to live . . . not long before she hanged herself,” condemning the play to purely autobiographical status rather than the artist’s visionary work about mental illness. Brantley claims *Psychosis* is purely the author’s own struggle realized, that “the will to die assumes the brutal, instinctive force usually associated with the will to survive” (October 2004), and implies Kane uses the piece to justify the reason for taking her life. He further demotes the piece by writing that “This play’s scalding strength comes from its unparalleled ability to render the visceral, unanswerable tug of death to someone for whom living is simply no longer an option.” Here he connects the play’s strength to an apparent failing on Kane’s part. His view of mental illness colors his ability to see Kane’s work independently, limiting the playwright’s voice, undermining their strengths, exaggerating the weakness.

If Brantley took into account that Kane’s generation of playwrights in Britain wrote pieces which “often critique the conservative ideology that deems certain characters and subject matter unsuitable for art” (Urban 39), thus producing scripts with equal levels of emotionally challenging material as anything written by Kane, perhaps his critique of her work would take on a new dimension. Instead, Brantley’s vision of the play becomes limited by his interpretation of the work as a suicide note. By refusing to take the work seriously as theatrical art, Brantley does not have to take the artist seriously, and demotes both work and author to a position beneath the moral high road of what he might term sanity. As Margaret Price noted in an article about psychosocial disabilities, “when [one] is speaking as a mentally disabled subject, one is generally denied . . . the ability to be received and respected as a valid subject” (12). Brantley appears to

confuse Kane with her character. It is the character, not Kane, whose will to live has been lost in “a dramatic dialectic between the urge to order and the need for self-destruction” (Ravenhill).

Perhaps the atypical script formatting has a hand in the confusion. Kane’s work is a “performance script(s)” (Carney 288), but “it is inarguable that her work attempts to occupy a position in theatrical representation that is potentially impossible. Her plays seem to be at war with the substance of theatre itself, provoking theatre to raise questions about its own nature” (288). Thus Kane’s piece offends on at least two fronts: it could appear to be her own suicide note, using her occupation to ensure its publicity; and, two, in doing so she has the audacity to walk away from a long-accepted, centuries-old format. The poem-like presentation clearly distracts, or becomes an excuse for, those critics who would seek to view it as a suicide note rather than a variant art form.

The inescapable connection between Sarah Kane and the character is beautifully explained by Alicia Tycer who frames her analysis of *4:48 Psychosis* within Freudian psychology and trauma theory. Previous pieces examining Kane’s work have been done as though *Psychosis* is autobiographical. Kane’s death is a double loss to the theatre world in that she was a genius and left us with so few plays through which to embrace her worldview and learn her storytelling ability, but also because in light of her suicide and the community of mourning that resulted, it has not been until several years after her death that analyses of her works could move beyond the initial grief. It is so easy to presume *Psychosis* a suicide note because it helps the theatre community process that grief; and while her works speak with fervor about loss, death, sadness, pain and unrequited love, it is an error to attribute these qualities solely to the supposedly damaged mental health of the author. Easy, yes, but a disservice to the playwright, her works, audiences, and the deeper lessons yet to be gleaned from Kane’s short but extraordinary body of work, as demonstrated through Tycer’s 2008 article which successfully met the challenge of separating powerful themes from the author’s personal life.

Tycer's unique treatment of *4:48 Psychosis* deftly acknowledges the playwright's pain without allowing the possibly autobiographical elements to overshadow the play's intelligence. Tycer frames her article through reference to Freud's "Mourning and Melancholia" of 1917, which "differentiates between the two reactions to loss, arguing that because mourning is a reaction to a definable loss, eventually it can be overcome, but melancholia remains indefinitely." Because melancholia is tied to the ego "the individual cannot define or become conscious of what has been lost, leading to an inability to achieve closure." Here previous critics come under fire as Tycer derides them for attempting to connect the 'lost object' to which the ego attached itself as "the deceased author" and that such treatment of the piece "threaten[s] to annul the melancholic ambiguity that lies at the heart of the play's text and performance" (25). This ambiguity allows for the audience to interpret and identify with the piece on a deep psychological level, finding common ground as a result of the struggle to wade through the atypical formatting in search of the contextual answers playwrights are thought to provide. There are no easy answers – the audience provides their own – and thus the psychological tie-in and identification with the play, its unerring presentation of what Kane called "pathological grief" (223), resulting in a play that is not over for the audience when the lights go up.

