The Effects of Medicalization, Medical Practices, and Mental Disorder on the Subjective Experience of the Self in Sarah Kane's *4.48 Psychosis*

Mariia Haatanen
University of Tampere
School of Language, Translation and Literary Studies
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Pro gradu -tutkielmani käsittelee Sarah Kanen *4.48 Psychosis* -näytelmää medikalisaation ja mielenterveysongelmien sekä feminismin ja queer-teorian näkökulmista. *4.48 Psychosis* kuvaa mielenterveysongelmista kärsivän potilaan suhdetta itseensä sekä hoitohenkilökuntaansa ja hoitometodeihin, joista selkeimpinä esiin nousevat lääkitys, mielentilaa kartoittavat testaukset sekä psykoterapia. Tutkielma tuo esiin Kanen vähemmän tutkitun viimeisemmän näytelmän uudesta näkökulmasta, jossa lääketiede, tekstin rakenne ja asiasisältö sekä feministinen ja queer-teoria luovat pohjan analyysille, jossa korostuu sekä lääketieteellisten käytänteiden vaikutus potilaan minäkuvaan, että potilaan minäkuvan ja tekstin vuorovaikutus.

Pro gradu -tutkielma jakautuu kolmeen osioon: ensimmäisenä käsittelen medikalisaation sekä psykiatrian ja anti-psykiatrin teoretisointia ja analyysia, toiseksi käsittelen psykoterapian teoreettista pohjaa ja kritiikkiä, ja kolmanneksi tutkin postmodernin kirjallisuusteorian avulla tekstin rakenteen ja sisällön suhdetta potilaan minäkuvaan.

Medikalisaation, psykiatrisen ja anti-psykiatrisen sekä psykoterapeuttisen lähestymistavan pohjalta tutkin, kuinka lääketieteelliset hoitokeinot vaikuttavat potilaan minäkuvaan. Analysoin, saako potilas hänelle tarjotusta hoidosta hyötyä, ja jos ei, kuinka hoitoprosessin voidaan nähdä vaikuttavan häneen negatiivisesti. Lähestyn kysymystä lääkäri-potilassuhteen analyysin kautta, jonka lisäksi tarkastelen lääkityksen ja psykoterapiassa tehtyjen mielentilaa ja kognitiivisia kykyjä kartoittavien testien vaikutusta potilaan ymmärrykseen itsestään mielenterveyspalvelujen asiakkaana. Teoriapohjaa analyysille luovat erityisesti Thomas Szaszin, Peter Conradin ja Joseph W. Schneiderin tekstit.

Postmodernin kirjallisuusteorian pohjalta analysoin näytelmää myös sen tekstin rakenteen ja sisällön kautta. Painopiste pysyy edelleen potilaan minäkuvassa ja sen rakentumisessa näytelmässä, joskin fokus siirtyy medikalisaatiosta ja lääketieteen vaikutuksista itseilmaisun keinoihin. Tutkin potilaan minäkuvan sirpaleisuutta suhteessa tekstin sirpaleisuuteen, jota tutkin paitsi tekstin rakenteen, myös intertekstuaalisuuden tasolla. Teoriapohjana käytän ensisijaisesti Ihab Hassanin postmodernia teoretisointia.

Avainsanat: näytelmäkirjallisuus, postmodernismi, medikalisaatio, mielenterveys, feminismi

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1. Introduction

Sarah Kane was a British playwright born in Essex in 1971. She died in 1999, being only 28 years of age at the time. Although Kane died at such a young age, she was a productive writer: she wrote five plays and a ten-minute screenplay during her lifetime. She started writing in her childhood, and she wrote some parts of her first play, *Blasted*, already during her time in the University of Cambridge where she studied playwriting. Her plays are regarded as a part of a branch of theatre called in-yer-face, which is famous for its brutality, emotional honesty, and use of taboos and shock tactics.

The prime time of in-yer-face theatre was in the 1990s, and its main arena was Great Britain. The term "in-yer-face" was coined to this usage by Alex Sierz, a journalist, theatre critic and scholar (2002, 5). Sierz, who has done extensive work on both in-yer-face and Sarah Kane, states that in-yer-face was "the dominant theatrical style of the decade" (2001, 4). In his *book In-Yer-Face Theatre* Sierz argues that in-yer-face "saved British theatre" and that in the 1990s "contemporary theatre was in-yer-face theatre," explaining the importance of the genre to modern European theatre (2001, xii-xiii). Although this particular branch of theatre may not be that well known, perhaps because of its locality and radical nature, it has had a big impact on contemporary theatre. Sierz argues that in-yer-face playwrights have pushed modern theatre forwards by making it more experimental (2001, 4). In-yer-face can be seen as a theatre of extremes, since it forces its audience to react, not allowing any emotional detachment like traditional theatre does.

Themes typical in in-yer-face, such as violence and brutality, are nothing new in theatre, but have in fact been around ever since Greek drama. However, the way in which in-yer-face portrays them is essentially different from past styles of theatre, because whereas in previous styles of theatre violence has often been performed off-stage, in-yer-face brings the "shock-fest," as Sierz calls it, right in the face of the audience and pushes the limits of what has previously been considered as an impossibility in stage performance (2001, 36). Besides Sarah Kane, some of the most known playwrights in the in-yer-face tradition include names such as Mark Ravenhill

(*Shopping and Fucking*), Philip Ridley (*The Pitchfork Disney*), and Anthony Neilson (*Normal*) (Sierz, 2001 and 2012).

Sarah Kane is, as Catherine Rees describes her in the book *Modern British Playwriting: The 1990s* (edited by Sierz), one of the most "famous and infamous" and controversial playwrights of the 1990s (2012, 112). Kane's plays have indeed caused widespread criticism, and especially her first play, *Blasted*, raised a riot in the theatre circles of Great Britain in the mid-1990s. *Blasted*, first performed in the Royal Court Theatre Upstairs in 1995, is perhaps most famous for the comment made by Jack Tinker, a drama critic from the Daily Mail, calling the play a "disgusting feast of filth" (1995). Surely, the harsh themes of the play, such as cannibalism and rape, and its unconventional structure did not help the digestion of *Blasted* amongst theatre critics. The scandal *Blasted* caused can be seen as one of the main events in the in-yer-face timeline, which lasted from the early 1990s to the end of the decade. Rees even suggests that Kane's life and career can be seen as "framing the resurgence of new British plays" of the 1990s, as the scandal raised by *Blasted* happened in 1995 and Kane herself died in 1999, about the same time as in-yer-face theatre had "ran out of steam" (2012, 112). Although the golden age of in-yer-face is already in the past, Kane's plays are still widely performed all over the world. Kane's main themes are centered around love, violence (both mental and physical), hope and despair. Many have criticized Kane's plays for their brutality and violence, often missing the similes they portray to the Western culture and history. Even though in-yer-face theatre is quite a British concept, Kane's *Blasted*, for example, is widely regarded to be an allegory of the Bosnian civil war.

Although Kane could never have been described as a traditional playwright due to the nature of her plays, the textual form of her plays started to fragment only towards her final plays. Her first plays (*Blasted* and *Phaedra's Love*), though very violent in their stage directions and content, were, however, traditional in form. In her first plays the characters have names, their lines are marked clearly, scenes can be distinguished from one another, and stage directions are present. Since *Phaedra's Love*, first the stage directions became unrealistic and brutal in *Cleansed* ("she is raped

by the voices," "a flower bursts trough the concrete," "rats are eating my face"). In her last two plays, *Crave* and *4.48 Psychosis*, there are no stage directions, and they are much farther away from the naturalistic tradition than her earlier plays (Rees 2012, 58). In *Crave* the characters' names have been reduced to single letters in a Kafkaesque manner (A, B, C, and M), and in *4.48 Psychosis* the characters have no names at all, and there are no markings to tell which character is speaking each time. In *4.48 Psychosis* there are no stage directions and different scenes are barely distinguishable in the textual form by numerous hyphens. There is no evidence as to how many characters or speakers there are supposed to be in the play, and whether all the voices belong to different characters.[1] Besides the abandonment from traditional forms of theatre, towards her later plays Kane started what Graham Saunders, the author of *'Love me or kill me': Sarah Kane and the Theatre of Extremes* calls an "eschewal of realism in language" (2002, 88), which sets a very distinct mode to her plays. Kane's plays resemble each other through their themes, but the traditional form of theatre has quite clearly become less important towards the end of her career. When the form is quite free and poetic rather than theatrical, the text itself allows more interpretations both to the audience or the reader and theatre personnel (i.e. actors, directors etc.) executing the plays. The beauty in Kane's works lies in their ambiguous nature, which has become even more evident in her final plays.

In this thesis I will study Kane's last play, *4.48 Psychosis* (2000). Unlike most of her previous works, *4.48 Psychosis* received "unabashed critical success" from its first staging in The Royal Court Theatre in June 2000 (Claycomb 2012, 92). Besides the dramatic school of in-yer-face theatre, *4.48 Psychosis* can also be linked to a group of "psychotherapy plays" that have emerged especially in the United Kingdom and Ireland in the last few decades (Watson 2008, 191). The play has also been discussed in relation to postdramatic theatre, although this has created some controversy among critics (Rees 2012, 130-132). *4.48 Psychosis* is distinctly postmodern in style

[1] Although the play can be read with different numbers of voices, the first staging of the play had three voices and actors: all the actors spoke as the patient and at least the male actor in the group, Daniel Evans, played parts of the doctor (Saunders 2002, 174). The number of the voices can change due to different productions of the play, although many are loyal to the staging of the original production (Claycomb 2012, 97).

and content with its fragmented and ambiguous nature. The play has not been widely researched, as the main interest of studies on Kane has been on her more traditional pieces, such as *Blasted*, and mainly on themes such as violence and cruelty that are less evident in *4.48 Psychosis* than in her other plays. Besides, postmodern drama has not been widely researched as a whole, which has undoubtedly also affected the interest to carry out research on Kane in particular (Schmidt 2005, 25). This could perhaps be because not many postmodern plays have received much success as far as audiences go, or maybe because one of the latest trends in drama studies seems to be focus on performance (Schmidt 2005, 16, 26).

In essence, *4.48 Psychosis* is a play about a patient and a doctor, who discuss and evaluate the mental health of the patient, sometimes together, sometimes the patient having long monologues, sometimes the doctor describing the patient's treatment. *4.48 Psychosis* is the shortest and the most fragmented of Kane's plays: it has no stage directions, the scenes are barely separated from each other, and the characters perform in a vacuum-like space where time is not present and the set is only vaguely distinguishable as something resembling a hospital, a psychic ward, a psychiatrist's office, or perhaps a combination of these three. The characters have no names or other distinguishable factors, and during the majority of the play there are no clues as to which of the characters is speaking. Only in the dialogues between the patient and the doctor can the reader clearly distinguish which characters are speaking each time, as the play uses “dashes to indicate a new speaker” (Rees 2012, 128).

Perhaps the most interesting thing in *4.48 Psychosis* is that the reader cannot even be sure as to how many characters or voices there are supposed to be in the play. Sometimes the structure of the text (visible fragmentation and the locations of words on page) invites the interpretation of there being two voices for the patient that could be regarded as the “true” self and the depressed one, but as there is little distinction between any of the characters' voices in general, they are hard to distinguish. Saunders argues the play can be regarded as a set of discourses that are used as means to “express the boundaries between reality, fantasy and different mental states” (2002, 112).

Although I agree that the play certainly distinguishes between different mental states, it is still quite challenging to separate what Saunders refers to as "fantasy" (I would simply categorize this as an unreliable speaker) and "reality," as the long passages of the patient are anything but easily understandable in their fragmentary and sometimes even cryptic nature. Saunders probably refers to the patient's more depressed moments as "fantasy" because there is no real fantasizing or elements of fantasy in the play, and the word itself might not be the best to describe the mind-set of a severely depressed person.

In *4.48 Psychosis*, I have chosen to focus on the character of the mental patient as the primary object of analysis and the focus of this thesis. The basic storyline of the play consists of the patient's journey through different types of psychiatric and psychotherapeutic treatment and medication until the moment of her suicide. The patient is a nameless, ageless, featureless character; all we know is that she is a patient to a doctor, most likely a psychiatrist, and that she suffers from depression which has led to self-harm, and suicidal thoughts and actions. The patient is, in fact, a woman, although some critics such as Rees think that there is "no certainty about the gender of the protagonist" (2012, 129). However, there is clear textual evidence to the patient being female: the doctor's log refers to her as "she" and "her" several times (2000, 223-224), and she refers to her future self as "an old lady" (2000, 218). The text does not question the gender of the patient, although it is portrayed in quite an evasive manner, and as there is no textual evidence that would suggest that the patient would identify as male or any other gender, I think there is no reason to doubt the gender identity the patient herself has. Besides her being a mentally ill patient, there are absolutely no indicators giving any other factual information on her. Things such as age, class, or ethnicity have no role in the character of the patient, making her a universal example of someone with a mental illness. However, the fact that she is able to get medical treatment is evidence that she has, at least to some extent, a fairly privileged position in society and that she lives somewhere where this kind of psychiatric or psychotherapeutic treatment is available.

This thesis will be divided into three main themes, the first consisting of theory, critique and analysis of medicalization and anti-psychiatry, the second on the theory and critique of psychotherapy, and the third analyzing and theorizing the divide between the fragmented mind of the patient and the textual form of the play. In the first two parts I will discuss the phenomena of medicalization and medical power in regards to the effects they have on society. I am particularly interested in how medical procedures and treatments together with possible diagnoses can affect the sense of self of the individuals subjected to them, as well as how society perceives those who undergo such treatment. Although *4.48 Psychosis* is not about medicalization per se, I have chosen this point of view because mental illnesses – the topic of the play and my analysis – is one of the main areas that have been criticized when it comes to medicalization and the emergence of new diseases and disorders. Critique on medicalization and of both psychiatric and psychotherapeutic practices can be of help analyzing the play, as *4.48 Psychosis* presents failure in these areas.

I am interested in how the identification as "mentally ill" affects the psyche and self-image of the patient, and a particular interest of mine is how psychiatric practices, namely psychotherapy, psychiatric testing, and the use of psychoactive drugs, can be seen reflecting on the self-image or the physical well-being of the patient. Most importantly I want to examine whether there are any examples of these practices affecting the patient negatively or worsening her state. The idea behind this kind of analysis is to try to understand whether the patient was out of the reach of treatment, or whether unsuitable treatment could be at least partly blamed for her suicide at the end of the play. If such evidence could be found, it would prove an interesting combination with my theoretical sources that, at least to some extent, condemn the medicalization of most mental illnesses and are highly skeptical to most methods of treating mental disorders.

My main theoretical background will be theories on medicalization and anti-psychiatry by Peter Conrad, Joseph W. Schneider and Thomas Szasz, who discuss how non-normative behavior can be seen and made into mental disorders. I have chosen to focus on theories on how mental illnesses are being created and recognized in Western society, and how these disorders and

especially the treatment used for them affect the patient. Often the focus is merely on the diagnoses and on recovery, and there is not much research on how the actual treatment to a psychiatric disorder can affect the patient, otherwise than potentially curing them or in regards to side effects of the medicine. I will also examine the patient-doctor relationship, and following some of my feminist theoretical sources, study if the process of psychotherapy and the therapeutic encounter can be seen as gendered. In a treatment that affects the psyche of the patient, the relationship between the doctor and the patient is remarkably different than in regular doctor-patient relationships where one treats the body, and therefore I think it is particularly important to study how this relationship is formed and how it develops through the process of psychotherapy.

In the third part of this thesis, I will examine how the fragmentation and collapse of the textual form compares and reflects to the self-image of the patient. The main question of analysis is how the fragmented psyche of the patient corresponds to the fragmentary form of both the text and its contents. I will analyze the textual form itself, the separation between the body and the mind of the patient, and the intertextual references found in the text, and analyze how these together form the fragmented image of the mind of the patient. Theories on the textual form, particularly on the fragmentation of the text and postmodernist theories are used to examine how the fragmentary form of the play and the mind could be considered postmodern. The works of Ihab Hassan and other postmodernist scholars serve as the starting point for my analysis. The "highly textual, almost poetic" (Rees 2012, 131) form of the play invites this kind of analysis of the form.

Since I have not been able to find any official recordings of *4.48 Psychosis*, this thesis will be focused on the textual form and content of the play. However, on some occasions I will make notice of how the text, intended to be performed and acted out on stage, can also be analyzed as a play. So, I will not use any particular performances of the play as reference but rather on a theoretical level understand that the text being analyzed also functions as a play on stage. Unlike many who have studied Kane, I do not consider her comments on her plays, or her life in general, in regards to her plays. This is a very conscious choice, for many who read Kane's life into her plays

often reduce the deeper meanings of the plays. On the one hand, some see her suicide as validating her plays, and on the other, people see her art as mere product of depression. In too many cases her death has become "the lens through which to view and discuss" her plays, as Rees notes (2012, 112). Since authorial intention cannot easily be studied after Kane's death, I think it is best to study the plays as autonomous textual formations meant to be performed on stage, and not to read Kane's personal life into them, as this could result in "too reductive a reading", as Saunders puts it (2002, 110). Following in the footsteps of poststructuralism and theorists such as Roland Barthes (*The Death of the Author*, 1967) and Michel Foucault (*What is an Author?,* 1969), I aim to avoid the intentional fallacy by leaving Kane's life and autobiographical facts out of the analysis in this thesis.

2. Medicalization and its Effects on Society

In this chapter I aim to study the relationship between medicine, medicalization, medical power and authority, diagnoses, and how these might affect people, especially those diagnosed with diseases or disorders. First, I will consider medicalization from a historical perspective, giving a glimpse of medical history so that one can better understand the present situation. I will then examine and problematize the postmodern trend of medicalization, and assess some of the effects it has on society. In this chapter my main theoretical sources will be several different books and articles by Thomas Szasz, Peter Conrad and Joseph W. Schneider, who cannot be passed when medicalization is in question. Szasz's anti-psychiatric works undermine the whole basis of psychiatry and questions its intentions towards the patients, which connects to my research question of how psychiatric diagnoses and treatments affect the ones being treated. Szasz was among the first to criticize medicalization of mental disorders, and has written numerous articles and books on the subject of psychiatry and later on its medicalization, specifically regarding its relation to social control. Also Peter Conrad, sometimes along with Joseph W. Schneider, has been one of the most prolific writers theorizing the phenomenon of medicalization of mental diseases, however, his focus has mostly been on the medicalization of deviance.

2.1 The History of Mental Health Care and Medicalization

I shall now examine the histories of medicalization and mental illness, beginning from the hospitalization of mental patients and its effect on society, then proceeding to the more recent phenomenon of medicalization. I will go through the advancements of these two phenomena in order to gain basis for the analysis in the following chapters. Understanding the historical aspects and developments of both of these is important in understanding the present situation in mental health care, which serves as the background for the play being analyzed, *4.48 Psychosis*. As the characters in the play operate in the environment of mental hospitals and in the ground of psychiatric and psychotherapeutic treatment, it is important to know how medicine, and psychiatry

in particular, have evolved to the state in which they are now in terms of diagnosing disorders and treating patients (by means of drugs, therapy, and hospitalization).

I will start going through the history of mental illness and the treatment of the mentally ill first as the phenomenon is much older than that of medicalization. Although it is not possible to know whether mental illnesses have always existed or if they have come to existence either in some specific period of time or eventually as the human race has developed, one can still examine how the treatment of the mentally ill has developed through the centuries. The history of treating mental illness and the so called madhouse goes on as far as the fourteenth century. One of the most infamous – and first ever – hospitals to take care of mental patients was the Bethlehem Hospital in London, which from 1377 onwards was used to house mental patients (Szasz 1977, 325). At such an early period mental hospitals were used to incarcerate different types of deviants from madmen to poor people, and the number of actual mental patients was quite small. This was the case for many centuries. Although incarceration of mentally ill people started in the fourteenth century, mental hospitalization as we now understand it begun later, in the seventeenth century. By the end of the century mental illness had gained momentum as the "trade in lunacy" flourished (Szasz 1994, 103, 107). In 1656 The Hôpital Général was founded in France, containing up to one percent of the French population (Foucault 2006, 39). The first institution in the United States open for mental patients was the Pennsylvania Hospital founded in 1752, and the first institution to exclusively take care of mental patients, Eastern State Hospital, was opened a few decades later in 1773 (White 1920).