Instead, readers and audience members alike are set face-to-face with their own demons, now awakened, or the common grief which we too often dismiss as 'the human condition.' Perhaps one can continue to ignore the inner melancholy of their humanity after reading or viewing *4:48 Psychosis*, but it will come back to haunt us. Words and images are powerful tools, empowered further through associations of our own making formed in the struggle to understand what we prefer to think of as a dramatic suicide note. It leads one to wonder if Kane's supposed suicide note is not hers, but ours.

*4:48 Psychosis* loses its power if we attribute it to Kane's mental health (or supposed lack thereof) instead of her remarkable insight and the gifted hand which translated torment into words on a page. For some, the 'in your face' approach of her work could seem a purposeful affront to

the polite, sophisticated world of the theatre which handles blood and guts and pain with kid gloves. It becomes too easy to disregard the genius of the work for the painful ramblings of a psychotic woman. A different approach might be to consider the metaphor of atypical script and the characterization that in itself expresses.

Putting aside the implications of Kane's suicide, the rest of this chapter will focus on the main character of *Psychosis*: her responses to cultural norms and outcomes of those responses within the framework of Rosemarie Garland-Thomson's statement that contemporary society views disability as "a flaw, lack, or excess" (*Feminist Disability* 1557). Utilizing three pieces of text from the play, it will be shown that these three negative differences are found in the character's social situation, her rejection of cultural values and outcome. Within this demonstration of difference the cultural creation of mental illness through interaction, or social constructionism, will become apparent through the relationship between patient and psychiatrist. That relationship grants opportunity to observe how a diagnosis of mental illness results in marginalization and what responses of 'difference' serve to reinforce its existence.

In the first few pages of the play, the character, who has "resigned [her]self to death this year" knows some "will call this self-indulgence" but "they are lucky not to know its truth" but "some will know the simple fact of pain. This is becoming my normality" (208), and the rest of the play follows her spiral down into a whirlwind of frustrating conversations with a psychiatrist, attempts at accepting society's answer in the form of psychotropic medication, and the hopeless because "nothing can extinguish my anger. And nothing can restore my faith" (210) A world with no answers, condescension and pills which serve as a "chemical lobotomy" (221). In what might first appear grandiose terms, the character exhibits flaw, lack, and excess in each of these statements. But "for Kane, hell is not metaphysical; it is hyperreal, reality magnified" (Urban 45). She cannot connect with the psychiatrist who belittles her, nor can she live in a world knowing the brutality of which people are capable. "This is not a world in which I wish to live" (210). There is no starker language than this, as she takes upon herself the crimes of humanity

I gassed the Jews, I killed the Kurds, I bombed the Arabs . . . 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 and when I die I'm going to be reincarnated as your child only fifty times worse and as mad as all fuck I'm going to make your life a living fucking hell I REFUSE I REFUSE I REFUSE LOOK AWAY FROM ME (227).

The rage and despair and hopelessness painfully evident in this monologue reflect a person who knows full well the realities of the world. She is not disconnected, she is painfully aware. The world is not always a happy, peaceful place. Innocents are hurt; bodies become mangled flesh and bone. The horrors of war, the atrocities human beings are capable of inflicting on one another, are an awareness the character cannot shake. Kane once said she did not take these things from her imagination, because she was not that "sick" (Rebellato 1998), rather even the most brutal events her work depicts comes from recent events. Giving her character knowledge of them would indeed impart a grief too big for any chemical lobotomy to effectively answer. In the character's response to a harsh world Garland-Thomson's triad is discovered.

The character's lack is her inability to process horrific events, which then turn into an excess of pathological grief. Her reaction is a deviance, making personal the larger issues of the world and unwilling or unable to look away and console herself with some trite platitude. This could only mean a flaw, misdirection in her mind's biology that ensures humanity's survival in the face of such horrors. This weakness has to be medicated since it cannot be consoled.

Unspeakable world events too big to manage or process becomes part of the character's own personal torment, the belief that the world cannot heal from such things, and knowing that she, too, is mortal. Yet she is a mortal who cannot relinquish the evil that pierces her heart, she is unable to avert her eyes, even as she demands at the end of the monologue for the psychiatrist to stop looking at her. But Kane's piece "offers neither solutions nor redemption" (Urban 37), and so she agrees to the psychotropic medications to cover up or alleviate symptoms for a disease which nothing on earth can cure. Thus she is ill, and the rationality of her choices and thought are

questioned. The first example of this is a conversation, presumably with her psychiatrist, about her desire to kill herself. The second example is when she cuts herself, and the conversation in which she tries to justify why.

Certainly Western society views purposeful self-injury as willful deviance, but it is also a perfect example of what Tobin Siebers termed “performing difference” (118). Self-cutting is an act that requires a certain amount of tolerance to pain, but also leaves evidence. Society is groomed to reject those who perform a stigmatized difference, and as Siebers noted, performing difference “exposes and resists the prejudices of society.” The character wants her psychiatrist to notice, the cut on her arm is apparently, from their conversation, in plain view. The response to her injury contains all the patient weariness of one conversing with a small child, and in the play script runs just over two pages. The choice to hurt herself is also used by the psychiatrist as a demonstration of her illness. “Why don’t you ask me why? Why did I cut my arm?” (Kane 217) The character demands of her psychiatrist. But a game has commenced, and the psychiatrist won’t ask until a conversation of at least pages has taken place. After “a long silence” the shrink relents. “Why did you cut your arm?” One can imagine the wearied tone of a haggard professional. “Because it feels fucking great” comes the elated response, “Because it feels fucking amazing.” A moment later the psychiatrist asks, “And you don’t think you’re ill?” (217). “No,” the character says confidently, or perhaps angrily. “I do. It’s not your fault. But you have to take responsibility for your own actions. Please don’t do it again.” (218).

After a list of nine medications, their dosage and her various reactions, a doctor’s note reads “Refused all further treatment.” Immediately afterwards suicide is attempted via “100 aspirin and a bottle of Bulgarian Cabernet Sauvignon” (225). The character’s lack is one of effort. Her refusal of the societal standard to want to ‘get better’ more than anything else, her refusal to abandon herself for the wisdom of psychology’s answers, moves her into the realm of the incurable. She “refused all further treatment” (227), had one further conversation with her psychiatrist, bid the world farewell, and was gone.

Suicide is the only door left open when the character cannot abide the despair of the world, or remain within the supposed haven of a psychiatric institution. There is nothing left for her, no lover, no hope, no thing to make life worth the pain of living. "I can fill my space," she tells us, "fill my time, but nothing can fill this void in my heart" (219). Certainly the chemical lobotomy of psychotropic medication leaves her with a half-life, a life without the fullness of her feelings and desires. It cuts her off from a vital part of herself, but the pain of reality is beyond her ability, beyond the world's ability, beyond the psychiatrist's ability, to heal. Because she will not live with the half-life, half-heart, zero soul of a medicated mind, Sarah Kane's character is destined by Western society to die. She is honor-bound to kill herself and remove the living hopelessness from the world's view, so it can feel sorry for her in her passing, and leave the rest to hope they never have to suffer like that.

Contemporary understanding of disability as excess is represented in *4.48 Psychosis* as undesirable trait to eliminate. The character is excessively sad, pathologically so, and blamed for the inability to rid herself of it. The psychiatrist voice says the character "allow[s] it," even though it's "not [her] fault." The main character insists "there's not a drug on earth that can make life meaningful," but is told "you allow this state of desperate absurdity" (220). At the end of the conversation, she consents. "Okay, let's do it, let's do the drugs, let's do the chemical lobotomy, let's shut down the higher functions of my brain and perhaps I'll be a bit more fucking capable of living." Even in the consent there is an excess of words, highlighted by the brevity of the psychiatrist's response, "Let's do it" (221). Consenting to the medical model society has presented as treatment for her grief results in the character abandoning herself.