Interestingly, when the last executions for witches in Europe and America were carried out around late 1600s and 1700s, the beginning of psychiatric institutions and hospitals started to form their modern ways. Thomas Szasz sees a clear parallel between the witch hunts and mental illness, as he claims that both concepts serve the same "social function" and the "logical and empirical status" (1977, 19). He argues that institutional psychiatry is comparable to the Inquisition, as they both have the same aim of protecting society from a deviant group. According to Szasz the only

difference between the Inquisition and the concept of mental illness is whom the society is being protected from. Szasz's main argument is that the binary setting between good and evil, healthy and ill, conformist and non-conformist is central to any society, and the righteous man needs a scapegoat, someone to other from the group or society. Szasz calls this the “perennial scapegoat principle,” and applies it through historical process to witches, and later on, to mental patients (1977, 317). The process of othering can be seen in society not only in the case of mental illness but in everything that is not deemed conformist, consider, for example, the treatment of sexual and gender minorities and ethnicities other than white. Othering is a typical trait of the Western world, and it is possible to find it almost anywhere in culture, for example in fairy tales, horror literature or films et cetera.

Although it is clear that psychiatric care has developed since Szasz wrote his book in the 1970s, it still offers relevant notions on medical authority and its power over individuals, the history of treating mentally ill people, and most importantly, critique on psychiatry as a whole. Even if it is not relevant to consider psychiatric care equal to the Inquisition nowadays, one should remember that incarceration due to mental illness still happens, though not in the same volumes as it used to. Reliable statistics on the matter are hard to come by, so there is no sure way of knowing how much psychiatric care has actually developed in relation to human rights. Nowadays it seems that one of the more serious problems might be that individuals seeking psychiatric help may not be able to get it due to long waiting processes and small budgets on treatment. Szasz's arguments regarding mental illness have been radical in their time, and they are still quite relevant, because the status of mental patients is still filled with stigma and it is definitely that of an other, although the situation is slowly getting better.

Now that we have established that the treatment of the mentally ill has been paired with the incarceration of deviants and non-conformists throughout its history and that there was little to no separation between these two, we can consider how the process of establishing something as a mental disorder goes. According to Peter Conrad, *medicalization* is the process by which non-

medical aspects of human life gain diagnostic labels and become treated as medical problems (1992, 209). Medicalization is a sociocultural process involved in the politics of naming, since medicine defines "a problem in medical terms [and uses] medical language to describe a problem, adopting a medical framework to understand a problem, or using a medical intervention to "treat" it" (Conrad 1992, 211). Medicalization constructs society so that it has the power to define almost any part of life as an illness. However, one must note that medicalization does not always lead to medicine taking care of that particular illness (e.g. the treatment of alcoholism) (Conrad 1992, 210).

According to Conrad, medicalization can be seen to happen on at least three different levels: the conceptual, the institutional, and the interactional level. The conceptual level covers the medical vocabularies and contracts that are used to define a problem into a medical one. On the institutional level the process is taken into the hands of different organizations that may adopt a medical approach to problems in which the organization specializes in, but the treatment is not done by medical personnel. The interactional level comprises of physicians defining a problem as medical, and the results can be seen in the doctor-patient relationship, for example, the doctor does a diagnosis or prescribes medicine to treat an illness. (Conrad 1992, 211). Some studies, however, show that medicalization may be rarer on the interactional level than has been assumed (1992, 228). As regards to *4.48 Psychosis*, my analysis will be on the interactional level of medicalization in the form of the doctor-patient relationship and the treatment given to the patient and the drugs prescribed to her. Interestingly, in the play the doctor does not give a proper diagnosis to the patient, but he does offer her psychiatric and psychotherapeutic treatment and several psychoactive drugs to treat her illness.

Medicalization can be seen as a "broad definitional process," in which the direct results of medicalization can be seen only on two of these levels, and only one of these two includes medical personnel (Conrad 1992, 211). It is important to notice that medical personnel are not always involved with the process of medicalization, but that the process is interactive, and that "organized lay interests" may often play an important role in the process (Conrad 1992, 219). Since the 1970s

many diseases that are now widely known have gained their diagnostic labels in the medical classification system, and have thus gained more attention and possibilities of treatment. Many critics of medicalization argue towards a trend of overmedicalization, since medicalization happens not only to actual illnesses but also to deviant types of behaviour and natural life processes, such as childbirth and menopause (Conrad 1992, 212-213). However, Conrad notes that medicalization is not an either/or situation, but there are different degrees to it (1992, 220). Although medicalization is bidirectional, meaning that also demedicalization occurs (e.g. the case of homosexuality), Conrad still argues that there is strong evidence for medicalization being on the increase in society (2004, 158).

The term medicalization started to emerge in theoretical writings of American social scientists along with the rise of a number of these new illnesses in the 1970s, as the first critics of the phenomenon, such as Thomas Szasz and Irving Kenneth Zola, started to regard it in relation to social control (Conrad 1992, 210). The first theorist to conceptualize social control to medicalization was Talcott Parsons, whose book *The Social System* was published already in 1951 (Conrad 1992, 215). Only two decades later, Zola argues that medicalization has become a "major institution of social control" that could even replace law and religion as gatekeepers of the social norm (1972, 487). Although critics and theorists have not been able to provide clear reasons as to why medicalization has increased so rapidly, they have been able to point out the social factors and contexts that have made it possible. Conrad lists secularization of the Western world and the rising status of the medical profession as the two most important factors that enabled medicalization to take place (1992, 213). On the one hand, a cynical person viewing the situation might argue that new disorders and diseases are being created just so that the drug industry could sell more products and gain more profit, and on the other, a positive one might argue that new disorders and diseases are merely being found all the time because of the development of medicine, resulting in improvement on the conditions of people suffering from these diseases. Whichever way one thinks,

it is undeniable that nowadays there are far more known diseases and disorders than there were, say, 50 years ago, before social critics started to examine the situation.

As the concern of this thesis is on the psychiatric school of medicine, I would like to examine some criticism on the aspect of the medicalization of mental illnesses. What is notable is that some of the first critics of medicalization of psychological states were from the field of psychiatry themselves, such as Thomas Szasz (Conrad 1992, 210). Szasz, a psychiatrist and an avid critic of the concepts of *mental illness* and *institutional psychiatry*, covers the historical process of medicalization of mental illness in his book *The Manufacture of Madness* (1977). The book deals with the history and issues of institutional psychiatry, and how nonconformist behaviour has come to equal mental illness. One of Szasz's main questions is whether or not mental illness actually exists, and if not, how can the treatment of mental patients be justified? Szasz lists cruelties such as dehumanization, oppression, persecution, and the stealing of personal dignity and political liberty as some of the most serious actions aimed against mental patients, either on purpose or as a side effect of their treatment (1977, 16-17). Because of Szasz's interest in the field of psychiatry and his critique towards medicalization, his theories fit the framework of this thesis very well. As I will study the processes of psychiatric treatment in regards to the well-being and the self-image of the patient, it will prove interesting to see whether any of above-mentioned (side) effects Szasz lists can be seen occurring in *4.48 Psychosis*.

Szasz's main argument throughout his writings is that there is no such thing as mental illness, only non-normative behaviour, and that medicalization in the area of psychiatry is a form of social control (1977, 21, 54). Although Szasz is very critical towards the existence of mental illness and argues that it is an entirely "fictitious entity," he notes that this does not mean that "personal conduct exhibited by persons classified as mentally sick, or certain kinds of social disturbances attributed to them, do not exist" (1977, 20, 53). By this he means that different types of behavior and models of thinking typically affiliated with mental illness do exist, but that these are not enough reason to claim the individuals as mentally ill. Rather, Szasz regards these kind of phenomena as

non-conformist behavior or deviance that has been diagnosed as an illness in order to be able to treat and consequently conform the patients to the social norms of society. This is an important point to remember, as in *4.48 Psychosis* there certainly are behavioral models and non-typical or non-conformist acts that can definitely be linked to mental illnesses such as depression (e.g. self-harm, suicidal thoughts and actions, decreased cognitive skills, trouble sleeping etc.). Szasz does not to deny that these kind of actions and thoughts exist, but merely questions whether they are a good enough basis for the medicalization of the phenomena. In his book *Cruel Compassion* Szasz argues that psychiatry began with "the relatives of troublesome persons seeking relief from the suffering the (mis)behavior of their kin caused them" (1994, 103). These kind of arguments take away the base of psychiatry as a humane way of treating and helping the "mentally ill" and makes psychiatry seem more like way of families and society to get the deviants out of sight. However, one should remember that although many institutional practices, such as psychiatry and mental hospitalization, have a problematic history, they can – and often will – evolve from that, and that the present practices should not be judged on the basis of their history alone.

According to Szasz the phenomenon of medicalization is not new, although it can be seen as a distinct trait of the postmodern era. In fact, Szasz states that "medicalization from above," that is, medicalization that aims to control other people, has developed later on along with the birth of psychiatry (2007, xvi). He argues that "everything that people do or that happens to them" could be examined in the field of medicine, and therefore become medicalized (2007, xiii). The opposite of medicalization is the absolute faith in a higher power and a spiritual realm that overrules all that is material (for example, religion). Since in the postmodern era it is generally thought that people have rejected grand narratives and replaced them with small ones, it is understandable that medicalization, which could be regarded as the epitome of the fragmentation of the human condition, has taken place in our society (see Bennet & Royle 1999, and Lyotard 1992). Medicine divides the "natural" human condition into smaller and smaller pieces in the form of new disorders and diagnoses, it develops new techniques of examining and imaging the body, deconstructing the

naturalness and the wholeness of human bodies. One could consider organ donors or blood donations as an example of this: a body is no longer simply one's own nor is it undisturbed. Some also argue that medicalization has affected in a Descartesian separation between the mind and the body, fragmenting peoples' minds from their matter (e.g. Ramirez-Galvez 2009).

In regards to *4.48 Psychosis* and mental disorders in general one could ponder upon the division and differences between a healthy mind and the thought patterns, actions, and disabling effects that come with mental illness. A disease of the body would be easier to separate from oneself than one that originates in the mind or the psyche, as it can be hard to distinguish when thoughts are one's own, original ones or ones that have come with the illness. For example, one might wonder whether they are really pessimistic by nature or if that is a change that has come with the mental disorder. The separation between the mind and the body is also visible in *4.48 Psychosis* in the form of the collapse of integrity between the mind and the body, further analyzed in chapter 5.3.

Peter Conrad argues that there are several social factors that have allowed the rise of medicalization, such as: “the diminution of religion; an abiding faith in science, rationality, and progress; an increased reliance on experts; and a general humanitarian trend in Western societies” (1992, 213). Already in 1972 Zola predicted that medicalization would surpass law and religion as the main institutions of social control, and indeed, just a few decades later Conrad and Schneider argue that medicine “has replaced religion as the most powerful extralegal institution of social control,” and Szasz agrees that “medicine has replaced theology” (1992, 241 & 1977, 19). Conrad, however, has also argued that medicine has not exceeded other forms of social control, though agreeing that it has expanded its scope (1992, 216). Indeed, one might argue both ways, but it has to be noted that religion, for example, still has widespread influence on people and in some cases it does bypass the power of medicine (think, for instance, about abortions or the general negative attitudes towards sexual education or contraception in some countries).

2.2 Medicalization and Medical Power in Society

Medicine has a great deal of power in modern society, and this power is not only attached to medical authority, but also to financial dealings and different kinds of corporations that are related to the industry. In this chapter I will examine medicalization and its connection to medical power in society, focusing on medicalization of mental disorders and deviance. Peter Conrad and Joseph W. Schneider discuss the phenomenon of medical power in their book *Deviance and Medicalization: From Badness to Sickness* (1992). They claim that medicine is no longer just a branch of science but an industry which includes "pharmaceutical, medical technology, and health insurance industries" (1992, 15). There is a lot of money involved in all of these industries, and this only adds to the power medicine would have anyhow. As discussed in the previous chapter, the jurisdiction of medicine has expanded, and Conrad and Schneider state that it now encompasses many forms of behavior and human conditions that were not seen as medical entities some decades ago (1992, 209).

Since medicine has gained such prestige, it has come to control virtually all medical education and licensing, not to mention that it has a monopoly over anything that has been defined as an illness or a disorder (1992, 36). Medicine has become a part of social control, a "political mechanism" as Conrad and Schneider put it, by which people can dominate others (1992, 21). This view contrasts strongly with the meaning system associated with medical professionals in the Western society that regards them as beneficent. It is important to distinguish medicine as a discipline, that is, as the art of knowing and healing the human body and the diseases threatening its existence, and medicine as an industry, which has gained all aforementioned power in society and that deals with the issues of power and finances. In this thesis I aim to analyze and criticize both aspects of medicine, because though medicine as a discipline could be seen as the "innocent" part of the pair, it could be scrutinized because of its patriarchal history. On some levels it might be hard to distinguish where the line between helping people and controlling them is drawn, for example in the case of the medicalization of women and female bodies, which I will further discuss in chapter 2.3.

Deborah Lupton has accounted three major sociological views on the power of medicine in *Medicine as Culture* (2012). These perspectives are: the functionalist, the political economist, and the social constructionist, and each of these regard the origin of medical power in different ways (2012, 105). The functionalist perspective sees power as a "generalized social resource," and in the case of medicine this resource has been earned by its contribution to society. This view sees medicine as beneficent to society, which is how it explains the power it yields. According to the functionalist view, medical dominance is a "desirable method of maintaining social distance" in the doctor-patient relationship, as this allows the doctor to take control of the healing situation which is said to give emotional comfort to the patient. This results in a balanced doctor-patient relationship where the asymmetrical nature of power is justified. However, this is problematic since it allows no agency to the patient over their treatment as the doctor has all the power in the medical situation, and this power is seen as something that has been earned and is therefore righteous. (Lupton 2012, 106-107).

The political economist perspective that draws from Marxist thought views the doctor-patient relationship in an entirely different way the functionalist view does, as it regards the doctor-patient relationship as characterized by "conflict of interests between the doctor and the patient". In the political economist perspective power is seen as something granted by the patronage of state, and in the case of medicine this can be seen in the form of strict restrictions on the profession, for example entry to medical schools. The political economist perspective sees medical power as a derivative from the profession, and in the case of medicine entry to the profession is "strictly controlled". According to this view, doctors are likely to "reinforce dominant capitalist ideologies," for example by prescribing medication or suggesting taking up physical exercise. In essence, the political economist perspective regards doctors as legitimizing and reinforcing social class structures and the economic system. (Lupton 2012, 108-109). Lupton claims that:

> Power relations in the western medical encounter are related to the dominance of the corporate and middle class in positions of influence in the medical system (as medical professionals, researchers, medical board members and managers) over the lower middle class and working class, who comprise the bulk of patients and lesser-skilled workers in the health-care system and who have little control over their medical treatment or work conditions. (2012, 109.)

Altogether, the political economist perspective views the power of medicine and power in doctor-patient relationships in relation to capitalist ideology, which is seen to be prevalent to medicine.

The third view on the power in medicine, the social constructionist perspective, is highly influenced by the works of Michel Foucault. The social constructionist perspective views the power in relation to the process of clinical examination, in which the power is perceived to be "everywhere" because of both the influence of the authority figure (the medical professional) and the individual's "unconscious self-surveillance". In the clinical examination the patient is both the object and subject of information, and the examination itself is seen as an apparatus of disciplinary power. The examination is typically a voluntary one, although Lupton notes that psychiatric institutions, for example, may use more violent means of surveillance on the body. However, in general the medical power is not seen only as repressive and punishing, but also as productive as it gives gratification for proper conduct. The social constructionist perspective views medical power as something necessary for the medical professionals to manage the medical encounters. This perspective is closely related to the critique of medicalization and the anti-psychiatrist perspectives I have discussed previously in this thesis, as both view medicine as means of social control which is one of the aspects of the social constructionist views as well. (Lupton 2012, 112-113).

Medicalization is by no means a straightforward issue; although it has brought help to many a patient by decreasing the "moral and punitive consequences" of some disorders by bringing forth "objective and therapeutic circumstances," it is still highly problematic (Zola 1972, 489). According to Conrad and Schneider, it is in the nature of medicine as an institution that it can "create its own demand" (1992, 15), and this raises a moral and ethical question as to whether medicine creates new diseases and disorders to boost its own power in society and the power of other branches related to it. One might question whether people are being treated for conditions that are absolutely natural,

but chosen to be deviant by an elite minority. Conrad argues that "what constitutes as a real medical problem may be largely in the eye of the beholder or in the realm of those who have the authority to define a problem as medical" (2007, 4). Medicine may create labels for human conditions that are not subject to the social and cultural norms, and in this sense, medicalization can be considered as a form of social control, which invades the body by means of diagnoses, medication, surgery etc. Zola, though arguing that medicalization has reduced some forms of punishment, adds that "punishments cannot be seen in merely physical terms, nor only from the perspective of the giver," meaning that some forms of treatment may feel like punishment for the ill individuals (1972, 489). Conrad and Schneider state that medical treatments have, indeed, become a "new form of punishment and social control," and that medical designations are the new social judgment (1992, 1, 35).

Although medicalization is oftentimes judged by whether or not its consequences have been effective, one ought to remember that there is a social side to the matter that occurs, as Conrad notes, "regardless of medical efficacy". The processes of medicalization essentially individualize and decontextualize a number of issues that would otherwise be regarded as collective social problems. (Conrad 1992, 223). Conrad and Schneider note some of the negative aspects of medicalization to be, for example, "the assumption of medical moral neutrality, […] depolitization of behavior, dislocation of responsibility, using powerful medical technologies, and the exclusion of evil" (1992, 248-252). Considering the power medicine has in our society, these accusations should be reviewed with particular concern. As there has been much discussion on the negative aspects of medicalization, one must note that its counterpart, demedicalization, has brought help to countless of people. Demedicalization happens when a problem loses its medical definition (Conrad 1992, 224). One of the most important examples of this is the demedicalization of homosexuality, which the American Psychiatric Association removed from the DSM-II (the Diagnostic and Statistical Manual of Mental Disorders) in 1973 (Conrad 1992, 225). By noting this I am not arguing that the phenomenon of demedicalization would be better than that of medicalization, but merely noting that

there have been several medicalized issues whose medicalization has clearly been used as a form of social punishment, and this proves many of the points made by both Szasz and Conrad and Schneider.

As one of the main interests of this thesis is in the field of psychiatry because of the aspect of mental illness in *4.48 Psychosis*, it is useful to consider some of the criticism psychiatry has encountered. Psychiatry differs drastically from other fields of medicine as the diseases it treats often carry severe stigmas in society. Even though the situation is slowly getting better, mental illnesses are still often not regarded as illnesses in the same way one would recognize for example cancer, heart and vascular diseases, or other such conditions that are perhaps more easily seen to be corporeal. Conrad and Schneider argue that medicalization may reduce this stigma by giving deviant, non-normative behavior an explanation as diseases, but taking note on Szasz who does not believe mental diseases exists, the matter becomes more complicated (1992, 247, 1977, 21). If one would agree with Szasz that there are no mental illnesses, labeling non-conformist behavior as a disease instead could not be considered as helping or aiding the people whose behavior is condemned by society, as the result of medicalization is in most cases some sort of treatment, which in this case would be unnecessary.

Szasz divides the psychiatric sector of medicine into two fields that differ in the way they view their patients. *Institutional psychiatry* is the field Szasz opposes to and that is the subject of his criticism. By institutional psychiatry he refers to the public domain of psychiatric health care, in which he claims psychiatrists have "full control," as opposed to *contractual psychiatry*, which happens in the private sector and is based on a "mutual contract" between the doctor and the patient (1977, 23-24). Szasz claims that institutional psychiatry is "the characteristic abuse of medicine," that abuses "both the human personality and the healing relationship" (1977, 25). He sees it is designed to "protect and uplift the group [...] by persecuting and degrading the individual" (1977, 25). Szasz argues that institutional psychiatry is "patently fraudulent, coercive, and harmful," but sees that as it has gained the support of "all classes, groups and organizations in our society" it

cannot easily be overthrown (1977, 92). Another substantial problem to institutional psychiatry, according to Zola, is the fact that it entails involuntary incarcerations and "concomitant removal of certain rights and privileges" (1972, 488). It will prove interesting to examine if the psychiatric and therapeutic encounters in *4.48 Psychosis* can be put under either one of Szasz's labels, institutional or contractual.

Now that I have discussed the connections between medicalization, mental disorder, and medical power in society, I will move on to a topic closely related to it, that is, the idea of medicalization of deviance. The medicalization of deviance means the medicalization of attributes that are considered *deviant* (consider, for example, alcoholism or addictions). The medicalization of deviance, just as medicalization in general, is a discursive process and highly contextual. The idea of medicalization of deviance is relevant to this thesis since, as discussed earlier on, critics such as Szasz argue that there is no such thing as mental illness, in which case all medicalization of the phenomena attributed to them would all fall under the medicalization of deviance. Peter Conrad and Joseph W. Schneider argue that deviance "consists of [...] categories of condemnation and negative judgement which are constructed and applied successfully to some members of a social community by others" (1992, 5). That is, deviance is a quality that is attributed to certain individuals by others, often more powerful individuals from inside a society. Conrad and Schneider argue that the medicalization of mental illness as deviant is "the original case" of medicalized deviance (1992, 38).