The play leaves no hope the main character survives her final suicide attempt, seemingly on a path of no hope, no escape as she says "despair propels me to suicide" (229). all dialogue with even the psychiatrist has faded after the conversation following her refusal for further medication, and she flies free of her incurable despair, out of the savings hands of the doctor, beyond the chemical answers her culture has found to numb her of the feelings society has not yet

found a healthy way to manage. She dies. The end. The fullness of who this person was could not be contained within a hospital, controlled by drugs, manipulated by those charged with restoring sanity. Sanity could not be restored because it was not lost in the first place. She was not crazy. She was not insane. She simply refused to cut off the corners of herself to fit into the mold of the world, and found bewilderment and despair, remarking “I’ve never understood what it is I’m not supposed to feel” (229). She was depressed, as she says, by the fact of her mortality. There were simply no answers in the world to her questions; no healing touch deep enough to answer the most painful of her feelings. She was too different, too much, yet not enough. Her flaw was her inability to keep her feelings in a box, her lack a lack of self-control to suck it up and move on. Her disability was her refusal to divorce herself from the excess of her feelings.

Ironically, Kane’s own work reflects the devaluation of feeling statements and the condescension from superior others which constantly challenges the legitimacy of the character’s experience. The character says “I feel like I’m eighty years old,” and the psychiatric voice responds as though she’d made a factual statement, not a feeling statement. “You are not eighty years old” (211), but she did not say she was. Kane’s character blurs that line whereas the two-dimensional character of the psychiatrist holds tightly to facts which twist the truth. Kane’s character addresses feelings which flavor the facts into a different picture entirely. “Your bare-faced fucking falsehoods that masquerade as medical notes” she calls them, angry at being misrepresented. Herein lies the challenge to the social psyche, to find that feeling statements can contain more truth than bald facts, the latter of which erase the full experience of personhood as much as, if not more so, than the mental condition itself. “Your truth, your lies, not mine” (210) she declares of what has been written of her. Kane writes a character who has completely rejected the medical establishment’s characterization, painfully aware that all the observation and notes in the world cannot end the grief she is unable to deny.

The deeper understanding of both the play’s character and author through feminist disability theory as perfectly human, intelligent and abled challenges cultural viewpoints of



mental illness to such an extent that the first and lasting approach is a simplistic label which saves the innocence of our false belief. There are some things we have a social agreement to not speak of, subjects believed too delicate for public consumption. Kane's mistake, if there was one, was to write a piece that went into those deep painful places, that touched the rawness inside of every human being, and to ask for, as Alicia Tyner noted, a "witness" (Kane 243). Perhaps the social psyche is not ready for lines like "something touches me in that still sobbing place and a wound from two years ago opens like a cadaver and a long buried shame roars its foul decaying grief" (209). Perhaps the psychological connection is that in asking, or demanding, a witness, Kane became confused with her character in the minds of those critiquing, even producing, her work.

It is easy to imagine that she is writing to her readers in the only format available to her, comfortable for her. Maybe *Psychosis* is her suicide note. And maybe it is more. Maybe it is the final wakeup call issued by a woman who could not save herself, and in turn saw that she was just as helpless to save society, which only continues to stigmatize and degrade the individuals it labels weak or inept.

## CHAPTER VI

### CONCLUSION

People with disabilities are the largest physical minority group in the United States (Lennard 1). Moreover, it is also the group that nearly every human being alive will join at some point, however temporarily, in their lifetime (Silvers 133). Within that marginalized group are those with mental illness, arguably the most stigmatized human difference in contemporary society (Hinshaw and Stier 372). For the most part, society views those with mental illness in dehumanizing, stereotypical ways. The medical model of disability has perpetuated this stigma and is entrenched in the way disabilities are even talked about. Language use in discourse about mental illness is primarily negative, and those so diagnosed are viewed as dangerous, pathetic, deviant, childish, and bereft of full social citizenship. But in the past few decades, feminists, disability scholars, and sociologists, to name a few, have become proponents of social constructionism. This theory finds much of the disability behind mental illness results from a wider social construct that shapes beliefs about what it means to be mentally ill, and that it is this construct, not the illness itself, which presents the social barriers those with mental illness experience.