Conrad and Schneider define deviance in five essential qualities: it is a universal phenomenon, though always contextual. Deviance is a social definition, and the processes of defining deviance and sanctioning deviant actions always involve power. Deviant actions are often sanctioned and the deviant individuals judged, as this is the way in which societies reinforce their norms and ideals (1992, 5-7). Conrad and Schneider state that although the definitions and designations of deviance are contextual, medicine has the legitimacy to construct and promote its views on deviance over any national or social boundaries. Diseases and disorders have an

international applicability, which means that when something that is considered deviant is medicalized, this will become applicable everywhere. Zola argues that psychiatry has become the “most dominant rehabilitative perspective in dealing with society's 'legal' deviants” (1972, 488).

Since psychological disorders and some actions related to them are often considered deviant (for example self-harm), the medicalization of deviance is very closely linked to psychiatry. Psychiatry as an institution is pro-medicalization by its nature, because it thrives on mental disease and the unwanted behavior of people. When examining the issue of medicalization of deviance from the perspective of mental illness, one has to make a conscious choice as to whether they believe mental illnesses exist, and if so, what constitutes them. Some, like Szasz, argue that mental diseases are not something to be medicalized at all, and his critique is of use when deconstructing the idea of medical power and its effects on individuals.

The problem with the medicalization of deviance is that when medical personnel diagnose people, they might at the same instant convict the rest of their lives to oppression and stigma, especially in the case of mental illness. Because of this I have chosen to illustrate the problems of medicalization and especially the medicalization of deviance and mental illness to this extent. Szasz claims that the “language of clinical description” is but a rhetoric through which the patients are invalidated as “normal persons” but as mentally ill (1977, 29-30). He goes as far as arguing that psychiatrists can interpret “any behavior as a sign of [...] mental illness” and claims them to be “disciples” of ecclesiastic inquisitors (1977, 30-31). This kind of view makes medicine and medicalization seem like an institute of condemnation, which is surely a bit exaggerated. However, it is important to examine critically whether medicine labels non-conformist traits and behavior as mental disease. If this was the case, medicine could solely put all of the population under a medical label, for no one would fit the ideal or the norm.

Although one could easily imagine medicalization to be in the hands of medical professionals, this does not seem to be the case in the modern day. As there has been change in the field of medicine, so has there been in the processes of medicalization. Conrad argues that:

“the engines behind increasing medicalization are shifting from the medical profession, interprofessional or organizational contests, and social movements and interest groups to biotechnology, consumers, and managed care organizations” (2005, 10). Conrad notes that medicalization is “increasingly an international phenomenon [as] the result of the expanding hegemony of Western biomedicine,” but there have been significant changes in the players of the field of medicine. Although medicine is the only true authority on its subject, Conrad argues that physicians, albeit being gatekeepers to medical treatment, are now in a more subordinate position regarding medicalization.

Nowadays, the major actors in the processes of medicalization are pharmaceutical companies, who (at least in the Unites States) are now able to market their products, even prescription drugs, straight to the consumers, therefore being able to first market an illness and then providing a drug for it. Besides pharmaceutical companies, Conrad notes that consumers themselves have started to affect medicalization as a result of private medical markets. Perhaps the clearest example of this is the field of plastic surgery, but consumers affect the field by choosing different types of treatments, insurances, and hospitals for themselves or their families. It would seem that the market forces are gaining more ground in the field of medicine and the processes of medicalization, which is disconcerting because as Conrad notes, pharmaceutical companies are essentially corporations that hold responsibility to their shareholders, not the patients to whom their drugs are sold. (Conrad 2005, 3-12).

2.3 Feminist Criticism of Medicine

According to Susan E. Bell feminists have scrutinized medicine and medical science since the 1960s and 1970s, after the women's liberation movement and second wave feminism gained ground (1995, 469). It would prove more useful to talk about feminisms rather than feminism as a unified ideology, as there is a lot of differentiation of thought under the label 'feminism', but in this thesis the basis for feminism will be that which is generally considered as the third wave of feminism, that is, feminism that is influenced by postmodernism and poststructuralism and that is concerned with intersectionality and queer issues. The third wave of feminism began in the beginning of the 1990s and is considered to be the current wave by most theorists, although some argue that the era of internet has brought forth a fourth wave of feminism (Siegel & Baumgardner 2007, 16, Munro 2013, 23). As some of the feminist critiques of medicine have developed during the second wave of feminism, one cannot afford to disregard the earlier waves of the movement though the main ideologies and priorities have partially changed and developed since those times.

Bell notes that feminists critics have studied the ways in which medicine produces diagnoses and treatments, especially those harmful to women (1995, 469). As the question of whether and how diagnoses and medical procedures may affect the patient is one of my main research questions in this thesis, this type of feminist stand-point to medicine is a natural choice to add to the theoretical background of this thesis. Feminists have thoroughly discussed and theorized gender and sex, and as these notions are quite noteworthy when analyzing *4.48 Psychosis*, a feminist reading of the text will allow a more detailed analysis of these themes. Feminists have questioned medicine as an "agent of social control," quite like Szasz, Conrad, and Schneider, and claimed that it "supports hegemonic ideologies defining gender roles," as noted by Deborah Lupton (2012, 137-138). Lupton argues that medicine and patriarchy have traditionally seen feminine biological traits as the "basis for women's inferiority" and men as the norm for humankind, and therefore it is understandable that feminists have claimed a critical view to medicine and its practices (2012, 137-138).

Joanna Kempner argues that biomedicine has the "cultural authority to define what is biological and therefore natural," which is a feminist issue, because for many centuries the "natural" biology has been that of a "white, middle-class man" (2006, 633). As I have discussed earlier on in this thesis, medicine has the power to define what is deemed as "normal" and from a feminist standpoint this is problematic because these definitions may often be gendered. Kempner argues that medicine is, indeed, one of the prime forces of gendering of bodies, as "medical knowledge reifies the naturalness of gender dichotomies," such as male-female, strong-weak or big-small (2006, 635). Christine Adcock and Karen Newbigging have a rather intersectional view towards treating female patients in the context of psychiatry, and they present the idea of female patients being devalued in two different spheres, both "as a women, and as having a […] mental health problem" (1990, 172). In their view, women with mental health issues are oppressed through two different aspects of their life: their gender and their illness. This kind of intersectionality, and intersectionality in general, is very important to modern day feminist thinking because it exposes all the different ways through which people can be oppressed in their lives instead of just labelling people as either oppressed or not, thus deconstructing simple binaries. Intersectionality adds a scale to oppression, and it allows people to see how some people may be oppressed in different ways, and that people can have different amounts of oppressing factors in their lives. For example, one might be a woman, have a mental health problem, and be oppressed through her ethnicity, class, bodily abilities and so on.

Feminists have resisted medicine by arguing against one of the most profound terms used to categorize humans: sex. In the 1970s feminists had a breakthrough when the sex/gender distinction was made, labelling gender as referring to the socially and culturally formed self and sex to the biological self (Kempner 2006, 635). Later on feminists have argued that even the biological sex is a social construction, because it is based on oversimplified biological attributes such as genitalia and chromosomes (e.g. Butler 1990). People could have as easily picked up some other form of labelling each other, such as height, hair color or the size of one's foot to make up a similar category as sex is. Of course, sex is a binary definition based on the reproductive organs of females and

males that are necessary for the continuation of the human species, and is therefore not as random as my previous examples. Still, sex, like most categories, fails in terms of inclusion: not all human bodies can be strictly assessed to either the category of 'male' or 'female' (consider, for example, intersex and transgender individuals). Later on in this thesis the division between the body and mind will be further discussed, and the analysis will bring forth the question of the sex/gender divide and the issue of gender minorities.

Medical power and its patriarchal implications allow an interesting feminist stand-point to this thesis and particularly to the relationship between the characters, even though medicine is not straightforwardly patriarchal in the modern Western society. However, as Rosemary Pringle points out, medicine has historically been seen as a "masculine territory," and thus it has been linked with patriarchal power and control, and can be examined from such a perspective (1998, 25). For example, in Great Britain this has mostly been because in order to practice medicine one needed to attend university and hold a degree, but for the longest time women were not allowed to study at universities (Pringle 1998, 25). Though the patriarchal history of medicine is quite evident, especially psychiatry can be seen as being based on patriarchal constructions, where women have not had a place for themselves (Adcock & Newbigging 1990, 172). One must consider the gendered history of psychiatry, filled with cases of disorders only women seemed to suffer from, for example hysteria, and the fact that women could be incarcerated in mental hospitals with just a word from their husbands or male relatives. Bell claims that "medical science is uncertain and ambiguous, infused with cultural assumptions of gender," and it is by no means "objective and value free" (1995, 469-470). Adcock and Newbigging agree by discarding the idea of psychiatry as "neutral, value-free and thus beyond reproach" (1990, 173).

Although, as stated before, medicine is not a purely patriarchal entity in the modern day, it can still be regarded as an agent of patriarchy as it is clear that "cultural imagery of gender is projected into medical science," as Bell argues (1995, 471). The language and vocabulary of medical science both embodies and reinforces the norms and values inherent in society, also those

relating to gender, which results in medical science becoming a part of "creating gender" (1995, 492-493). As these norms, ideas and imageries become naturalized through medical science, it is clear that feminist criticism – or any other valid critique – of medicine is still needed.

Bell uses the example of feminine cyclicity (the cycles of menstruation) to prove her point, which also doubles as an example of how the natural states of female bodies can be controlled by medicine (standardizing of the menstrual cycle through hormonal drugs) (1995, 473). Female bodies are far more medicalized than male ones in regards to natural aspects of life (think, for instance, pregnancy, menopause, menstruation and pre-menstruation syndrome, whereas male bodies have mostly been medicalized since the invention of Viagra and other generic drugs targeted for the treatment of impotence). The fact that medicalization seems to target the lives of women more than those of men makes it a very valid and current feminist concern. Bell uses the example of a hormone DES, or diethylstilbestrol, given to women as treatment during pregnancy as a warning example of how the "truth" in medicine can be far removed from the world of research, and how this has affected the lives of women and their children in rather drastic measures (1995, 492).

In the past decades there has been a plenty of feminist critique towards psychiatry and its practices (e.g. Chesler 1972, Showalter 1987). Perhaps one of the most obvious problems has been "the over-presentation of women as patients in the mental health system," and thus the claim that women would suffer more from different mental illnesses (Coppock and Hopton 2000, 91). These claims are often supported by statistics, but as Coppock and Hopton note, the statistical data may often tell more about the institution and its practices than the actual situation (2000, 92).

I have chosen to include a feminist stand-point to medicine and psychiatry in this thesis because the nature of the play demands it. As the play has a universal female character as the patient treated by an equally universal, genderless doctor, the play can be seen as a dialogue between women and psychiatry. Besides, as the history of psychiatry has been less than benevolent towards women (think of incarceration by demands of relatives and the case of hysteria as

examples), I think it is important to study if these kinds of gendered attitudes can be still seen in the portrayal of psychiatric practices in literature.

3. Psychotherapy and Its Criticism

In this part I will examine the historical aspects of psychotherapeutic practices and see how they have evolved into the practices that are used presently. I shall briefly describe the different methods and schools of psychotherapy, and go through some of the criticism that is aimed towards the practice. This introduction to psychotherapy and its criticism is important so one can better understand the analysis of the psychotherapeutic sessions between the doctor and the patient that will be dealt with in chapter four. I have chosen to examine psychotherapy separately from medicalization and psychiatry, since psychotherapy is not necessarily linked to medicine, although it may be performed by medical professionals. Psychotherapy originally stems from psychology, not psychiatry or medicine, and although it is used for the treatment of psychiatric disorders, I shall discuss it in its own chapter in this thesis.

3.1 The Basis of Psychotherapy

Since the dominant medical discourse in *4.48 Psychosis* is a psychiatric one, it is important to examine the psychiatric methods used in the play before moving on to the textual analysis. The predominant mode of treatment used in the play is psychotherapy that occurs along with psychotropic treatment. As stated before in chapter 3, psychotherapy is not necessarily linked to psychiatry, but in *4.48 Psychosis* it can be argued to be a psychiatric method since the person performing it is called a doctor, which indicates them being a medical professional. This can, however, be problematized as the patient does not receive any diagnosis in the play, even after doing numerous tests that scan her mental state. This is could be noteworthy, as psychiatrists are usually the ones to diagnose their patients, not therapists. Whatever the professional status of the character of the doctor, psychotherapy differs much from typical, bodily invasive medical practices, and this is why it will be discussed separately from medicine in general in this thesis. As I am about to examine the doctor-patient relationship mostly based on their interaction in the patient's psychotherapy sessions, it is a good idea to outline some of the history and present of

psychotherapy and some critique surrounding the practice.

Psychotherapy is an umbrella term for numerous different types of therapeutic branches that have different aspects and solutions to the patients' treatment and possibly to the origin of their disorders. There are three major psychotherapeutic schools: the psychodynamic, the cognitive behavioural and the humanist/existential (Lawrence 2007, 73). The goal of psychotherapy is in its simplest sense to "alleviate human suffering and to facilitate individuals to realise their psychological and emotional potential" (Lawrence 2007, 72).

The origin of psychotherapy can be located in the hypnotism practised in the nineteenth century (Etchegoyen 2012, 3). The works of Jean-Martin Charcot, a neurologist who was one of the first to search for psychological causes for physical symptoms and the founder of the hypnotic treatment, inspired many famous practitioners of psychotherapy, such as Sigmund Freud (Hamlyn 2007, 6-7). Horacio R. Etchegoyen notes that psychotherapy is an "old art and a new science," stating that antecedents of psychotherapy can be found as early in history as the times of Hippocrates, but that the actual scientific practice we know today was founded later on in the 1900s (2012, 3-4).

Sigmund Freud can be seen as the modern father of psychotherapy as a scientific treatment, as he introduced psychoanalysis and formed the theoretical basis and practice for this new way of treatment often referred to as "the talking cure" (Hamlyn 2007, 7). Since Freud psychotherapy has been a "treatment directed to the psyche, within the framework of an interpersonal relation, and with the backing of a scientific theory of personality" (Etchegoyen 2012, 5). From Charcot's hypnotism Freud extended psychotherapy to include "free association," in which the patient could talk about whatever came to their minds (Hamlyn 2007, 8). Freud's essential concept of psychoanalysis was the *unconscious*, which one would normally have no access to except in dreams and slips of the tongue or pen, nowadays often referred to as Freudian slips (Minsky 1996, 3). Generally the thought of unconscious penetrating into the present is seen as an incident where one is not "themselves" because people do not consider this unconscious as part of their identities, but the

aim of psychoanalysis is to allow people to gain access to their unconsciousness or disassociated parts of their identities (Minsky 1996, 3, 11). In essence, psychotherapy is a method to treat a number of mental disorders or traumas through its base instrument, communication, with its framework being the doctor-patient relationship (Etchegoyen 2012, 5). The emphasis on communication as a means of recovery differentiates psychotherapy drastically from medicine.

Some of the most basic phenomena occurring in psychotherapy are *transference* and *countertransference*, which were found by Sigmund Freud and analyzed in his lecture "Transference" (Freud 1981, 494-495). Transference happens when the patient redirects or "transfers" some feelings or a relationship model from an important person in their past onto the therapist (Freud 1981, 494). The transferred feelings are usually originally felt in childhood, and most typically towards a parent. The reverse of this situation is called countertransference, and in this case the psychotherapist projects feelings from their past onto the patient. It is usually perceived that neither of these phenomena have anything to do with the actual persons of the patient nor the therapist, and they could be regarded as natural by-products of therapy. (Masson 1988, xx). Some critics, however, argue that transference is caused artificially by the therapeutic frame and setting and the heavy focus on the past of the patient (especially in psychodynamic therapy which is the modern heir of Freudian psychoanalysis) (e.g. Lawrence 2007, 88).

Ariel Watson compares the phenomenon of transference interestingly to that of a play, describing it as a "*tromp-l'oeil* fiction of the narrated/remembered trauma". In a sense, she regards transference as a sort of play acted out by the patient and the psychotherapist, and emphasizes its theatricality. (Watson 2008, 188). Watson points out that mental illness in general can be seen to have a "radical theatricality" embedded in it, explicit in all the processes of treatment (2008, 197). From this perspective a play about psychotherapy seems almost like a play within a play, reminding the reader of a Russian nesting doll, revealing yet another construct within a construct. If one would like to add even more layers to this, they could consider, for example, the idea of gender as a performance or social roles within the play (those of a patient and a doctor, a sick and a healthy

individual). Watson also notes the ideas of the “construction, performance, and perception of identity” and “the patient's performance of illness” (2008, 190). The idea of performance and play is particularly interesting when considering the subject of this thesis, a play about mental illness. In here we can first see the performance of the actors acting out the scenes of the play, and then on a more theoretical level the acts performed by their characters.

When considering psychotherapy as a treatment, it is important to understand that it is just that, *a treatment*. By this I mean that psychotherapy should not be considered as an absolute cure, as not all who are treated by its means benefit from it. Like any treatment that is targeted onto the body, also psychotherapy can fail in its attempts to aid the patient's psyche. Even the most promising studies on the evidence base of psychotherapy claim that around 75 percent of the patients significantly improved during longer periods of therapy and 50 percent in shorter periods (Epstein 2007, 53). There are, however, some links between the therapy and its possible outcome. The quality of the patient's participation is the most essential factor to the outcome of the process of therapy, but also the therapeutic bond between the patient and the therapist and the contributions of the analyst are important factors (Epstein 2007, 58).

Asay and Lambert (1999), have proposed there to be four therapeutic factors that are “the principal elements accounting for client change,” and have documented percentage roles of these factors in determining the outcome of the therapy (quoted in Epstein 2007, 61). The therapeutic factors and percentage roles are as follows: “client/extratherapeutic factors (40 per cent),” “therapeutic relationship (30 per cent),” “technique (15 per cent),” and “hope (15 per cent”) (Asay & Lambert, quoted in Epstein 2007, 61). It is perhaps rather surprising how big a percentage role they base on the patient and their lives alone (55 per cent), and how little on the actual technique and expertise of the therapist (15 per cent). Surely, when addressing the most uncomfortable and undesirable feelings and thoughts of the patient, it takes quite a lot from the patients themselves to be able to open up during therapy. Lawrence agrees on the importance of the “involvement and co-operation” of the patient but adds that any therapy is only as good as the therapist who offers it

(2007, 73). This becomes especially clear in *4.48 Psychosis*, as further chapters and analysis on the character of the doctor will prove.

3.2 The Criticism of Psychotherapy

I will now continue to examine some of the critique towards psychotherapy. This is to better examine and understand what it is in the process of psychotherapy in *4.48 Psychosis* that made it unsuccessful for the patient. Quite like the previous critique from the anti-medicalization theorists, Jeffrey Moussaieff Masson argues in his book *Against Therapy* (1988) that “a profession that depends for its existence on other people's misery is at a special risk [because] the very mainspring of psychotherapy is profit from another person's suffering” (1988, 251). This idea is quite similar to the critique of medicalization and medicine, claiming that soon everything could be medicalized and thus profited from by medicine and its beneficiaries, such as the drug market. Hence, the essential criticism remains the same for both medicine in general and psychotherapy: who has the power to categorize what is deemed as “normal” and what are the characteristics that do not fit into this category? However, the difference between medicine and psychotherapy lies in that psychotherapists do not make diagnoses unless they are also psychiatrists, and therefore they do not assign disorders to their patients.

While Masson’s work dates back some decades, the majority of his criticism is still valid. One of the main problems Masson sees in therapy is the therapists themselves, as he believes that therapists (either by accident or on purpose) will try to install their own values and structures onto the patients (1988, 240, 249). A particular problem Masson analyses, and which also arises in *4.48 Psychosis*, is the psychotherapists’ lack of interpretative abilities: Masson argues that therapists cannot apply their knowledge into the troubles of individual patients but that the patients have to fit into the theories the therapists are familiar with (1988, 240). Besides this, Masson has stated that each form of psychotherapy he has analysed (besides feminist and radical therapies) shows a lack of interest in physical and sexual abuse, and social injustice (1988, 240). Briefly put, psychotherapy

seems to be a mere extension of the dominant society and its norms (1988, 250). Masson argues that since psychotherapy depends on the suffering of people, the profession is corrupt by default, and he states that his criticism is aimed both to the profession of psychotherapy and individual psychotherapists (1988, 251).

Feminist scholars have criticized psychotherapy for many reasons. As stated before in chapter 3.1, Freud is regarded as the father of modern psychotherapy, and as Margaret W. Matlin notes, this creates an instant problem from a feminist stand-point since Freud considered women to be inferior to men in many aspects, the typically known phallic envy being only one of them (1987, 397). Besides the envy and shame the lack of penises cause women, they are also more narcissistic, masochistic and less morally developed than men. Freud also proposed arrogant ideas about female sexuality, such as that vaginal orgasms were a more mature way of handling one's sexuality than clitoral ones. (Matlin 1987, 397). Perhaps the most problematic feature is that Freud considered it necessary for the relationship between the therapist and the patient to be that of a dominant and a submissive, "a superior and a subordinate," adjectives which at the time could be seen as synonymous to that of a man and a woman (Chesler 1997, 138). As a result of this, Matlin argues that therapists from the psychoanalytic branch have negative views on women that affect the therapy given by them (1987, 47).

This kind of notion is close to that made by Phyllis Chesler, who has discussed the idea of *clinical bias* in her book *Women and Madness* (1997, 8). Clinical bias means that therapists may have double standards in their evaluation of mental health, favoring men who act out the stereotypical role of the man but disregarding women both performing in the traditional role of women and women who reject it, making mental illness essentially a gendered issue (1997, 103-108). The idea of clinical bias is also intersectional, including not only sexism but also the judgements clinicians make based on ageism, racism and homophobia (1997, 8). As one of the only things the reader is allowed to know about the patient in *4.48 Psychosis* is her gender, it will prove worthwhile to study what kind of a role she performs as a woman, and whether this might affect the

interpretations made of her by the character of the doctor.

Carl Rogers offers a more therapist oriented means of successful therapy: the ability of the therapist to be a "real person" with the client, the ability to accept their patient as "a separate person," and "real, empathetic understanding" (quoted in Masson 1988, 189). Lawrence argues that although a good therapist might inspire the patient to participate more, it is still up to the patient themselves to suffer through the process (2007, 73). Both the factors of successful therapy and the criticism of psychotherapy offer good ways to study the psychotherapeutic sessions in *4.48 Psychosis* and help one to analyze why the therapy did not help the patient. Etchegoyen notes that since psychotherapy helps people solve their "traumas, memories or conflicts" and is very personal in its nature, the ethics of it should not be regarded as "a simple moral aspiration but as a necessity". What is interesting in regard to my following examination of the doctor, the patient, and their interaction is that Etchegoyen argues that the psychotherapist cannot maintain "a dissociation between the profession and private life" because the personality of the therapist is their main tool of work. (Etchegoyen 2012, 11-12). It shall prove interesting to see whether the character of the doctor in the play maintains to separate their private life from their profession.

4. Identity, Medical Power, and Psychiatric and Psychotherapeutic Practices in *4.48 Psychosis*

In this chapter I will focus on Kane's *4.48 Psychosis*, and examine how the medical treatments affect the character of the patient, and analyze how she builds and shapes her self-image in the play both through and throughout her period of treatment. I am particularly interested in how her subjective experience of herself is intertwined together with the notion of being mentally ill, and in which ways does the illness affect her views of herself. I will also study the character of the doctor, and examine if and how the character and other medical professionals mentioned use medical authority and power over the patient, and how the doctor-patient relationship is realized in the play. *4.48 Psychosis* allows the reader a particularly interesting view to psychotherapeutic sessions, which would not be possible in real life because of the restrictions created by the requirements for confidentiality, and this allows one to examine both the doctor-patient relationship and the character of the doctor from a unique perspective. Besides analysis on the character of the doctor and the interactive elements of psychotherapy, I will also analyze if and how the negative effects of medicalization theorized by Szasz, Conrad, and Schneider could be seen in the play. The focus of this chapter will be on text analysis and close reading paired together with theories of medical procedure in the case of mental illness.

4.1 "Doctors you'd think were fucking patients": The Doctor-patient Relationship(s) in the Play

As I mentioned in the introduction to this thesis, the relationship between mental patients and their doctors is significantly different from that of a regular doctor-patient relationship in which the illness lies more straightforwardly in the body. Although mental disorders can, and often are, treated with different types of medication, it is still debatable whether the imbalances of the brain are a symptom or a cause to these disorders. Still, it should be noted that generally speaking mental disorders are regarded as diseases of the mind rather than the body, although this is slowly changing to the image of mental disorders as diseases of the brain. When treating psychological disorders, the relationship between the doctor and their patient is set on a rather different level as people with

psychological disorders are expected to open up to their doctors on their greatest failures, fears, and traumas, and because of this the relationship needs to be built on mutual trust and understanding. The chemistry between the parties also serves an important part of the success of the therapy. In chapter 3.1 I have presented statistics from Asay and Lambert that state that the relationship between the patient and their therapist accounts for 30 percent of the outcome of therapy. As the percentage is notable, it becomes a necessity to analyze the relationship of the doctor and the patient in *4.48 Psychosis* if one would like to understand why the therapy did not prove successful. Also, as the expertise of the therapist accounts for 15 percent of the outcome, it is essential to analyze this factor as well and examine whether the character of the doctor has the expertise and features of a medical professional.

Deborah Lupton argues that there is a myth-like understanding of physicians as “beneficent” and “god-like” beings, which is culturally and historically understandable in the light of how they have cured people and saved lives (2012, vii). Szasz agrees with Lupton on this, stating that psychiatrists are seen as “loving men” (notice the gendered pronoun) “who do great good for committed mental patients” (1977, 91). On a contrary note, Lupton also says that physicians are accused of “oppressing their patients, for malpractice and for indulging in avarice” (2012, vii). One can conclude that the general image of doctors and physicians is quite contradictory, to say the least. The accusations of avarice are most likely to be related to physicians' relations with the drug industry, and the claims that physicians benefit from prescribing certain brands of medicine to their patients. The question of prescription drugs is also present in this thesis, and it will be further analyzed in chapter 4.2.2. The “sociocultural artefact” that is medicine is subject to many contradictory ideas and beliefs (Lupton 2012, ix), and in the following chapters it will be scrutinized from the viewpoint of the psychotherapeutic encounters between a single patient and her doctor in *4.48 Psychosis*.

4.1.1 The Character of the Doctor as a Medical Professional

In *4.48 Psychosis* the character of the doctor is quite intriguing, not only because there is surprisingly no clue as to their gender, but also because there is no certainty of their actual profession.[2] As the patient refers to them as "doctor," it is most likely they are trained in medicine, and it could well be speculated that they could be a psychiatrist on the basis of the therapy sessions they are holding, as general practitioners do not treat their patients by means of therapy. The epicrisis of the patient would also indicate toward them being a psychiatrist, as psychotherapists would not probably have as extensive a knowledge on the medication of the patient. The only clue to the character being a psychotherapist is that they do not diagnose the patient even after having her do extensive tests to scan her state of mind.

Altogether there is not much for the reader to know about the character of the doctor, but some small details of their personal life are revealed during the patient's therapy. Considering the basis of therapy (i.e. a patient discussing their problems), it is rather curious that we learn anything at all about the doctor in these sessions, as those should be only about the patient, her disorders, and her issues. Although we do learn about the social and private life of the patient, too, it is sometimes hard to distinguish whether this information is factual or not because of the obscure and sometimes cryptic language of the patient, and the fact that we cannot be sure whether her speech is metaphorical. The reader is faced with the unreliable voice from the patient, mainly because of the fact that the patient is mentally ill, which could possibly affect her reliability in the sense that her sense of reality might be altered, as cognitive problems are indeed typical in disorders such as depression. The discussions between the doctor and the patient carry on almost through the entire play apart from the last few pages in which only the patient is speaking. There is only one part in which only the discourse of the doctor can be heard, and this is the epicrisis of the patient, or at least

[2] In this thesis, singular *they* is used when referring to the character of the doctor. As the choice of pronoun in this case would be highly political, I consider it best to use a gender neutral pronoun for the character. Singular they has been in use for centuries in the English language when the antecedent is indefinite, which is why I prefer it to the recently formulated pronouns for gender neutral use (see, for example, Zuber and Reed 1993). As the gender of the doctor is, in fact, indefinite, singular they fits the occasion.

a part of it, although some critics do argue that even here the reader witnesses the patient reading her own epicrisis because of the rude language and obvious irony present in the scene (2000, 223-225).

Though there is no indication as to the gender of the doctor, one can see the medical power they use as traditionally and stereotypically masculine, as medicine has a strong patriarchal history and also present, at least to some extent. Therefore, it is not particularly important to know the gender of the doctor, as the theories and practices psychiatry and psychology use are derived from mostly male theorists and practitioners of medicine.[3] Indeed, as Maye Taylor argues: "since the most current theory and practice is imprisoned with this patriarchal ideology, it is logically inevitable that psychotherapy partakes of that ideology, and therefore that it is permeated by sexism" (1990, 105). Phyllis Chesler also notes that the gender of the clinician does not matter as the institution of therapy is a patriarchal one (1997, 139).

It is interesting to consider that in most stagings of the play the doctor has been portrayed by a male actor, though there is no textual evidence to support that kind of a reading. Perhaps the casting directors have wanted to convey the image of patriarchal medicine, or maybe they have just read the character to be male because of this association between medicine and patriarchy. One could argue that the profession of medicine is culturally seen as so inherently masculine that there would not be even a question as to whether the character should be portrayed as male or not. Taylor states that psychiatry has been one of the components of the "subordination and oppression of women" and that women have "historically acquired the role of the patient" whereas "men have largely taken on the position of doctor" (1990, 104). Taylor also argues that this has led to an assumption of women as "mentally unstable" and men as "mentally healthy," and thus better suited to practice medicine (1990, 104). Maybe these kinds of reasons could explain or justify why both doctors in general and the character of the doctor in *4.48 Psychosis* are almost always understood to be male. This could also be linked with Szasz's lists of negative side-effects of psychiatric care,

[3] Consider, for example, some of the most famous theorists among the field: Sigmund Freud, Erik Erikson, Carl Jung et cetera.

since seeing the profession as so inherently masculine could be seen as a form of oppression.

I will now proceed to examining the character of the doctor as a medical professional in the play. The character of the doctor can be seen as problematic because it seems that rather than trying to help the patient, it seems the doctor is judging, patronizing and condemning her in numerous different ways, actions which could be read not only as harmful but also as patriarchal and oppressive. The most help they seem to offer is suggesting the use of psychofarmaceutical treatment, which the patient reluctantly accepts.

From the very first page of the play the interaction between the doctor and the patient is set on a slightly unsympathetic tone. The doctor seems to almost interrogate the patient numerous times throughout the play, starting from the first page, where they repeatedly question the patient on "what do you offer your friends to make them so supportive" (2000, 205, also repeated on pages 236-237). The idea that a mentally ill person would need to *offer* something to gain the support of their friends is quite unusual, and it makes relationships between people seem almost like a market in which there must always be a balance of giving and receiving. Surely, I do not claim that at least some of the basis of human relationships would not be based on this kind of a balance, but ill people should not be expected to offer anything in return for the support they are given. Although the question of the doctor seems quite cynical, it must be noted that this kind of a question could be seen as an attempt to try to get the patient to see the good qualities in herself that would make her friends want to support her in her time of need. This kind of action could perhaps motivate the patient to see herself in a different, more positive light, and also help her remember that she does have friends who are willing to help and support her.

Most of the interrogations of the doctor are not this ambiguous in their nature, but straightforwardly insensitive. Here, the word interrogation is used to underline how the doctor does not even try to reformulate their questions in order to help the patient answer, but blatantly repeats them to the patient until she is willing – or compelled – to answer. Considering the cognitive state of the patient as someone who suffers from depression, the doctor should understand that forming

coherent sentences analyzing her own state and thoughts can be difficult, and thus it might help that the doctor would assist the patient by reformulating their questions, asking different questions altogether, or just noting that the patient seems to have a hard time answering or finding the right words.

The character of the doctor continues their one-sided questioning of the patient by using the same questions several times in a row again in the next dialogue between them and the patient. The doctor first notes, “You are not eighty years old,” followed by the question “are you?” repeated twice, following with “or are you?” (2000, 211-212). Although the last questions could seem to allow the possibility of the patient’s original statement, her being eighty years old, it does not seem sincere in the context. In the following dialogue between them the doctor continues their questioning. Again the form of the question does change slightly, such as “did it relieve the tension” to “did it give you relief” (2000, 216). Although the form of the questions changes slightly in both examples, the doctor still uses the identical forms of the questions at least two to three times. This could be seen as a failure to understand the patient and see things from her perspective, because though the patient is either silent or denies the interpretations the doctor has expressed of her state, they continue asking the same questions over and over again, as if they were hunting for a specific answer that they could agree on and analyze in relation to their education. It becomes clear that the doctor does not allow any other interpretation of the patient's actions but their own, as after the patient has denied cutting herself giving her relief or relieving the tension and gives an explanation of her own, the doctor still states “Lots of people do it. It relieves the tension” (2000, 217), which erases the agency of the patient as an expert of her own feelings.

It would seem the doctor is so embedded in their education and conceptions of how mental disorders function and how mentally ill people act that they are not able to change their views even in the face of a contradictory case. Perhaps their education on the medical theories of mental disorders do not allow them to view these types of cases as “exceptions to the rule,” or maybe they just refuse to make changes to their own views altogether. Even the patient comments to the doctor's

questioning on her cutting with "I don't know where you read that, but it does not relieve the tension," pointing out the doctor's academic but not necessarily practical knowledge of mental illness (2000, 217). Ariel Watson argues that *4.48 Psychosis* discusses particularly the failure of psychiatry, and specifies that the particular failure in the play is that the doctor cannot see the patient as an individual but as a mere diagnosis that should conform to the typical patterns of the illness in question (2008, 189). Masson, whose theories I discussed in chapter 3.2, has also argued that the main problem in psychotherapy are the therapists themselves, mainly because he sees that they will try to impose their own structures and the structures of dominant society onto their patients, which is quite precisely what is happening in *4.48 Psychosis*. In chapter 3.1 I examined theories on psychotherapy by Lawrence, and according to her the goal of psychotherapy is to alleviate human suffering. It is clear that this goal was not reached either in the dialogues analyzed in this chapter or in *4.48 Psychosis* as a whole, as the patient seems to be suffering throughout the entire play.

Besides relentlessly questioning the patient, the quality of the therapy given by the doctor is quite questionable. They often patronize the patient and belittle her ideas and threats, not taking her seriously as a fellow adult. For example, the doctor comments on the patient cutting herself: "that's a very immature, attention seeking thing to do" and later on when she discusses her plans on committing suicide the doctor simply states that "it wouldn't work" (2000, 216, 210). The first quotation shows well the judgemental tone the doctor has towards the patient, added with downplaying her as "immature" and "attention seeking," adjectives fit for a child or a rebellious teenager. Even if the actions of the patient could be described as such, it is doubtful whether hearing these kind of words from her doctor would aid her situation. In essence, the character of the doctor is reducing the actions of the patient to those of someone who is clearly not equal to them in maturity. Watson argues that "the anxiety of the patient is a result of a sense of being judged or assessed" (2008, 190), and here I think the actions of the doctor only add to this. Cutting and self-harm are serious matters, and a doctor specialized in psychiatric issues should be able to handle

these kind of actions and situations better than by making the patient feel even worse about themselves by blaming them for their actions and by attributing the symptoms of depression to their personalities.

The second quotation about her suicidal plans shows how the doctor's attitude towards the patient as an adult capable of committing acts such as suicide as completely absent. It is obvious that a doctor should not encourage their patients to these kind of acts, but it is still notable that the only reaction to the patient's plan is a simple note that she would not be able to manage to commit suicide properly, although the patient has quite an extensive plan on how to commit the act ("take an overdose, slash my wrists then hang myself," 2000, 210). One would assume such a statement of hopelessness and severe depression from a patient might be met with fear for the patient's life, sympathy and understanding, and perhaps a plan on how to prevent the act from happening. In his book *The Suicidal Mind* Edwin S. Shneidman claims that about 90 percent of people who have committed suicide have been found to give verbal clues on their actions in a retrospective study, so any talk about suicidal tendencies should be taken very seriously (1996, 56). Prospectively speaking, only two to three percent of people talking about committing suicide will actually do so, but still one ought to be careful with a patient with such precise, infallible plan to kill herself.

In the end of the play, after one failed attempt, the patient does manage to commit suicide exactly the way she originally planned it, and so the indifferent response of the doctor could even be taken as neglecting the patient when she had clearly verbally stated her plans to kill herself. In the case of the patient the intention to kill oneself was evident and even the method thought out, and one might only wonder if hers was a case that could have been prevented by proper care and preventive measures. The reader cannot be sure whether the patient is already hospitalized when she is discussing her plans, so it is impossible to know whether (involuntary) incarceration could have prevented her suicide.

In this chapter I have examined how the doctor reacts to the patient's statements during their therapeutic session, but I have yet to analyze what the reader learns about the doctor in the play

besides the dismissive attitude towards the patient. I think it is important to study which facts of themselves the doctor allows the patient to know and which they decide to keep for themselves, not only because the doctor is not really supposed to tell anything about themselves and concentrate only on the patient, but also because it might help the reader to understand why they are acting as they are.

The reader does not learn anything about the personal life of the doctor until after halfway through the play, and even the patient states "I know nothing of you" (2000, 236). Until this point the doctor has tried to keep up the appearance expected from a medical professional, but in the last fourth of the play it seems they have a slight mental collapse of their own. There is a harsh confession from the doctor, stating that they "fucking hate this job" and that they need their "friends to be sane" and "really together" (2000, 237). From the same page we also learn that the doctor has a lover, something that is known about the patient, too, but with her this information cannot be fully confirmed. The doctor does apologize for their behaviour, saying they were trying to "explain..." and the reader can connect this to the fact that on the previous page they were trying to explain the state of their relationship with the patient and that it is only professional (2000, 238). The personal, confessional mode of the doctor allows the reader to understand that they are not acting fully professional with the patient, and with this knowledge paired with the previous analysis on their behaviour during therapy the reader can start to question other aspects of the therapy they are providing as well.

Although the doctor tries to convince the patient – and perhaps themselves too – that their relationship is purely professional, some of the doctor's reactions towards the patient's distress almost invite the reader to believe the doctor cares for the patient in a way that is more than just professional. For example, the doctor tells the patient there is nothing to worry about because "I'm here" and tells her "I like you [and] I'll miss you" (2000, 228, 237). These exemplify how the doctor crosses the line between the "professional relationship" they think they have with the patient (2000, 237). The doctor's opinion of their patient should not matter, only the fact that they are getting better

because of the treatment given to them. These kind of statements from the doctor seem a bit suspicious, especially if one were to read the character as a representation of the male aspects of medicine. Patients should be able to heal in therapy, not wonder about what their doctors might think about them. One might wonder what is the doctor's objective to say such personal things: perhaps they are infatuated with the patient, perhaps simply ignoring the guidelines of professional behavior, or maybe trying to convince the patient that she is well-liked because they themselves like her and therefore she should feel better about herself. Whatever their objective, the behaviour of the doctor is undoubtedly affecting the patient in a manner preventive of her recovery. It is hard to see the character of the doctor as a "supposedly morally neutral and objective expert" as Zola claims doctors are generally seen, because it seems their personal life is tangled with their professional one (1972, 487).

We can conclude that the doctor's attitude towards the patient is quite questionable, and so is their relationship to her, and the way they handle themselves as a medical professional. On the other hand they seem to clearly want to distance themselves from the patient as a medical professional doing their job, but on the other they seem to use their fondness of the patient as a sort of reason for their knowledge that the patient will eventually get better. To get back on Szasz's list of the negative side-effects of psychiatry, it would be possible to apply at least stealing of personal dignity to the actions of the doctor, since they actively belittle the patient and sometimes seem to forget that she is suffering from a severe mental illness and treating her as if her cognitive abilities were fully intact. This in itself is rather contradictory: on the other hand they are claiming the patient to be immature, on the other they are expecting full cognitive abilities and mature actions from her. This could make the patient feel even worse about themselves, maybe even that she would not be smart enough to answer the doctor's questions, and this could be seen as an oppressive action, as it makes the patient feel inferior.

Considering Conrad and Schneider's critique on medicine (discussed in chapter 2.2) and Masson's critique on psychotherapy (discussed in chapter 3.2) that claim that both medicine and

especially psychotherapy are dependent on the suffering of people in order to gain profit, one might wonder if this kind of thinking could be applied to individual doctors or therapists. If a patient would not recover from their illness, it would mean a longer therapeutic relationship, and therefore more work for the doctor or therapist in question. This seems like a rather bleak scheme, but in essence it is the main argument of Masson's criticism. Regarding Szasz's distinction between institutional and contractual psychiatry (presented in chapter 2.2), it would be hard to see the therapy given by the doctor as anything other than institutional. It seems the doctor is quite contradictory, sometimes even confrontational in their actions, and understandably this affects not only the doctor-patient relationship and the patient's recovery process, but also the way the patient sees her doctor, which is what I shall examine in the next chapter.