As a “cultural category” (Horwitz 123) mental illness bears examination as a construct of social assumptions and interactions. Mulvany argues that such an “approach to disability demands an identification and analysis of the . . . conditions that restrict the life opportunities” (584). Social constructionism thus offers considerable insights into the interaction between

society and mental illness, but it has also been criticized for ignoring the bodily realities of the disabled (Siebers, *Social Constructionism* 739). For example, an individual diagnosed with anxiety will still experience that reaction whether or not society devalues mental illness. Therefore, to simply say that disabilities are purely socially constructed may be misleading. It also does not address the perpetuation of stigma which arises in the negative word usage prevalent in social—and to some degree academic—discourse that tends towards binary language comparing non-normative with normative bodies.

Thus the necessity of introducing a theoretical approach which challenges the social assumptions, language use, and perspectives of what constitutes normative. Garland-Thomson's proposal of a feminist disability theory challenges society's negative assumptions that "flaw, lack, or excess" (*Feminist Disability* 1557) are inherent components of disability, applied here to mental illness. The trifecta of "flaw, lack, or excess" speaks to the wider social belief that those with a disability are fundamentally or biologically different. Garland's argument allows deeper analysis than does social constructionism into the ways in which society limits, marginalizes, and categorizes those with disability. Its inclusive standpoint encourages acceptance of human variation, a stark contrast to the medical model's view of disability as negative difference.

Feminist disability theory challenges social thinking "by insisting that readers do not fall back on essentialist definitions of disability as inferior embodiment" (Garland-Thomson, *Feminist Disability* 1558). It is within the language of how disabilities are talked about that the implied cultural meanings are brought to mind. Calling

attention to the hidden norm that lurks behind our understandings of disability . . . can dislodge the pervasive negative notions we all learn about disability and shake up our assumptions (1559).

Challenging prevailing social thought means exposing the framework in which that discourse occurs. Due to the continued medicalized view of disabilities in social discourse, in what Snyder and Mitchell term "cultural locations" (3), the mentally ill are viewed as not quite human or

biologically flawed, exempting mental illness from consideration as being within the range of normal humanity. Stereotypes in the medical model then go unchallenged, and are presumed fodder for representations that border on caricature. There are locations of culture, including entertainment, in which it may be safely asserted that stereotypical representations are routine. Thus the application of feminist disability theory to representations of mental illness in theatre reveals the negative social contribution to disability and demonstrates the stigmatizing effect of the medical model while inviting acceptance of a wide range of human differences in a positive light.

As noted in the introduction, Johnston stated that “few figures, tropes, and themes are as ubiquitous in world drama as those involving mental illness” (756). David Mitchell notes that “in general, literature projects cultural assumptions about physical or cognitive difference into its presentations of disability” (*Modernist Freaks* 349). Dramatic literature provides a window to see the ways in which stigma is reinforced and perpetuated. In short, this is the location of dramatic literature’s power. Due to theatre’s ability to reflect culture back on itself in addition to challenging norms and stereotypes, it may be approached as a near-ideal source of information regarding social beliefs about mental illness. At the outset of this paper, the decision was made to utilize four post-1990 play scripts which covered a range of stigma or negative beliefs.

Of the four pieces chosen for their representation of mental illness, Tracy Letts’ *Bug* is by far the most violent. It also contains the greatest number of stereotypes, including fringe social and legal behavior, domestic abuse, drug and alcohol use, poor citizenship, and unemployment. Creating characters literally on the edge of a city, who hurt themselves and each other, and who walk away from military obligations, perpetuates deeply negative stereotypes. There are few if any redeeming or lovable qualities about either character; rather they are to be pitied or feared. Agnes, because she cannot protect herself, is the ever-vulnerable woman who succumbs to the creepy but charming stranger. The character development of Peter speaks to the social fear of the

normal-looking psycho who draws in the unsuspecting, socially disconnected woman, using her in a myriad of ways before causing her destruction.

Kitt and Yorkey's *Next to Normal* received rave reviews and awards. Although critical reception included comments that the piece accurately reflected the experience of those suffering with bipolar disorder, what the reception and the musical do not acknowledge is the paradigm of the medical model in which the piece is written. Only at the end does Diana appear to give up on medication and therapy, but she also walks away from her family and their future together is dubious. Throughout the musical the authors perpetuate belief in the medical model as Diana and her husband Dan repeatedly seek standard treatment. Frustration is voiced, but hope held out as being around the corner if they can only persist in their efforts to seek help. The medical model is evidenced in Diana's search for an answer or cure because her search is confined solely to the realm of the medical establishment. The right pill, the right therapy, the right treatment, the right doctor—all are seen as possibilities for achieving the desired level of physical or mental normality. It puts the cure in the hands of "professionals" and blames the individual should a so-called cure not be effective. Failure to cure reinforces the belief that difference may be an inherent brokenness or invisible flaw.

In David Auburn's *Proof*, a deceptively simple story about mental illness and family dynamics illustrates an oft-overlooked component of mental illness. The younger sister Catherine, who chooses to stay home and care for her mentally ill father, is arguably bestowed with the indignity of secondary stigma. Research in sociology and psychology have demonstrated that family members caring for the mentally ill at home are often subjected to what Erving Goffman first coined "courtesy stigma" (*Stigma*), and has been termed secondary stigma in recent decades. Catherine's willingness to set aside her own education and any semblance of a social life disturbs her older sister as well as critics and scholars who have written about the play. Such writings indicate that Catherine did herself a disservice by putting the needs of her father first; one scholar framed the representation of Catherine as anti-feminist. However, Catherine

stands by her decision even after her father's death, and soon emerges from the cocoon she chose. The quiet strength of the character and the lingering question about whether or not her genetic inheritance includes mental illness seems to challenge cultural perceptions.

Of the four, the work with the least amount of positive reception was Sarah Kane's *4.48 Psychosis*. Interestingly, Kane's piece provided the greatest challenge of the four to current perceptions of mental illness, serving perhaps as a reminder of what society as a whole would like to ignore. Western culture has largely refused accurate, non-medical representation of mental illness. Reminders of the reality are met with the strongest possible resistance in order to maintain social norms and beliefs. This is particularly true when the medical model, still prevalent in social attitudes and discussions about mental illness, are demonstrated to be fully ineffective. Kane's character experiences mental illness within the confines of the medical model as does Kitt and Yorkey's Diana; treatment includes therapy and medication, the only answers the character is offered.

However, the challenge to the medical model goes unanswered, as both medication and therapy fail the client. Unlike the character Diana, there is no quasi-happy ending or ambiguous hope for answers within the medical model. The character, who repeatedly confronts the psychiatrist, has nowhere else to turn and appears to commit suicide at the end. This is somewhat similar to *Proof* in that the individual with mental illness dies, but Kane's character does not have the unwavering familial support as did Catherine's father. Although Peter and Agnes in Letts' *Bug* serve as one another's social support, it is to their detriment, and like Catherine's father and Kane's character, they too die.

The final work of a playwright whose suicide appears to mirror the end written for the character is unlikely to meet with full acceptance in current culture. Its reminder of the complex but fragile human psyche may be too threatening, and it undermines the mainstream answers society offers the mentally ill. It is easier to take Brantley's approach and write the play off as the author's suicide note, however brilliant, beautiful, or tragic.

This thesis is an attempt to utilize evidence produced by Western culture to uncover its attitudes about mental illness and the social norms which result in the perpetuation of the most stigmatized condition in our society. There are multiple ways to accomplish this task, but one of the more fascinating is to examine the stories culture tells itself. What ideals are reflected there? What fears, what values? Reinforcing what society accepts as safe and normal is par for the course in theatrical entertainment. But theatre as a living entity embraces change and challenge. It refuses to stand still and be told what to do. Ever pushing the envelope, those involved in theatre have used this marvelous form of entertainment as an instrument promoting causes of the marginalized. At its worst, theatre uses stereotypes to tell the audience which characters to root for and which characters to abhor based on verbal and behavioral cues which line up with unwritten standards of social conduct.