4.1.2 The Patient's Attitudes towards Her Doctor(s)

I have now examined and analyzed the actions of the doctor towards the patient in their therapeutic relationship and their actions as a medical professional, and will now proceed to study how the patient feels about her current and previous doctors. Although the play concentrates on the current therapeutic relationship between the patient and the doctor, the patient does mention some of her previous doctors, too. These previous doctors are not characters in the play, merely mentioned in the discourse of the patient. One might want to argue that the patient's opinions of her doctor would be of vital importance to the success of therapy as the Asay and Lambert statistics I presented before in chapter 3.1 gave such importance to the life and attitudes of the patient in regards to the outcome of therapy. As the client themselves and/or extratherapeutic factors can account for up to 40 percent of the outcome of therapy and the doctor patient relationship up to 30 percent, it is evident that these themes need to be analyzed in regards of the play. As the patient's attitudes towards their doctor can result from other factors than the actual relationship between them, such as their previous experiences with other doctors, one needs to consider both the extratherapeutic and therapeutic factors.

On many occasions the patient's attitude towards her current doctor seems overly affectionate and the patient seems to be quite invested in their ability to cure or save her. This is shown in many of the patient's statements, such as: "I trusted you. I loved you," "I beg you to save me from this madness that eats me," "I came to you hoping to be healed," "you are my doctor, my saviour, my omnipotent judge, my god, the surgeon of my soul" and "you are my last hope" (2000, 209-210, 226, 233, 236). It is evident that the patient has high expectations of her doctor, which could be explained by the patient's experience that her current doctor is the first that has truly cared about her well-being. This is shown in statements such as the following: "the only doctor who ever touched me voluntarily, who looked me in the eye, who laughed at my gallows humour […] who took the piss when I shaved my head" (2000, 209).

A significant factor when considering the citations of the patient is that she seems to have an understanding of her healing or recovery as something the doctor would do or perform on her rather than herself taking an active part in it as one does in therapy. This is quite an essential clue if one is to examine why the patient does not seem to benefit from her therapy. Overall, it should be noted that the patient's feelings on the care and treatment of the doctor may not be on a fully – or at all – professional level, but I will examine that issue further later on in this chapter. However, it is evident that the patient considers her current doctor to be somehow different than her previous ones, as she states "I was believing that you were different" (2000, 210). It seems as the doctor was the first one to actually take interest in her or seem like a trustworthy medical professional, as her previous doctors are described as:

> Inscrutable doctors, sensible doctors, way-out doctors, doctors you'd think were fucking patients if you weren't shown proof otherwise, ask the same questions, put words in my mouth, offer chemical cures for congenital anguish and cover each other's arses. (2000, 209)

The citation is interesting, because as analyzed in the previous chapter 4.1.1, also her current doctor seems to be asking the same questions repeatedly and their involuntariness to accept the patient's answers could be seen as "putting words" into her mouth. The patient also receives medication during her treatment with the current doctor. The patient also comments on her previous doctors: "A

room full of expressionless faces staring blankly at my pain, so devoid of meaning there must be evil intent" (2000, 209). This memory of doctors being so clinical and coldly professional that the patient is no longer sure if they are there to help her helps the reader to understand why the patient seems so fond of her current doctor, one that shows emotion towards her, as examined in the previous chapter.

Although it would seem the patient is content with her current doctor, she does indicate very early on in the play that she does realize that all doctors are in essence the same, and that her current one is only slightly better than her previous doctors. It might be that she feels this way because she has formed an emotional bond to them. After stating her love for the doctor ("I loved you"), she makes it known she knows the doctor is lying to her ("who lied and said it was nice to see me") and continues on a cruelly realistic note: "it's not losing you that hurts me, it's your bare-faced fucking falsehoods that masquerade as medical notes" (2000, 209, 210). Also, quite alarmingly she states: "You know, I really feel like I'm being manipulated" (2000, 215), which could be read as the patient actually criticizing the doctor's abilities as a therapist and their professionalism as well.

The patient does indeed seem to have quite a contradictory view on her current doctor, and the feelings she expresses could be seen as evidence of a love-hate relationship. On the one hand the patient seems infatuated or even in love with her doctor, on the other she seems to detest them. The patient's feelings are, however, quite understandable given the doctor's own actions that reflect the same sort of attitude towards both their patient and their profession, mentioned in the previous chapter. Mixed feelings aside, it would appear the patient is hopeful for her treatment with her current doctor, who she seems to hold in an almost god-like position with a unique ability to cure her (compare with Lupton's commentary on the image of physicians in chapter 4.1), but then again she does realize the doctor has no personal interest in her and that for them she is just another patient to be treated. Still, the patient states: "of course I love you" and "I've always loved you, even when I hated you" (2000, 240).

There are a few parts in the play in which the reader cannot be sure whether the patient is

talking about the doctor or someone else, but I am inclined to think she is talking about her current doctor in at least some of the cases. This is because the patient is clearly addressing someone ("you") when she speaks, and because the layout of the page gives the impression of a single-sided discussion (first the patients speaks, then a "silence" takes place, and this turn-taking continues throughout these pages) (2000, 214-215). The reader can understand the silence as the doctor's part or response in the conversation because there are other parts in the play where his turns in conversation are marked in a similar manner (e.g. 2000, 211, 217), and there are also cases where the same "silences" equal as the patient's parts in a conversation (e.g. 2000, 205, 212). From the examples it can be noted that the silence is not only a pause in a monologue, but a pause that is appointed to a certain person, in this case, the doctor. When these passages are understood as being addressed to the doctor, the reader is allowed an even deeper understanding of the contradictory and almost disturbing nature that lies in the patient's view of her doctor.

Indeed, when explaining how she feels about her current doctor, the patient seems to be in agony:

> Sometimes I turn around and catch the smell of you and I cannot go on I cannot fucking go on without expressing this terrible so fucking awful physical aching fucking longing I have for you. And I cannot believe I can feel this for you and you feel nothing. (2000, 214)

I think these lines alone could express what is essentially wrong with the patient's image of her doctor. It is obvious that the patient does not regard the doctor as a mere physician but she has formed some kind of an emotional bond for them, although a single-sided one. As the actor Daniel Evans has noted in his interview with Graham Saunders, it seems there is an "incredible craving to find the beloved" and that the "unbearable" for the patient is that her love is not reciprocated (2002, 173). As the patient has no one for whom she could express her love, it would seem as if she is overflowing with the emotion, but not in a positive sense but rather in the sense of almost drowning in the excess of it ("I cannot go on without expressing this terrible so fucking awful psychical longing I have for you" 2000, 214). On the one hand the reader gets the feeling that for the patient the presence of the doctor would be essential for her well-being, but on the other hand there are

quite a few points in the play where she seems to despise them. For example, she refers to her doctor (and everyone else, for that matter) as a “stupid mortal cunt,” which is hardly an expression of love (2000, 210). Another extreme example is presented when during a therapeutic session the patient threatens the doctor as she is anguished by the anger and pain of how awful a person she is: “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” (2000, 227). The citations analyzed here allow the reader to further understand the idea of how extremely the patient’s emotions of love and hate for her doctor truly alter, and also how disturbing the doctor-patient relationships seems from the patient’s perspective.

Since parts of the play, particularly those in which the doctor and the patient are interacting, can be recognized as psychotherapeutic sessions, it is important to consider one of the most typical phenomenon that occurs in the doctor-patient relationship during psychotherapy. As I have mentioned before in this chapter, the patient seems to have a rather contradictory attitude towards her doctor, stretching from feelings of love and longing to contempt and hate. As I have explained before in 3.1, transference is a typical occurrence in psychotherapy, and the reader might wonder if the extreme reactions of the patient could stem from this phenomenon. The act of transference might explain some of the emotions the patient has for the character of the doctor, but the reader cannot be sure of this as no previous relationships of the patient are discussed in the play, apart from three mentions of a lover (“my lover is dying,” “I shall hang myself to the sound of my lover’s breathing,” “I am jealous of my sleeping lover,” 2000, 207, 208). However, the feelings the patient directs towards the doctor seem to fit into Freud’s descriptions of transference. Freud states: “transference can appear as a passionate demand for love or in more moderate forms; in place of a wish to be loved” (1981, 494). Indeed, the patient states “the vital need for which I would die” several times, each time addressing love as this most essential of all her needs (2000, 219, 242). Freud also notes that: “the hostile feelings as a rule make their appearance later than the affectionate ones and behind them: their simultaneous presence gives a good picture of the emotional

ambivalence," and adds that "the hostile feelings are as much of an indication of an emotional tie as the affectionate ones". Freud states that transference is not something to be worried about unless it becomes a hindrance to the process of psychotherapy. (1981, 494-495). In the case of *4.48 Psychosis* the reader might wonder whether the transference of the patient has become an obstacle for the process of therapy, and if this might be why the patient does not seem to benefit from her treatment. However, with no indication of past relationships of the patient, this could merely be recognized as an educated guess.

Although it seems the emotions and feelings of the patient are directed towards the doctor as a whole, a single persona the patient has created of them in her mind, it is interesting that the patient is aware of the contradiction between her doctor as a medical professional and as a private person. When the patient states "fuck you God for making me love a person who does not exist," this becomes evident to the reader (2000, 215). As the patient realizes she has fallen in love with the image she has of the doctor rather than an actual person, she suddenly realizes her love is without foundation. However, as the doctor themselves has given the patient numerous clues that they might be interested in her more than professionally, it is understandable that the patient might have felt confusion between the professional and the private, the doctor and the actual person.

Now that I have examined the patient's views on her doctors, I will proceed to analyze the patient's attitudes towards her treatment as performed by both her previous doctors and her current one. In this part I will only consider her treatment in an interactive context, as I will examine the more impersonal and generic methods of treatment in the following chapters. Earlier I explained how the silences in dialogues can be addressed both as the doctor's and the patient's responses or turns in conversation, but I think these silences also hold an important meaning as the patient's responses to her treatment. As the main element of psychotherapy is discussion, silence could be regarded as resistance to the treatment. It could also be read as the patient not finding the right words to discuss her state, but seeing the silences as a form of opposition would fit the context better, as most of the play is filled with just the patient talking and it seems that not being able to

speak is not a particular concern for her, even if her utterances made no sense. One could argue that the patient would not be silenced by her doctor until she would specifically want to remain silent, as she seems quite self-reflexive about her life and her mental state throughout the play. Watson argues that the silences could be regarded as “a means of resisting the theatricality of the therapeutic encounter” (2008, 194). She elaborates:

> It is a refusal to act within the script of expectation and diagnosis, an assertion of the individuality of each case, each patient, each subjectivity. As such, it is accompanied by the refusal to show wounds (psychic and real), to act for the spectators – the medical profession and society. (2008, 194)

Watson adds that “the patient persona's unresponsiveness also mirrors and co-opts the conventional use of silence by therapists, putting the pressure of speech and elaboration on the observer” (2008, 195).

Indeed, when the patient remains silent the persona of the therapist becomes exposed as they have to continue the conversation in order to be able to continue the therapeutic session. Under this pressure of speech the mindset of the therapist becomes evident as they have to go on elaborating and explaining what they meant so that the patient would understand and eventually react to their speech (same, of course, happens the other way round in typical therapeutic sessions). Watson notes that the silences in the therapeutic environment can be regarded as a power play of sorts, and argues it is precisely this “power play of silence” that characterizes the therapeutic encounters between the patient and the doctor (2008, 207). The idea of the therapeutic encounter as having a power play is rather interesting, as in this thesis some of the emphasis has been on the power granted by the medical profession, but in this case both the patient and the doctor are presented with equal opportunities to control the situation. Especially interesting is that in this case the power seems to emerge from ostensible passivity, the act of remaining silent. However, one might still argue that the patient has no true power in the situation as she needs to be treated and preferably cured of her condition. As the patient states: “no way to reach out / beyond the reaching out I’ve already done,” the desperation of her situation becomes obvious (2000, 238). Essentially, the patient states that the psychiatric treatment she is currently invested in is her proverbial last straw, the last possible

method to be healed.

What one needs to remember when analyzing the play is that the behavior of the patient is affected by her mental illness, and because of this we cannot blame her for her actions and attitudes as we cannot know to what extent it is of her own nature and to which her illness. Considering the patient as a mentally unstable person reminds the reader of the responsibilities of the doctor, which in the play they have seemed to forgot, at least partially. Giving the patient mixed signals of their emotions towards her and allowing her to form an emotional bond to them beyond what is considered a healthy and professional doctor-patient relationship is quite questionable. It is understandable the patient would turn to her doctor in her time of need, but it is the doctor who should be able to draw the line to their relationship. As no clear line is drawn, it has resulted in the confusion of the patient, and perhaps even in the worsening of her state.

4.2 Psychiatric and Psychotherapeutic Methods

In the previous chapter I have analyzed the relationship between the doctor and the patient and the interactive aspects of her treatment, and will now proceed to examine and analyze the more generic, impersonal aspects of the treatment, namely psychiatric medicine and different types of tests used for scanning mental disorders. In *4.48 Psychosis* the patient receives different types of medication and she does different sorts of tests that help evaluate her mental state, and in this chapter I will examine how these are significant to both the patient's well-being and her image of herself as a mentally ill individual. As the doctor does not diagnose the patient during the play, these tests help the reader understand what sort of mental states the patient has in different parts of the play and what kind of a disorder she is suffering from.

Both the psychiatric test and the medicine prescribed for the patient can be seen as results of the medicalization of mental disorders, as without the process of medicalization there would be no need for such diagnostic measures as the tests or such options for treatment that the drugs represent. Since both the tests and drugs can be seen as results of the medicalization of mental illness, it is particularly important to study how these affect the patient as it provides information on how medicalization can affect people on an individual level. One must notice that the representations of psychiatric methods of treatment and their effects on the character of the patient exemplified in *4.48 Psychosis* are fictional, and therefore the results of the analysis found in the following chapters cannot be generalized in a universal manner, but they can be treated as examples of how medicalization and medical power could affect individuals and how these effects are represented in drama and literature.

4.2.1 Psychiatric Testing

In psychiatry and psychotherapy, there are several types of tests medical personnel can use for screening depression and other mental disorders in their patients. Often these tests come in forms of different types of questionnaires that either the medical professional or the patient can fill in. Most

of these tests are in textual form (unless they are spoken out loud by the medical professional), and most often they include questions that are answered along a scale. When answering these tests, the patient can often predict what sort of an outcome the test will give about their current state as they are often quite simple and the answers can have, for example, different numbers that are easy to connect to the final result of the test. An example of this will be given in the case of the Beck Depression Inventory that will be analyzed later on in this chapter.

Different types of psychiatric tests are often used in addition to verbal information given by the patient during the therapy, but they are especially useful when one needs to assess the state of a patient quickly. The tests can also be used as a quick way of diagnosing different disorders, and they are especially useful when assessing the severity of a disorder the patient is already known to have. Remaking of these tests can also be used as indication of whether the patient's state has gotten worse or better by comparing their previous and current results. The fact that psychiatric tests can be used for diagnosing makes them particularly interesting for the analysis of *4.48 Psychosis*, since this allows the audience or the reader to diagnose the patient themselves. These types of tests also serve as clear examples of the medicalization of mental disorders, as they bring forth the act of assessing and diagnosing a mental disorder to a patient.

In *4.48 Psychosis* the psychiatric tests become evident in the text itself, as the patient evaluates herself through them. Oftentimes these tests are not recognized as such by critics, and therefore I consider it important to bring out the medical nature of these “list of numbers of unknown significance” or “random spread of numbers” (Urban 2001, 44, Rees 2012, 132). There are long passages in the play in which the patient lists her answers to the tests, and these are intertwined with her own verbal assessments of her state. In the very beginning of the play the patient is citing her answers to, or currently answering, one of the most used tests for screening depression, the Beck Depression Inventory (BDI or BDI-II for the newer version). The BDI was created in 1961 by Aaron T. Beck et al., and it uses 21 questions which have four different answers each, all scoring the answers from zero to three points. The basic premise of the test is the more

points one gets, the more depressed they are (the results range from zero to 63).

Some of the citations or answers of the patient differ slightly from the original BDI form, and she does list some things that are not in the BDI. However, it is clear that at least to some extent she uses the BDI or BDI-II as a basis of evaluating herself and her state. Compare the following statements from the patient to those of the BDI and/or BDI-II. Here are the statements of the patient:

> I am sad
> I feel that the future is hopeless and that things cannot improve
> I am bored and dissatisfied with everything
> I am a complete failure as a person
> I am guilty, I am being punished
> I would like to kill myself
> I used to be able to cry but now I am beyond tears
> I have lost interest in other people
> I can't make decisions (2000, 206)

Here are the same statements from the BDI (where the form of the patient matches the BDI-II better, I have used that and marked it with an asterisk):

> I am sad all the time* [or] I am blue or sad all the time and I can't snap out of it
> I feel that the future is hopeless and that things cannot improve
> I am dissatisfied with everything
> I feel I am a complete failure as a person (parent, husband, wife)
> I feel quite guilty [or] I feel guilty about many things I have done or should have done/I feel guilty most of the time/I feel guilty all the time*
> I feel I am being punished or will be punished
> I would like to kill myself*
> I used to be able to cry but now I can't cry at all even though I want to
> I have lost most of my interest in other people and have little feeling for them [or] I have lost all my interest in other people and don't care about them at all
> I can't make decisions any more without help [or] I can't make any decisions at all anymore (Beck et al. 1961 and 1996)

As one can see, the statements are almost or completely identical between the patient and the BDI or BDI-II, which supports my argument that the patient is evaluating herself at least partly through the means of her treatment, particularly through the psychiatric tests that are used on her.

Different types of tests are perhaps the clearest parts of the treatment from the viewpoint of the patient, and they can often be easily understood without extensive knowledge of medicine, psychiatry or psychotherapy. Unlike the notes made by medical personnel, the tests provide

methods of assessing one's illnesses that are both available for the patients and possibly even easily understandable (for instance, the BDI(-II) where the amount of points corresponds to the supposed amount of depression). Here, if one would analyze the answers the patient has given, her result of the test questions that are answered in the play would range from two to three, but being mostly threes, which would indicate severe depression. As the part resembling the BDI(-II) is on the very first pages of the play, it sets the tone for the patient's condition for the rest of the play. Positioning the BDI(-II) on the first pages of the play is an interesting choice, since there is no actual diagnosis present in the play, but the condition of the patient has to be interpreted through her answers to the psychiatric tests appearing in the play. The only actual mention towards a diagnostic state is in the title of the play, *4.48 Psychosis*, however, one should note that psychosis in itself is usually a symptom in a disorder rather than a diagnosis itself (e.g. psychotic depression, different psychotic disorders).

What I consider significant in the passage in which the patient in answering the BDI(-II) questionnaire, is that intertwined with the answers to the actual questionnaire are some of the patient's own assessments of her state, such as: "I am fat," "I cannot love," "I cannot make love," "my hips are too big," and "I cannot be alone" (2000, 207). It would seem the patient adds her own analysis of why she is as depressed as she is, and does it in the same form as her answers to the questionnaire. The patient's own added commentary turns the impersonal questionnaire form from "faceless to the particular," highlighting the patient's own experience and narration of her depressed state (Claycomb 2012, 102). Perhaps her own additions could even be regarded as her way of letting the doctor know about the issues she would like to discuss or what she thinks the doctor should be pointing their attention to instead of the questions of the questionnaire. If one would take this reading, it could be elaborated to an understanding of the patient trying to take agency in regards to her own treatment, or even as the patient trying to fight against the methods of the therapy and/or the therapist. This could be supported by the oppositional silences analyzed in chapter 4.1.2, which could also be read as taking agency in the psychotherapeutic treatment.

Another typical method of assessing the mental state of a patient is the Mental State Evaluation, or the MSE. Unlike the BDI(-II) which is quite typical a test in its textual form and multiple choice answers and gives an answer to whether or not the patient is depressed, the MSE offers a sort of brief summary of the person in question as a whole, a “snapshot of a patient’s behavioural and psychological functioning”. The MSE includes the patient's appearance, behavior, mood and affect, speech, cognitive state, thoughts and their content, and abnormalities in perception, insight, and judgement. (Goldberg & Murray 2006, 64-68). There is also a shorter version of the MSE called the Mini-mental State Examination. What is important in both of these in regards to *4.48 Psychosis* is that both of them use a test for screening cognitive abilities, particularly concentration, called *serial sevens*. The test in serial sevens is simply counting backwards from 100 in series of seven (100, 93, 86 etc.). The test can be used for different kinds of purposes: besides screening for cognitive effects of mental disorders, it can be used for example to evaluate the severity of head trauma. When analyzing the serial sevens test, the medical professional should take note of both the answers (are they correct) and the time it takes for the patient to give the answers (Goldberg & Murray 2006, 68).

In *4.48 Psychosis* there are two parts in which the serial sevens is used. The first time this occurs in the beginning of the play, the patient cannot get the counting right, and the numbers she utters are in no particular order: “100, 91, 84, 81” etc. (2000, 208). This numeric indication of her state would allow the reader to interpret that she may not be at her full mental capacity. Her fail on the serial sevens may be caused by a decrease in her cognitive abilities, which is typical during depression. Besides failing the serial sevens test, the numbers are presented in a cloud-like layout on the page, which further indicates a sort of scattered sense of the patient's mind-set. The first time the serial sevens appears in the play is very early on, and one can assume that in the beginning of the play the mental status of the patient is quite poor, based on the serial sevens test, the BDI(-II) test analyzed earlier, and the fact that she talks about committing suicide (“I have decided to commit suicide,” “I have resigned myself to death this year” (2000, 207-208). Although serial

sevens is not by itself a diagnostic device, it still provides valuable information about the cognitive state of the patient.

When the serial sevens occurs the second time towards the end of the play, the patient does get the counting right, and this time the numbers are neatly placed one below each other, emphasizing the clearness and organized nature of her mind at that moment. The second time the serial sevens occurs in the play it is preceded by a scene which is highly fragmented in form and content, giving indication to the shattered mind-set of the patient at the time. The placement of the second serial sevens test is best described by the citation in the scene following it, “Sanity is found at the centre of convulsion, where madness is scorched from the bisected soul” (2000, 233). If one was to take the correct answers to the serial sevens as proof of “sanity,” it would indeed be found just after one of the most fragmented and incoherent scenes in the play, after which the patient starts to sound more lucid, talking about recovery with the help of her doctor. After the second serial sevens the patient states: “I know myself / I see myself” (2000, 233), indicating that the result of the serial sevens correlates to the lucidity of her mind.

The patient in *4.48 Psychosis* often gives long lists of depictions of her mental and physical state (e.g. 206-208), and these provide an important means of understanding how she sees herself and her illness. Particularly important are the parts where her self-assessment intertwines with medical models of assessment, because it helps to confirm my hypothesis that psychiatric care affects the self-image of the patient in ways that cannot simply be classified as recovery. As the self-reflective abilities of the patient often develop during therapy, they can start thinking about themselves and their current mental states through the means used in the therapeutic sessions. They can evaluate their mental well-being using the same tests used by medical personnel and in this way the treatment may affect their lives more permanently. Of course, the knowledge and understanding of the self that is essential to therapy will also remain with the patients. This differs greatly from the possibilities of evaluating one's physical well-being because analyzing even the most basic medical test, such as a blood test for example, takes extensive medical knowledge gained from education in

the subject.

Although the last questionnaire or test I shall introduce is not one commonly used in psychiatric or therapeutic practices, it is worth mentioning because of its significant relation to the content of the play. In *The Suicidal Mind* (1996) Edwin S. Shneidman discusses the Murray Need Form, originally developed by Henry A. Murray in 1938 (1996, 18-20). The basis of the Murray Need Form is a list of twenty basic needs people have, and it works by each individual rating the needs they have from the most important to least important. Individuals rate each need with a score they see fit from a scale of 0 to 100, so that the entire score of all their needs add up to 100 (e.g. one might rate the needs to achieve something as 20, the need of admiration and support as 5 etc.). The number assigned to each need correlates to the person's desire to attain it, and the higher the number, the more crucial the need is. This also means that the order in which different needs are placed is not important, only the numbers reflecting the importance of each need. In his book Shneidman uses the Murray Need Form in rating the most important needs of patients that have tried to commit suicide in the past, and showcases how the different needs of people affect their actions, and how this should be taken into account in their psychotherapy.

In *4.48 Psychosis* the patient lays out a list of needs, some of which are almost or completely identical to that of the Murray Need Form. Consider the following content, the first one from the patient's list and the second from the Murray Need Form:

> To overcome obstacles and attain high standard
> To overcome opposition
> To have control and influence over others
> To defend myself
> To defend my psychological space
> To vindicate the ego
> To excite, amaze, fascinate, shock, intrigue, amuse, entertain or entice others
> To be independent and act according to desire
> To obliterate past humiliation by resumed action
> To feed, help, protect, comfort, console, support, nurse or heal
> To be loved (2000, 233-235).

> To accomplish something difficult; to overcome.
> To overcome opposition forcefully; fight, attack.
> To control, influence, and direct others; dominate.
> To protect the self and one's psychological space.
> To vindicate the self against criticism or blame.
> To excite, fascinate, amuse, entertain others.
> To be independent and free; to shake of restraint.
> To avoid humiliation and embarrassment.
> To feed, help, console, protect, nurture another.
> To have one's needs gratified; to be loved. (1996, 20)

Yet again, it is clear that a psychiatric practice has affected the patient so that she analyzes herself in the same manner as the test does. In this particular section she may either be currently doing the Murray Need Form, recalling her answers to the test or just reciting the different needs listed in the test. She lists her needs, many of which are identical in nature of those listed in the Murray Need Form, and as in the case of the BDI(-II), she adds her own definitions of her needs amongst the definitions of the test. Some of her own additions include: “to receive attention,” “to be seen and heard,” “to defy convention,” and “to be forgiven” (2000, 234-235). Unlike with the BDI(-II), with the Murray Need Form there is less of the patient's own statements than those of the test. Perhaps this could be read as a positive attribute to the Murray Need Form because it could be more comprehensive in its listing and therefore has accounted for almost all of the basic needs of a person, resulting in the patient having to add only a few needs of her own to the test.

Interestingly, there is one part of the need form in which the patient has turned the need the other way round: “to be fed, helped, protected, comforted, consoled, supported, nursed or healed,” whereas the original (which she also states) is: “to feed, help, console, protect, nurture another” (2000, 235, 1996, 20). It could be read that in this part the patient explicitly states her need of help from others in her situation of mental illness. As the reader cannot be sure whether the list the patient utters is a monologue with herself or a situation in therapy in which she is filling out the Murray Need Form, one might either conclude that she is allowing herself to feel helpless and recognize the fact that she needs outside medical help in her state, or she might be stating her need of help to her psychotherapist. Either way, this is not the only time in the play when she admits needing help, as after the Murray Need Form she has commented on her therapist as her “last hope”

(2000, 236), and comments many times on how she feels the doctor is the only one who could save her.

I consider the final three statements in the need list of the patient the most important ones: "to be forgiven / to be loved / to be free" 2000, 235). These needs are expressed in the simplest manner out of all of those in her need list, and this could be taken to mean that these needs are the most urgent ones the patient has. The simplicity of the statements of the needs could be argued to represent the most basic, most essential needs. The fact that these three needs are listed last should hold no meaning, since if the patient would be answering to the test correctly, she would need to give numbers reflecting the importance of each need, not list them in different ways. Although none of the needs are numbered in order of priority, the fact that the patient cites "to be loved" two times in the play might suggest that this would be her most important need (2000, 235, 243). The second time the need emerges is at the very end of the play, where the patient states "this vital need for which I would die / to be loved" (2000, 242-3). This gives evidence that the need to be loved would indeed be her most urgent one, as it is the one for which she would die.

As discussed in this chapter, it is clear that the therapeutic methods affect the patient even out of therapy. Although one cannot always be sure whether the patient is currently in therapy when citing her answers, these sections of the play give clear evidence as to the impact of the psychiatric tests on the patient. The fact that in most cases she is not simply answering the questions or doing the tasks in each test (expect in the case of the serial sevens, in which she tries to do exactly what the test asks her to), she remodels the answers to suit her own states of being. It would be unlikely that a therapist would allow her to do this as this would affect the test results or even make them impossible to analyze as the questions and answers would no longer match. Because of this it can be argued that the answers the patient states during the play are not happening in therapeutic sessions but on her own time of self-reflection, which would indicate that the tests have left some sort of an impact on her as she continues answering to them and evaluating her well-being through them even out of therapy.

Given that there is no actual diagnosis present in the play, one could argue that the position of the doctor and the process of diagnosing is given to the audience or the reader, who could analyze the test results of the patient and then come to a conclusion of her state. This reading could be confirmed by the fact that in order to understand the lists in the play as answers to medical questionnaires requires some knowledge of psychiatry or psychotherapy. This brings forth the question of medicalization and medical power, which in this case would be granted to the audience or the reader. If one was to analyze the audience or the reader as the medical professional, it would complicate their position considerably, as in the play it becomes evident that medicine is not able to help the patient and the character of the doctor is quite problematic. Therefore this could force the audience or the reader to feel the suicide of the patient as a result of them not being able to help the patient. This type of a reading would certainly fit the context of in-yer-face theatre, where the audience is often forced to feel uncomfortable for one reason or another.

These types of affects, emotions and identifications that *4.48 Psychosis* might set in the audience have not been widely studied. Alicia Tycer has elaborated on the effects the play has on its audience, but the focus of her studies has been on how *4.48 Psychosis* affects the audience by using Sigmund Freud's melancholia as a central notion and developing this into the ideas of melancholic identification and witnessing (2008). However, Tycer has also noted the power positions that come into play for the audience, analyzing these through the division of "Victim. Perpetrator. Bystander." that appears in the play itself, but in her analysis she has not commented on the possibilities of transferring the medical power to the audience (2008, 32).

As psychiatric tests can be seen as results of medicalization of certain mental states, the fact that the patient reflects on herself through these tests is of particular importance. Here the reader is faced with the question of whether or not they believe mental diseases actually exist or whether these disorders are merely a result of the medicalization of deviance. The effects of medicalization become clear in the character of the patient in the sense that she uses methods used by medical professionals in aid of diagnosing their patients as means of reflecting her own mental states outside

of medical contact. Simply put, the patient assesses herself in a way that is used to assess mental disorders, meaning that she has internalized the language of medical discourse and in a Foucaultian style she seems to be surveilling herself via the medical procedures known to her. Even outside a psychotherapeutic session, she continues to test herself and how severe her illness could be perceived. One could argue that she has adopted the medical questionnaires into her self-reflexivity, and therefore medicalization has become a part of assessing and compiling her sense of self.

4.2.2 Forcing the Medicine

The use of psychopharmaceutics is based on the idea that mental illnesses can be seen as an imbalance of the brain, and the drugs help the patients by altering the neurochemistry of the brain (Blum and Stratuzzi 2004, 270). As Linda M. Blum and Nena F. Stracuzzi note, in the case of treating mental illness with psychopharmaceuticals, "the mind is primarily of the body" (2004, 270), meaning that the "mind" or "soul" is seen as an outcome of the physiological base of the human body. Mental disorders are often seen as diseases of the mind rather than the matter that is the human body, but the use of psychofarmaceuticals in treatment of mental diseases alters this view to a more biological one.

In *4.48 Psychosis*, there are several notions of the patient receiving different types of medication, although at the beginning she states she is "terrified of medication" and she even begs for the doctor to: "Please. Don't switch off my mind by attempting to straighten me out" (2000, 207, 220). I have discussed medical power and authority before in this thesis, and the continual prescription of psychofarmaceuticals is one of the most significant and concrete examples of the use of it in *4.48 Psychosis*. From a feminist perspective this forms a clear point of intersectional difference in the play, as the level of power the character of the doctor possesses is clearly above that of the patient, and here the educational background (often also indicative of a social background) allows the character of the doctor to influence the care of the patient even against her original wishes. The prescription of drugs for a mental disorder is also a clear example of the results

of the medicalization of the mental illness in question, as prescription drugs can only be prescribed when there is a valid reason for this, such as a diagnosis. In the play the patient is clearly against taking medicine, but her doctor persuades her to do so and she believes them because of their supposed knowledge of what would be best for her. This surrendering of one's agency reflects the functionalist view of medical power introduced in chapter 2.2, in which the patient allows the doctor to make the decisions for them because their authority has been earned by beneficent actions and altruism. However, one could argue that in the play the doctor does not showcase any particular altruism towards the patient, nor do they seem especially beneficent.

After the doctor tells the patient she is "allowing" her situation that they call a "state of desperate absurdity," the patient finally gives in: "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" (2000, 221). It is clear that the patient is afraid of medicine interfering with the functions of her brain so that she would not be able to "think" or "work" (2000, 220). It is problematic that she accepts the medicine so she could be, as she states, "a bit more fucking capable of living," as this reminds the reader of her doctor's questions of what she offers her friends that was analyzed in chapter 4.1.1 (2000, 221). As the patient is already living in a physical sense of the word, one must assume that the hoped effect of the medicine is to allow her to live on the norms of modern society: productive, effective and beneficial to society and the market economy. Here the criticism of psychotherapy by Masson, introduced in chapter 3.2 and further analyzed in chapter 4.1.1, becomes yet again evident: it is clear that the doctor is trying to mold the patient to the norms of society by means of medicine.

The actions of the doctor could be seen as beneficent if one is to believe that the only way to be a part of society would be to be (mentally) healthy, and from this perspective the functionalist view of medical power would be justified, as the patient would benefit from the expertise of their doctor. Also, if the medicine actually helped the patient, the persuasion to take it could be seen as more justified. A lot depends on the type of ethical background the doctor has, however, these are

not made present in the play. It is still possible to criticize the actions of the doctor regarding the patient’s treatment by drugs, since, firstly, the medication prescribed did not help the patient and she had to be induced to take the medicine against her initial judgement on the matter, and secondly, because the price to be living in any society should not be as extreme as having to try out several different types of medication that may have severe side-effects. In the case of *4.48 Psychosis* this is especially notable, as most of the medicine the patient takes seem to make her situation even worse.

The questions remains one of medical power and the ethics of the medical personnel: to which point are they allowed to continue treatment in a way they deem most beneficial to the patient, even though the patient would suffer during their processes of trial-and-error. As discussed in chapter 2.1, the prominent view of medical professionals in Western societies is that of a beneficent, humanitarian worker in whose expertise patients trust. This can result in patients allowing their doctors to make all decisions for them, as they believe the doctors sincerely try to act on what would be best for their patients. Nowadays differing opinions are on the rise, as people are growing suspicious of the connections between drug companies and medical professionals, and therefore the questions of medical power in the case of prescribing drugs is becoming more problematic. As the trade of medicine is not very transparent in itself or in its relations to drug companies, it is difficult to properly criticize the use of prescription drugs in cases such as the one presented in *4.48 Psychosis*, which, though being fictional, represents what is reality for many a patient with mental disorders.

In the play the patient receives eight different types of medicine for her illness until she refuses further treatment and tries to commit suicide by taking loads of aspirin combined with wine (“100 aspirin and one bottle of Bulgarian Cabernet Sauvignon,” 2000, 223). The exact drugs used for the patient are: Sertraline, Zopiclone, Melleril, Lofepramine, Citalopram, Fluoxetine hydrochloride, Thorazine and Venlafaxine (Melleril and Thorazine are trade names of drugs whereas the others are names of the general compound). It seems almost every type of psychofarmaceutical medicine available has been tried with the patient: Sertraline, Citalopram and

Fluoxetine hydrochloride are drugs that inhibit the reuptake of serotonin in the brain, so called SSRIs (selective serotonin reuptake inhibitor), Melleril and Thorazine are antipsychotics, Lofepramine is a tricyclic antidepressant, Venlafaxine an SNRI antidepressant (a serotonin-norepinephrine reuptake inhibitor), and Zopiclone is a hypnotic taken for insomnia (Aldrich 1999, 135, Goldberg & Murray 2006, 210, Kinsella & Kinsella 2006, 56, Hermann et al. 2009, 49, Katona et al. 2012, 78).

The epicrisis of the patient shows how she reacts to each drug, and the side effects include such as “wants to die,” “increase in suicidal thoughts,” “delusional ideas,” “paranoid thoughts,” “short term memory loss,” and “tremors” (2000, 223-224). The side effects of the medicine are both psychological and physical, and in most cases they are quite severe and worsen her state even further. Sometimes it may be hard to separate the side effects from the actual illness, as in some cases the side effects can be exactly the same as the typical symptoms of the disorder (e.g. SSRI drugs can cause thoughts of self-harm when starting the treatment). Generally it is thought that new symptoms that have started after taking a particular medicine are considered side effects rather than symptoms of the disease, but of course it may sometimes be difficult to know where to draw the line between these two.

In scenarios such as the one presented in *4.48 Psychosis*, one must question whether it is acceptable to force medication on people who do not wish to take it. Some see mental disease as mere lack of certain neurotransmitters, and in this case medicine would indeed be a perfectly valid choice of treatment. Also, some patients do benefit from medication, and in some cases one needs to try at least some medication before being allowed further treatment, for example, being committed to a mental institution. However, Conrad and Schneider point out that physicians sometimes neglect the rights and wishes of their patients, which is what seems to have happened in the play (1992, 35). Here the reader is faced with the issue of one's right to their own bodily autonomy versus the obligation of physicians to try to heal their patients. The question of bodily autonomy has been central to feminist criticism and theorization for many decades, and although it has typically

covered issues such as abortion, contraception or the sexual rights of women, the question of medication and medicalization can easily be linked to the matter, as discussed previously in chapter 2.3, where I have presented the case of DES, a prescription drug solely for the use of women during pregnancy.

On the question of bodily autonomy in the case of mental illness there are a few notions that should be acknowledged. On the one hand one must question whether a mentally ill patient can be trusted to be capable of making their own decisions when it comes to their treatment, but on the other, is it humane to force medicine upon someone against their will? The main problem of this dilemma, besides the obvious right to self-autonomy, is the fact that one can never be sure whether a sick patient is themselves, "in their right minds," so to speak. It would perhaps be easier to allow a person to decide for their treatment if one could be sure that the disease would not cloud their judgement. The question of involuntary treatment by psychoactive drugs is very complicated, and one cannot easily compare it to another medical situations where a patient denies their treatment (for example in the case of a terminally ill patient or people of certain religions that forbid some forms of medical treatment).

The question of forcing the treatment relates to the involuntary incarceration which I discussed earlier on in chapters 2.1 and 2.2. In most Western countries involuntary treatment is used only as a last resort, and usually the patient needs to be in danger of hurting themselves or others or that no other form of treatment has worked in order for them to be put under involuntary treatment. Nowadays involuntary treatment is restricted by mental health laws, and there are different criteria in different countries and states that need to be fulfilled in order for the treatment to be legal. Although persuading a patient into taking medicine and treating them involuntarily in mental institutions are two very different things, it is still troubling to wonder when does the persuasion and coaxing turn into involuntary treatment but just by the means of drugs. As in the case of the patient in *4.48 Psychosis* the drugs prescribed to her either did not work or made her feel even worse, it should be carefully considered when to order patients to take medication, especially if they

are not initially willing to do so. I am not arguing that any patient should feel the negative side effects of medicine, but I would assume that if one would take their the medicine willingly from the beginning they could be better equipped to deal with the possible repercussions.

5. The Collapse of the Textual Form and the Self

I will now move to the third, and final, part of my thesis: analyzing the relationship between the dramatic form and the subjective experience of the self of the patient in *4.48 Psychosis*. As both the text and the patient can be seen to go through different states or phases, it is interesting to examine whether these two correlate together and how the physical form of the text on page can reflect the mental states of the patient. I will examine whether it is possible to notice the fragmentary nature of her self-image through the layout of the text of the play and through other features of the text, such as intertextual references. I will also analyze how the medical procedures can be seen in correlation to the different states of the patient's mind and self-image, linking the third part of the thesis to the previously analyzed material.

5.1 Fragmentation of Textual Form in Literature

As most of my theoretical basis of analysis in this chapter originates from postmodernist theory, a brief notion of postmodernism will prove useful in understanding this theory in its context. Although the exact history and origins of the term remain uncertain, the first traceable uses of the word *postmodern* were in the 1930's and 1940's by Federico de Onís and Dudley Fitts (Hassan 2001, 115). Postmodernism is not easily defined, and some theorists even claim it defies definition. Postmodernism can be seen as a reaction to modernism, and because of this it can be said that there exists as many forms of postmodernism or postmodernisms as there are modernisms.