The marginalization of those with mental illness speaks to the underlying social beliefs about the inherent flaw, lack, and excess disability represents. These assumptions disguise the deeper beliefs about what it means to be fully human, and what society is willing to accept as normative representations of humanity. In the world of theatre color-blind casting has received its share of lip service, but what about ability-blind casting? Could anyone accept the role of Blanche DuBois being played by a woman known to have bipolar disorder who was not taking medication? The immediate reaction could very well be “of course not,” calling upon the demands of actors in professional theatre without stopping to consider the implications of instantaneous rejection. Society has a long way to go before fully accepting mental illness as something other than deviant, lacking, flawed, or biologically imbalanced.

As the review of scholarship demonstrated, social attitudes and norms can be explored through a society’s literature, including the literature of theatre. Theatre holds significant promise for both evaluating current beliefs about mental illness and challenging them. Of all disabilities, mental illness has the greatest amount of representation within theatre. Thus, using contemporary play scripts as material for evaluation of current beliefs, this paper explored present-day thought

about mental illness through the theoretical approach best suited to challenging it. In 1998 Linton remarked that “even a cursory review of the [academic] curriculum reveals only patronizing and distorted representations of disability, and these are left largely unexamined and unchallenged”

(4). A review of the literature which has emerged since those words were written indicate a slow-growing but ever-stronger recognition within the academy that disability studies, and the challenge it presents to contemporary representations of disabilities, hold value for not just the disabled, but the whole of social and academic discourse.



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VITA

Sunshine Anne Stevens

Candidate for the Degree of

Master of Arts

Thesis: A FEMINIST DISABILITY THEORY APPROACH TO  
REPRESENTATIONS OF MENTAL ILLNESS IN FOUR POST-1990 PLAY  
SCRIPTS

Major Field: Theatre

Biographical:

Education:

Completed the requirements for the Master of Arts in Theatre at Oklahoma State University, Stillwater, Oklahoma in December, 2011.

Completed the requirements for the Bachelor of Science in Liberal Studies at Eastern Oregon University, La Grande, Oregon/USA in 2007.

Experience:

Teaching Assistant, TH 2413 (Intro to Theatre)                      Fall 2011  
Professor Don Childs, supervisor  
OSU Theatre Department

Teaching Assistant, TH 3913 (Dramatic Literature)                      Fall 2010  
Dr. Maria Beach, supervisor  
OSU Theatre Department  
Oklahoma State University

Professional Memberships:

Golden Key International Honor Society                      Oct. 2011- present  
Literary Managers & Dramaturgs of the Americas                      Feb. 2011- present  
OK-AHEAD                      March 2010 - present

Name: Sunshine Anne Stevens

Date of Degree: December, 2011

Institution: Oklahoma State University

Location: Stillwater, Oklahoma

Title of Study: A FEMINIST DISABILITY THEORY APPROACH TO  
REPRESENTATIONS OF MENTAL ILLNESS IN FOUR POST-1990  
PLAY SCRIPTS

Pages in Study: 98

Candidate for the Degree of Master of Arts

Major Field: Theatre

Abstract:

Despite efforts to change society's perception of mental illness, it remains one of the most highly stigmatized disabilities. The medical model of disability, which locates the supposed defect within individuals, shapes discourse about mental illness and perpetuates stigma. It places value on normative bodies and stresses the importance of overcoming what it views as negative difference. In recent decades theorists have embraced a social constructionist point of view, which examines the impairment disabilities represent as a result of interaction between individual, society, and environment. However, this view has been criticized for not fully realizing the difficulties disabled individuals face. Feminist scholars, Rosemarie Garland-Thomson in particular, have proposed a feminist disability theory which more accurately takes into account both social factors and the physical realities of disability. Feminist disability theory also overcomes the gap created by historical feminism, which has attempted to promote equality using a strength-based approach which may not be applicable to the non-normative or disabled. Because the literature society produces reflects commonly-held values and norms, this paper uses four contemporary play scripts to examine social attitudes and beliefs about mental illness, an ever-popular theme within dramatic literature.

ADVISER'S APPROVAL: Dr. Maria Beach

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