Ihab Hassan claims in his book *The Postmodern Turn* that postmodernism can be seen as a "significant revision, if not the original *episteme*, of the twentieth-century Western societies" (2001, 114). Hassan defines postmodernism as "a number of related cultural tendencies, a constellation of values, a repertoire of procedures and attitudes," and adds that postmodernism is "an artistic, philosophical, and social phenomenon" that:

> veers towards open, playful, optative, provisional (open in time as well as structure or space), disjunctive or indeterminate forms, a discourse of ironies and fragments, a "white ideology" of absences and fragments, a desire of diffractions, an invocation of complex, articulate silences. (2001, 115, 124).

According to Hassan the defining feature of postmodernism is what he calls *indetermanence*, a neologism of *indeterminacy* (defined by a large category of terms of unmaking, such as deconstruction, displacement, and demystification, and terms such as ambiguity, discontinuity, randomness, perversion, and deformation) and *immanence* ("the capacity of the mind to generalize itself in symbols […] and so become, increasingly, im-mediately [sic] its own environment") (2001, 122-123).

Bennet and Royle argue in *An Introduction to Literature, Criticism and Theory* that the characteristic form of postmodern literature is fragmentation, although it is not unique to it (1999, 233-234). Fragmentation in postmodern literature is essentially different from the fragmentation of modern and romantic eras: unlike these eras, postmodern text does not depend on an "original unity that can be lost," meaning that postmodern fragmentation is "without origins," that is, the texts are disseminated without any origin or centre to go back to (1999, 234). This would mean, for example, that the fragmentary texts hold no hidden meanings that the reader could work out, but that the fragmentation is the natural state of the text. Annjeanette Wiese argues that "contemporary fiction […] highlights and reclaims the importance of narrative structure in relation to identity and the human experience," and it is interesting to see whether this argument could also be relevant to *4.48 Psychosis*, which is, after all, a product of contemporary, postmodern theatre (2012, 2).

Kerstin Schmidt argues that the main concern of postmodern theatre is "the exploration of the dramatic form" and that the main trait of postmodern drama is fragmentation (2005, 31, 20). In this sense Kane's *4.48 Psychosis* seems to be an exceptionally good sample of postmodern drama. The dramatic form, as discussed in the introduction to this thesis, is the most unconventional of all of Kane's plays with no clear characters, scenes, stage directions, or even a plot. The text itself is very fragmented and positioned on the page in a vast amount of different visual styles. Hassan discusses the turn from form ("conjunctive, closed") to antiform ("disjunctive, open") in

postmodern literature and notes that the "dramatic form seems to move from unresolved tensions to symbolic elusiveness, from the latter to surreal or expressionistic contortion, and finally comes to rest in absurdity" (2001, 40, 121). Hassan calls this new form of literature *the literature of silence*, which goes well with Maurice Blanchot's notion that postmodern literature seems to move towards its own disappearance (quoted in Hassan 2001, 42). In other words, "abstraction begets death" (Hassan, 2001, 44).

Before moving to the textual analysis of fragmentation in the play, I will examine some of the postmodern theories applied to the subject of identity, self or subject(ivity) in the field of postmodern theatre. The self can be examined from many perspectives: as a philosophical, psychological, and a social category (Schmidt 2005, 44). The importance of individualism has been considerable in the twentieth first century, but in postmodern theory and literature identity and the experience of the self have been questioned, deconstructed, and then reconstructed. Schmidt argues: "the Modern notion of an original unity of the self and of dramatic character as a given entity has been lost in both postmodern drama and postmodern discourses at large (2005, 47). In general the fragmentation of the self is already quite evident in drama because of the "actor/character split," meaning that there is a certain actor performing as a certain character, and therefore neither the actor or the character as themselves are whole but they need the other to become fully embodied (Schmidt, 2005, 10). Postmodern drama, however, dives even deeper into the matter of self and regards it not as a "given entity but a construct [...] contingent upon its cultural context" (Schmidt 2005, 45).

In *4.48 Psychosis* it is interesting to examine whether the fragmentation of the textual form corresponds to the mental states of the patient. As I have explained before in the introduction, it is possible to read more than one voice for the character of the patient, which is particularly intriguing considering the general fragmented nature of the text. Karoline Gritzner has argued that in *4.48 Psychosis* the "thematic flights of the self from the world" can be seen reflecting in the experimental dramatic forms of the play (2008, 335). In the following chapters I will analyze how

this "experience of alienated and fragmented subjectivity" can be associated with the collapse of the dramatic form (Gritzner 2008, 336).

5.2 "My Mind Is the Subject of These Bewildered Fragments": Parallels between the Collapses of the Textual Form and the Patient's Identity

In *4.48 Psychosis* both the textual form and the state of the patient appear to be highly fragmented. In this chapter I will study how the fragmentary nature of the text of the play can be seen in parallel to the fragmentation of the patient's experience of herself. Watson states that the character of the patient in the play is "formed out of a profound fragmentation," while Claycomb describes the character having "a deeply divided self" (2008, 191, 2012, 111). Watson divides the play as having stages of reflection and refraction that take turns in the mind of the patient (2008, 191). The fragmentation of the self of the patient becomes evident when reading the play, as there is no one style of speech that would somehow become typical to the patient. In a sense, the reader does not get a sense of a complete character but rather glimpses of different sides or different mental states of one character. Saunders has argued that *4.48 Psychosis* could be seen as formations of different mindscapes, rather than actual events, places, or situations (2002, 225). It would seem as if the different emotions the patient experiences would guide her experience of herself and her environment, transforming her into several different personas with different expectations, dreams, hopes, fears or anxieties.

The text of the play offers several different forms: dialogues (between the patient and the doctor), monologues, lists, words and numbers that have been scattered on the page, and different types of visual formations of the aforementioned on the page. Although it seems there is no distinction between different scenes in the play as they seem to merge into one another, it is possible to distinguish 21 different scenes. As there are no pauses between scenes or "traditional act and scene divisions" (Tycer 2008, 26-27), the beginning of a new scene is always marked with "- - - - -", which helps the reader to notice the subtle changes in the subject matter. However, the lack of clear pauses or intervals between the scenes causes them to merge into each other, and as there is no

clear setting in the play, all scenes can be performed straight after one another. In a way, the play is almost dream-like in form, as everything blends together without explanation as to why and how different events and episodes are happening. The form of the play as a whole could be read as a metaphor to the state of the patient's mind whilst suffering from depression. Here, I consider it notable that the most lucid and non-fragmented textual content is found in dialogues with the character of the doctor, allowing an understanding of the more fragmentary forms to be products of the mind of the patient, and most likely her inner monologue.

The structure of the play can be argued to be non-linear as time or clear progress of the plot cannot be found in it (except the eventual process towards the suicide of the patient). The text offers numerous repetitions, and one could read these as evidence of non-linearity together with the evident lack of a clear plot. Tycer argues that this "non-linear structure of the play facilitates a trauma-based reading" (2008, 27). One could even argue that the scenes could be in any other order and that this would not change much on how the audience or the reader would view the play. Perhaps the only fixed point has to be the scene where the patient commits suicide, as this offers a form of closure to the play in regards to the very little plot there otherwise is.

Some examples of non-linearity can be found right at the beginning of the play and towards the end of the play, where the exact same lines emerge:

> (A very long silence.)
> - But you have friends.
> (A long silence.)
> You have a lot of friends.
> What do you offer your friends to make them so supportive?
> (A long silence.)
> What do you offer your friends to make them so supportive?
> (A long silence.)
> What do you offer?
> (Silence.) (2000, 205, 236)

As it is very unlikely that there would be two scenarios in the patient's psychotherapy sessions in which an identical discussion would be had, the reader can take this as evidence of the plays non-linear structure. Possible further readings of the situation might be added, for example that the patient is re-living the therapy sessions in her mind and that would be why they do not appear to be

in a linear order. The non-linear structure could also be credited to the mental illness of the patient along the lines of what Tycer suggested, in which case one could regard the whole play as events and inner monologues in no linear order. Besides the example above where the lines are exactly identical in two different parts of the play, there are some recurring themes or clusters of words that occur in several parts of the play. One of these is the time 4.48, which is mentioned in the play five times altogether (2000, 207, 213, 229, 233, 242). The other recurring elements are the lines "Hatch opens / Stark light," that occur four times in the play (2000, 225, 230, 239, 240) and the lines "Remember the light and believe the light," that occur three times (2000, 206, 228, 229). As there are so many recurring dialogues and lines in the play, one could argue that the structure could be seen as cyclical. These cycles could be interpreted as different states or moods of the patient, or even different voices of the patient, if one would read the play as having more than one voice for the character. The fact that the play provides clear distinctions between lucid and more psychotic moments of the patient could be seen as evidence for the reading that the cycles represent different aspects or different states of lucidity of the patient.

Besides the general form of the play, the reader is allowed a sense of fragmentation through the patient's statements on her own mental state. In the very beginning of the play, the patient states:

> a consolidated consciousness resides in a darkened banqueting hall near the ceiling of a mind whose floor shifts as ten thousand cockroaches when a shaft of light enters as all thought unite in an instant of accord body no longer expellent as the cockroaches comprise a truth which no one ever utters (2000, 205)

Here, the reader can note how there are no punctuation marks or capital letters, only endless thought, which can be seen as evidence of inner monologue. The lines themselves are rather contradictory, as on the one hand a "consolidated consciousness" could be seen as a fortified, strengthened consciousness, but on the other, it could be read as a consciousness still formed out of fragments. "A mind whose floor shifts" gives a clear impression of a mind that is unstable, a mind without a permanent foundation. Although the paragraph cited above seems to only add to the sense of fragmentariness through its form, the patient does also give statements that clearly allow the

reader to understand the fragmentary nature of her mind. The patient herself seems to be at least somewhat aware of the fragmentariness of her state, as she comments: “And my mind is the subject of these bewildered fragments” and that she is a “fragmented puppet” (2000, 210, 229). The patient does not elaborate on what *these bewildered fragments* are but on the context of the statement one could read these fragments to be her thoughts, ideas, and in essence, her reality. She also comments: “I don’t know who I am” and depicts her mind as a “piecemeal crumple” (2000, 225). The fragmentation can also be read through the contradiction of her statements, such as “I do not want to die” and “I do not want to live” (2000, 207). Also, contrary to her previous statement of not knowing herself, she later on states: “I know myself” (2000, 233). The last statement the patient makes, “It is myself I have never met, whose face is pasted on the underside of my mind” (2000, 245), gives the clearest example of how the patient views her never being quite in touch with herself.

The textual content offers plenty of evidence of the fragmentary nature of the patient’s mind, and when combined with the actual form of the text and its formation on page, the reader can clearly see how utterly fragmented the mind of the patient is. I have mentioned before that more than one voice can be read to the character of the patient, and I will now showcase why this is. Here is an example from the discourse of the patient:

> I’m dying for one who doesn’t care
> I’m dying for one who doesn’t know
>
> you’re breaking me
>
> Speak
> Speak
> Speak
>
> ten yard ring of failure
> look away from me (2000, 243.)

Here, the thought process is clearly divided into two distinct voices separated on the page. The other voice speaks first, the other answering or commenting on the first. The distinction becomes clear from the visual separation on the page, and added to this the other voice has capital letters in the

beginning of its lines while the other one does not. The citation I used above is from the last pages of the play, and it should be noted that the fragmentation transforms from appearing mostly in the written content (such as the citations analyzed previously) to appearing also in the form of the text. Compare, for example, these two extracts, one from the beginning and the other from the very end of the play:

> I had a night in which everything was revealed to me.
> How can I speak again? (2000, 205.)

> in death you hold me
>   never free (2000, 244.)

The first citation has two grammatically correct sentences with capital letters and punctuation marks, whereas the second citation is spread all over the page, and the lines seem like poetry or shattered thought. This type of evolution towards the fragmentation of form and escape from traditional formatting of text is clearly visible on page, and it guides the reader towards regarding the mental state of the patient as deteriorating towards the end of the play. Eventually, this is what happens as the patient commits suicide, and the major state of fragmentation the patient experiences could be seen as one of the reasons for this.

The most crucial point of fragmentation for the patient seems to be the loss of her original, "essential self" (2000, 229). The patient describes her states as being either "charmed by vile delusions of happiness" or as being "in her right mind" (2000, 229). It seems the patient sees that there are two sides to her being: the state of being her essential self and sane, and the state of being charmed and therefore insane or mentally incapable. These two states form the discourse of the patient, dividing the textual form and content to that of clear and easily understandable and that of fragmented and cryptic text. The patient describes her state: "Sanity is found at the centre of convulsion, where madness is scorched from the bisected soul" (2000, 233). Here, the dividedness of the mind or the soul is stated, and the patient clearly sees her existence as being categorized by either sanity or madness. Other ways to read this dichotomy will be analyzed in the following chapter.

5.3 “Body and Soul Can Never Be Married”: The Separation between the Body and the Mind

Now that we have established some of the fragmentary nature of the psyche of the character of the patient and its connections to the textual form, I would like to draw attention to the divide between the body and the mind that is repeated throughout the play. Although the play seems to ignore some of the more traditional binaries, such as gender, it does bring forth one of the most universal binaries: the one between the mind/soul and the body/matter. This division surfaces through the character of the patient, to whom it seems to cause anguish.

The character of the patient comments on her body and how she does not feel belonging in it several times during the play. The patient lists things she does not like about her body while she lists reasons why she is depressed early on in the play. On the other hand, the patient lists external factors that she does not care for in herself (“I am fat,” “My hips are too big,” “I dislike my genitals”), and on the other she lists ways in which her body does not function properly (“I can’t eat,” “I can’t sleep,” “I can’t think”) (2000, 206-207). Some of these functions are quite easily related to the mental illness affecting her cognitive abilities, some are more physical in nature. It is clear that these bodily sensations are somehow attached to her illness, either as a cause or as a symptom of it. The body seems to be a concrete place where the mental illness can channel into.

It should be noted that the patient tries to feel better through punishing her body by means of cutting herself, which can be seen as a desperate measure of trying to connect the mind and the body (2000, 216-218). It seems that although she does not like her body as it is, she is not trying to mend it more to her liking but using it as a means of both discipline and momentarily comfort by mutilating herself. Here, the body is simultaneously the source of both pain and pleasure, hopelessness and hope. However, the patient also includes physical means to her suicide plans and her eventual suicide, namely by cutting her wrists and hanging herself, along with taking an overdose (2000, 210-211, 241). Although the body could be seen as a source of momentarily release in the form of cutting oneself, it also allows the patient a more permanent way to end her pain by “killing the body” and herself with it.

The patient states the disconnection she feels between her body and her mind several times during the play. Early on in the play while referring to her previous doctors she states: "And I am deadlocked by that smooth psychiatric voice of reason which tells me there is an objective reality in which my mind and body are one" (2000, 209). This is an indication that the disconnection she feels has been a factor in her illness for some time now, as even her previous doctors have been trying to treat it. After this she notes: "But I am not here and never have been" (2000, 209), which can be read in at least two different ways. The patient could either mean that she feels she has not been physically or mentally present in her life or in society, whichever she uses "here" to refer to. On the one hand it is the *objective reality* that her body is, in fact, present in the world, and on the other it can be assumed that her mind is as well, otherwise she could not even try to be treated by means of psychotherapy. Either way, the disconnection the patient expresses with her material self and her mind could be used to argue either of the points presented above. However, I think it can be said with some certainty that she also feels a disconnection from the world or society, which is probably caused by the disconnection she feels about her mind and body. If one does not feel connected within themselves, it is hard to imagine how they could feel connection with anything else either.

As the play progresses, the disconnection between the patient's mind and body continues. The patient states: "Body and soul can never be married" and continues with "I need to become who I already am and will bellow forever at this incongruity which has committed me to hell" (2000, 212). The statement allows the reader to understand that the disconnection between the mind and body could be a possible cause for her mental illness, although one might also argue that it is a symptom of it. However, at least the patient seems to consider the incongruity between the mind and the matter as a reason for her "hell" which can easily be understood as meaning her mental illness. Later on she states: "How can I return to form / now that my formal thought has gone?" (2000, 213). This notion could be read as a contradiction to her previous statement which gave the impression that the source of her illness would be the disconnection between the mind and the body. The later statement could, however, be read in a reversed manner, claiming that the original cause of

her illness would have been the loss of “formal thought” which stops her from feeling the connection to her “form”. After this she states that her mental illness is “the sickness that breeds in the folds of my mind” (2000, 213), supporting the latter interpretation of the origin of her illness.

When trying to analyze the origin of her mental problems, one needs to understand that in scientific discourse the mind is seen to be of the body, and therefore such a binary opposition as presented above could not be made as such. This does not, however, prevent the reader from analyzing what the patient considers the reason for her mental illness. As this thesis concentrates on the subjective experience of the patient, the impression she has on her own state is essential to the analysis as a whole. The extracts analyzed in this chapter have pointed towards the patient feeling most disconcerted about the profound division she feels between her mind and her body.

The clear division of body and mind brings forth the question of gender minorities, especially from the feminist perspective used through this thesis. Gender minorities are often noted to include transgender and intersex people. Transgender people do not identify with the sex they were assigned at birth, whereas the term cisgender is used to refer to people who do identify with the sex they were assigned at birth. Transgender people may identify as women, men, both, or something outside the stereotypical gender binary, so the scale is extensive. There are also intersex people, in whose case sex cannot be assigned at birth as they are not simply just female or male from a biological perspective. Although I have previously stated the character of the patient to be a woman, this reading can be challenged from the perspective of the body/mind divide apparent in the character. As the patient does refer to herself as a woman this self-identification should be respected, but in the evidence of the apparent dichotomy between her mind and body one could argue that the character would not necessarily be a ciswoman. Adding a more *queer* reading to the play, the character of the patient could be read as a transwoman, as this would not erase her own sense of herself as a woman (which she states several times) but would allow the reader to consider the division the patient states there is between her body and mind.

Queer is both an academic theory and an activist movement born in the 1990s influenced by

poststructuralism and postmodernism. The purpose of queer is to destabilize binaries such as women-men or gay-straight and resist all kinds of categories in general. (Jackson & Scott 1996, 15-16, Hall 2003, 4, 15). In this sense, assessing the gender of the patient would not be queer. However, the verb *queer* means to deconstruct stereotypical readings and to find queer potential in a text where it has not been sought out before. This is closely related to the idea of resisting reading, a term coined by Judith Fetterley in 1978. However, as resistant reading is often connected to the idea of reading a text in a way it was not supposed to be read, I argue that the term queer reading fits this thesis better, as the reader cannot know how the text was originally meant to be read. Although the play can be read from a queer perspective, it is possible that the confusion and frustration that arises from the bodily states of the patient could also be seen as part of her mental illness. However, as the play itself is so ambiguous, the choice of interpretation is left to the reader. Still, it is important to point out the possibility of this reading, as it is indeed a viable one and not without basis, as I will prove in the following analysis.

Acknowledging different minorities, in this case gender minorities, as interpretive possibilities is of great importance as it also allows the reader to gain different kinds of insights to the texts analyzed which would not otherwise be possible. I will now examine whether the character of the patient could indeed be read as a transwoman. In the first page of the play, there is one line in particular in which the issue of gender minorities is spoken out loud and drawn to the surface: "the broken hermaphrodite who trusted hermself alone finds the room in reality teeming and begs never to wake from the nightmare" (2000, 205). Although "hermaphrodite" is no longer correct terminology and *intersex* is used instead, the term certainly guides the reader into thinking about the gender issues that may arise in the play, especially when this occurs on the very first page. As most of the discourse of the patient concentrates on herself, it is likely to assume the line is about her. It should be noted that since many important factors in the play, such as the BDI answers from which the patient's diagnosis can be analyzed occur on the very first pages, and therefore the patient referring to herself as "hermself" should be included in these clues that seem to define many aspects

that are relevant in the play.

Later on while listing things that the patient feels are wrong with her life she states “I dislike my genitals,” which could be either a clue towards reading her as a transgender person, but then again one could read it as just one thing in the list of other things she dislikes in her body, such as “I am fat” and “my hips are too big” (2000, 207). These kind of lists could just as well be evidence of body dysmorphic disorder (a preoccupation or worry that some parts of one's body are defective), much depending on the reading one would prefer. However, the patient does state: “I will drown in dysphoria / in the black cold pond of myself / the pit of my immaterial mind” (2000, 213), guiding the reader towards the reading that she belongs to a gender minority. Although one might argue that body dysmorphic disorder could be a part of the experience of being in a gender minority, this state is actually called gender dysphoria or gender identity disorder and is a different matter altogether. Gender dysphoria is created by the anxiety a person feels between their biological sex and social gender, whereas body dysmorphic disorder is a psychiatric disorder (Veale & Neziroglu 2010, xi). So, the fact that the word dysphoria is specifically mentioned could serve as further proof of the patient’s gender.

In the play the patient consistently outlines the dissatisfaction towards her body. The line “I need to become who I already am” can also be read as supporting the transgender perspective of the character, as one could see the gender the patient identifies as their own as the one they need to “become,” in this case most likely physically (2000, 2012). The patient further discusses her feelings about her body, stating: “I have reached the end of this dreary and repugnant tale of a sense interned in an alien carcass and lumpen by the malignant spirit of the moral majority” (2000, 214). Here, the phrase “alien carcass” could be read as supporting the patient’s transgender identity. If one would read the patient as a transwoman, alien carcass could easily be explained as a body the patient does not identify with. The patient also asks her doctor: “Do you think it’s possible for a person to be born in the wrong body?” (2000, 215), which can be read as a confession of the patient that she would indeed be transgender and wanting to bring the matter into focus in her therapy. The

phrase “being born in wrong body” is one of the most common ways to explain trans experiences, and therefore the question can be seen as holding specific importance.

At one point the patient discusses a “her” that the patient states she has “never touched” and that the patient and her will “never meet” (2000, 218). Although this *her* might be read as a possible lover (and through this the character could be read as non-heterosexual), it could also be analyzed in relation to the narrative of her gender identity. In chapter 5.3 I discussed the patient stating “it is myself I have never met” (2000, 245), which allows the reader to interpret that the “her” the patient is talking about would be the patient herself. Especially the line “I miss a woman who was never born” (2000, 219) can easily be added to the reading of being born into the “wrong body” the patient refers to earlier on.

I think reading and analyzing *4.48 Psychosis* from a queer perspective is of vital importance, especially since it allows a whole new reading to explain why the character of the patient does not benefit from her psychotherapy. I argue this is because she is being treated for the wrong reason: the symptom and not the cause of her mental health issues. If one is to adopt the reading I have presented in this chapter, arguing that the character of the patient would be part of a gender minority (a transwoman, to be particular), it could prove that the original cause of her depression would be gender dysphoria and possibly minority stress (stress caused by belonging to a minority), and that depression would be a symptom of these. Therefore, by treating only her depression and not her gender dysphoria the treatment given to her did not get to the root of her illness. As the treatment did not issue the original cause of the illness, it did not prove successful.

Sarah Kane’s plays have been analyzed from queer perspectives before, however, the studies have mostly focused on *Cleansed*, which explores both the themes of gender and sexuality from minority perspectives (e.g. Rayner 2009). Tycer discusses *4.48 Psychosis* and the gender of the patient in her research, but her base of analysis is Freud’s notion of melancholia and she does not discuss the possibility of reading the patient as belonging to a gender minority (2008, 35). The queer themes have not been as popular as other themes when analyzing Kane, and therefore there is

only a handful of academic texts discussing the queer aspects of her plays which is slightly surprising. In fact, as pointed out in this chapter, one could read non-heterosexual elements in *4.48 Psychosis*, but neither this nor the possibilities of reading the patient as belonging to a gender minority have not been discussed in academic contexts. As the play obviously allows queer readings, this would prove an interesting point for further studies on the play.

5.4 "Last in a Long Line of Literary Kleptomaniacs": Intertextuality as Fragmentation

Lastly, on the subject of fragmentation, I would like to discuss the highly intertextual nature of the play and examine how this intertextuality could be linked to the overall fragmentation of the play and especially to the fragmentation of the mind of the patient. *Intertextuality* is a term coined by Julia Kristeva in 1967, and she has defined it as a "mosaic of quotations; any text is the absorption and transformation of another" (Kristeva 1986, 37). There are several intertextual references in *4.48 Psychosis*, ranging from pop culture to the Bible. Many critics have described *4.48 Psychosis* as a "textual collage," and Ken Urban agrees that the play "has a citational quality to the language, as if it were culled from disparate sources" (2001, 44).

I claim that the intertextual references in the play can be read as proof of the fragmentary nature of the patient's psyche or mind. In chapter 5.2 I discussed how the patient feels the need to be in touch with her essential self, and when she does not feel the connection, she considers these the moments of insanity. Intertextual references, especially in the volume they are presented in *4.48 Psychosis*, might serve as proof of the patient not being in connection with her inner self, as these references are essentially loans of what other people have said, written, or put into action. All of the allusions in the play are presented in the discourses of the patient, making a distinction between the presumably healthy mind of the character of the doctor who can form their own sentences and the character of the patient who has to rely on words already uttered by someone else. When analyzed in this manner, the intertextual references can serve as proof of the patient's mental state, as people with severe depression have lowered cognitive skills and therefore producing statements of their

own can be harder than usual. One might argue that these type of allusions would be equally demanding as finding words of your own, but I would argue that finding the right words might be easier when they are already spoken or written by another. For example, it is easy to relate to a poem written by someone else and feel that it describes exactly what one is feeling inside, but it could prove agonisingly hard to try to put those feelings into words.

The literary loans provide a deeper understanding of the state of the patient than what she could have managed to form herself. They also show how she identifies with or draws inspiration from several different texts of different natures, and all of these texts reveal something new about her character. This is especially interesting because there is so little to know about the character besides her struggles with her mental illness, and therefore intertextual references allow the reader to get a better overall view of the patient. For example, loans of canonical literature or religious nature would point to the fact that the patient has read at least some classic works of literature and is familiar with the Bible at least to some extent, and these could be seen as evidence of education or perhaps religiousness.

As there are so many intertextual references in the play, a brief explanation on the ideas of originality and intertextuality might prove useful. Kerstin Schmidt states that the idea of *originality* blossomed during Romanticism, but before that intertextuality, or "imitative repetition," was highly appreciated in classical art theories (2005, 40). Poststructuralist critics and theorists tend to argue that all texts are intertextual as they bear traces of every text and discourse ever to have existed. Diverting from the poststructuralist views of intertextuality, Schmidt argues that spotting intertextual references might be particularly difficult in postmodern plays since noticing these references takes knowledge of both canonical and non-canonical literature and art, and because the changes made in the processes of adaptation makes them harder to notice (2005, 36). In this thesis my examination of intertextual elements shifts more to Kristeva's and Schmidt's definitions of intertextuality as quotations than to the poststructuralist view.

Examining the intertextual references in the play is particularly important because the whole

identity of the text can be seen as fragmentary through these loans. If one's original text would be regarded as uniform, a text that loans directly from other texts could thus be regarded as fragmented by nature. In *4.48 Psychosis* the text itself mentions intertextuality, which would lead the reader to understand the references within the play as noteworthy. Intertextuality is mentioned quite early on in the play in a clear manner: "Last in a long line of literary kleptomaniacs / (a time honoured tradition) / Theft is the holy act / On a twisted path to expression" (2000, 213). These lines clearly show how intertextual references are used in order to better express oneself. In this chapter, I shall examine this *twisted path to expression*, and analyze how the intertextual references add to the sense of fragmentation, both of the play as a whole and particularly the mind of the patient. My analysis will move from abstract to more definitive, as I will first focus on the intertextuality of themes, and continue to loans that are (almost) identical in form.

One of the recurring themes – and a part of the title of the play – is the time 4.48. Although the time is never specified to be am and not pm, its immediate context such as the lines "I am jealous of my *sleeping* lover and covet his induced consciousness / when he *wakes* he will envy my sleepless *night* of thought and speech unslurred by medication" allows an understanding of this time being during the night, when others are asleep (2000, 208, italics mine). Though the title *4.48 Psychosis* could lead the leader to consider this time of night as the time of psychosis or other mental turmoil, the issue is not as straightforward. Although there are lines such as "at 4.48 / when desperation visits / I shall hang myself / to the sound of my lover's breathing" followed by talk about suicide, which would suggest the situation of the patient to be worst at 4.48 am, there are also the lines "at 4.48 / when sanity visits / for one hour and twelve minutes I am in my right mind" and "at 4.48 / the happy hour / when clarity visits," which would argue just the opposite (2000, 207, 229, 242). There are also a more neutral alternatives to these two opposites, which are "after 4.48 I shall not speak again" and "at 4.48 / I shall sleep" (2000, 213, 233). The time of the night (or very early morning) as the point of either sanity or madness can be seen as reference to several different canonical literary works: mainly *The Silver Chair* by C.S. Lewis, "The Hollow Men" by T.S. Eliot,

and “Aubade” by Philip Larkin.

The idea of the patient having either moments of clarity or desperation in the middle of the night can be seen as quite a clear reference to the book *The Silver Chair* (1953) by C.S Lewis. In *The Silver Chair* the Prince Rillian is cursed, and during the night he suffers from fits of anger and rage and he has to be tied to a silver chair. In reality, the curse allows him to remember and to regain his sanity, which causes the violent fits as he realizes the situation he is in. The story of Prince Rillian resembles that of the patient in *4.48 Psychosis* quite accurately, as the patient asks: “Now I am here I can see myself / but when I am charmed by vile delusions of happiness, / the foul magic of this engine of sorcery, / I cannot touch my essential self / Why do you believe me then and not now?” (2000, 229).

As Prince Rillian is deemed mad at his hour of sanity, the patient suffers from the same. Watson argues that at 4.48 “lucidity and psychosis are both at their strongest” (2008, 197), and the extracts cited on the previous page seem to confirm this notion. However, although these extracts do not always give a very lucid image of the patient, they seem saner than some other parts of the play (compare with e.g. 2000, 225-226, 231-232, 242-244). I think it is problematic to regard some of the extracts as proof of psychosis being at its strongest since the play is filled with examples of severe fragmentation that could rather be read as points of psychosis. Surely, the lines after 4.48 am are uttered from the first person perspective, which allows the reader to connect the statements that follow to the patient, whereas some of the lists of words (my examples of psychosis above) can seem random in nature and therefore perhaps harder to connect to the patient.

Acknowledging the intertextual reference to *The Silver Chair* allows the reader to access some of the feelings of the patient. The patient, like the prince, feel as if they are “charmed” or that there is “magic” involved in their predicaments. While the prince is actually charmed and thus cannot escape his situation without the help of others, the “curse” that binds the patient is her illness which she by herself cannot get cured from. In the case of the patient the ones to help her break the curse are the doctors, and when one understands this reference it becomes more understandable why

the patient seems so dependent on her current doctor, who she claims to be her “last hope” (2000, 236). Indeed, sometimes mental diseases can occur unexpectedly and without any reason to seemingly random people. It does not always take a traumatic past or present to fall under mental illness, and thus it could poetically speaking be seen as a “curse”. Surely, curses almost always have someone to cast them, so the metaphor is not perfect in that sense. However, it is undeniable that *4.48 Psychosis* has many similarities to the story of *The Silver Chair.*

Still on the theme of the time 4.48 am, *4.48 Psychosis* bears resemblance to the poems “The Hollow Men” (1952) by T.S. Eliot and “Audabe” (1990) by Philip Larkin. “The Hollow Men” tells the story of men who are hollow but stuffed and left to themselves in what is most likely a desert. As to interpretations to who these hollow men are, an intertextual reference to Dante Alighieri's *Inferno* and *Paradiso* seem to be the most prominent ones, allowing an understanding of the hollow men as people who cannot move on either to Heaven or Hell although they have already died. In “The Hollow Men” the lines “here we go round the prickly pear / prickly pear prickly pear / here we go around the prickly pear / at five o'clock in the morning” (1952, 58) brings the reader to the same time frame familiar to that of *4.48 Psychosis*, although Eliot's time is not as exact as Kane's. From this time frame of “five o'clock in the morning” one can start to look at the mind-set of the hollow men, and begin to see resemblance to that of the patient in *4.48 Psychosis*.

From the very first lines, “headpiece filled with straw” (1952, 56), one can start draw parallels to the patient in Kane's play. As the hollow men's headpieces are filled with straw, the head of the patient is filled with drugs. Both the hollow men and the patient are filled with something, yet they remain “hollow,” empty. As this emptiness cannot be taken for its literal meaning, it must be taken to count for the emptiness of the soul or the mind. The lines “our dried voices, when / we whisper together / are quiet and meaningless” (1952, 58), bring to mind the certain passivity mental patients have of their treatment and the social stigmas that are still related to mental disorders. The following lines could almost be straight out of *4.48 Psychosis*, as they seem very similar in both form and content: “Shape without form, shade without colour, / Paralysed force, gesture without

motion" (1952, 56). The same problematic nature of form is present in both the play and in the poem, as is the sense of not quite being able to accomplish something. I would argue that just these lines could even be used to describe *4.48 Psychosis* quite comprehensively without losing much of the essential content of the play. In fact, there are lines in *4.48 Psychosis* that are quite close to the second lines of the citation from "The Hollow Men": "drowning in a sea of logic / this monstrous state of palsy" (2000, 233). The final lines in the last stanza, "this is the way the world ends / not with a bang but a whimper" (1952, 59), could be taken in a suicidal sense. Though suicide could surely be regarded as the proverbial "bang," it is still most likely that in the case of suicide one's life would actually end in a whimper, some last involuntary sound as the body ceases to function.

If the time frame of "The Hollow Men" was not as exact as that of *4.48 Psychosis*'s, Philip Larkin's "Aubade" (1990) continues on the same lines. The Oxford English Dictionary defines the word *aubade* itself as "a musical announcement of dawn, a sunrise song or an open-air concert" (OED Online). However, the line "waking at four to soundless dark, I stare" gives a more precise time frame to the poem (1990, 208). "Aubade" relates to *4.48 Psychosis* not only through the similar time frame, but also through its theme: death, and a certain kind of defeat. The poetic speaker states:

> Waking at four to soundless dark, I stare.
> In time the curtain-edges will grow light.
> Till then I see what's really always there:
> Unresting death, a whole day nearer now,
> Making all thought impossible but how
> And where and when I shall myself die. (1990, 208)

Although "Aubade" is not about suicide like most mentions of death in *4.48 Psychosis* are, it is clear that death is one of the main themes in both works. Death is also evident in "The Hollow Men," and so the theme binds all the three texts together. Whereas in the "The Hollow Men" the death has already come, in "Aubade" the tragedy of life is the fact that eventually everyone will die and the knowledge of this "slows each impulse down to indecision" (1990, 209). In "Aubade" there is no escape from either death or the wait for it to come, yet the thought of one's eventual decease cannot be accepted. In *4.48 Psychosis* death has not yet arrived to the patient, but she actively

discusses ("I have been dead for a long time," "I'll die / not yet / but it's there," 2000, 214, 226) and plans it ("I have resigned myself to death this year," "take an overdose, slash my wrists then hang myself," 2000, 208, 210). However, it must be noted that the patient does not look forward to taking her own life, as she states: "I have no desire for death / no suicide ever had" (2000, 244). As the final lines of "Aubade" bring forth a decided sense of defeat and the triviality of the mundane experience ("Meanwhile telephones crouch, getting ready to ring / In locked up offices, and all the uncaring / Intricate rented world begins to rouse […] Work has to be done," 1990, 209), so does the following line in *4.48 Psychosis*: "the morning brings defeat" (2000, 231). Both poems regard the early hours of the morning as a time of reflection and, to some extent, depression and/or lucidness, and the morning brings a sort of cold comfort of the world moving on despite what has been thought of in the darkness of the night.

From canonical literature and the intertextuality of themes, I will continue examining the religious references in *4.48 Psychosis*, namely ones from the Bible and especially The Old Testament. There are several intertextual references to the Bible, some of which are identical and some slightly altered. As there so many Biblical references, I will only analyze the most significant and perhaps easily recognizable ones, as analyzing all of them could be a thesis on its own. Most of the references come from the Old Testament, from which there are loans from the books of Leviticus, Isaiah, Jeremiah, Chronicles, Psalms, and Zechariah, and from the New Testament there are loans from the books of Matthew, Luke, John, and Revelation.

The most recognizable Biblical reference is the patient saying "my love, my love, why have you forsaken me?" (2000, 219), which can easily be recognized as a version of Jesus's cry "My God, my God, why have you forsaken me" (King James Bible, The New Testament, Matt. 27:46) while he is dying from his crucifixion on the cross. These lines can be interpreted in a similar manner from both sources: in both cases there is someone the speaker looks up to, and now they feel abandoned by them. In the case of the patient, *my god* or *my love* could be seen as referring to the character of the doctor who the patient confesses loving in the play and whom she in fact calls

“my god” (2000, 233). To understand the love or god as referring to the character of the doctor emphasizes the unequal nature of their relationship. Another significant sentence that is repeated many times throughout the play, “Remember the light and believe the light” (2000, 206, 228, 229), is a reference from the Book of John in the New Testament: “while ye have light, believe in the light” (12:36). The notion of light comes forth several times through different lines in the play, and I argue that “light” could be seen as a reference to the moments of sanity the character of the patients has from time to time. Reading “light” as equal to “sanity” connects the Biblical loan to the references of *The Silver Chair* analyzed before in this chapter, further emphasizing the distinction between the moments of sanity and lucidity and the moments of insanity or psychosis.

Besides the citations from Matthew and John analyzed above, all the other biblical references can be found in the same scene. This is particularly interesting, because there are altogether 17 references in the space of only two pages. This makes the scene in which they appear distinctly different in style from the rest of the text. From The Old Testament and the Book of Isaiah there are several references, the most notable one being perhaps the following “And they shall look unto earth / and behold trouble and darkness / dimness of anguish / and *they shall* be driven to darkness” (8:22). The first reference can clearly be seen as inspiring the following lines in the play “behold the light and despair / the glare of anguish / and ye shall be driven to darkness” (2000, 228). The change of *trouble and darkness* to *light and despair* is a clear revision to the themes of *4.48 Psychosis*, but one may only wonder what is meant by *darkness* here. Is it a reference to death, depression, or perhaps being a pariah in society? Certainly, all of these three can easily be seen in reference to mental illness. Again, the selection of Biblical loans could be seen as emphasizing the distinction between sanity and insanity. There are also a few other loans from Isaiah: “the mountain of the Lord’s house”/”Sanity is found in the mountain of the Lord’s house” (2:2, 2000, 229), “why should ye be stricken anymore, ye will revolt more and more, the whole head is sick and the whole heart faint”/”why am I stricken”, “the head is sick and the heart’s caul torn” (1:5, 2000, 228, 229), “gird yourselves, for ye shall be broken in pieces” (8:9, 2000, 228), and “come now, let us reason

together" (1:18, 2000, 229).

Another loans from the Bible include such as: "I saw visions of God" (Ezek. 1:1, 2000, 228), "if there be blasting" (Chron. 6:28, 2000, 228), "*that* preach ye upon rooftops"/"shall be proclaimed upon the housetops"/"shouted from the rooftops" (Matt. 10:27, Luke 12:3, 2000, 228),"fear God" (Rev. 14: 7, 2000, 228), "if the scall be not spread on skin"/"a scall on my skin" (Lev. 13:13 [the exact form of the verse changes between different versions of Bibles), 2000, 228), "and it shall come to pass" (Zech. 14:16, 2000, 228), "the abjects gathered themselves around me"/"we are the abjects" (Ps. 35:15, 2000, 229) and "and burn incense unto Baal" (Jer. 7:9, 2000, 229). There are more loans from the Bible alone than of any other text, and because of this it could be argued that the Bible could be seen as holding specific significance to the character of the patient. As the references are so plentiful and they show a working knowledge of the Bible, one could argue that the character of the patient could either be religious herself, or perhaps been raised in a very religious family or got her education at a religious school. Altogether the Biblical references form an atmosphere most critics agree to be apocalyptic, with notions of visions, darkness, light and despair. The fact that most of the references are found in a single scene could be significant, for example, one might wonder if the patient is trying to find consolation from religion in a certain point during her illness.

Lastly, there are a few intertextual references to popular culture which need to be examined. Recognizing these references is especially important in a postmodern framework that emphasizes the popular. From popular music, *4.48 Psychosis* contains the line "still ill" (2000, 223) known from a song by The Smiths that goes by the same name. "Still ill" (1984) contains a lot of the same themes as *4.48 Psychosis*, such as depression or illness ("for there are brighter sides to life / and I should know because I've seen them / but not very often"), death ("ask me why and I'll die / oh ask me why and I'll die"), and the division between the mind and the body ("does the body rule the mind / or does the mind rule the body / I dunno"). Again, the references bring forth themes crucial to the play, namely the divisions between the body and the mind and between sanity and depression.

The other popular culture reference is “the chicken's still dancing / the chicken won't stop” (2000, 243) that points to the movie *Stroszek*, directed by Werner Herzog. In *Stroszek* (1977) there is a little booth in which a chicken is “dancing” (the booth is named “The Dancing Chicken”) for a relatively long time. It seems the chicken itself is pulling a little string again and again so the music would not stop. This could perhaps be seen as an allusion to life, in which one would pull one string after another in order for life not to end and death not to come. It is also known that *Stroszek* was the last film watched by Ian Curtis, the frontman of the post-punk band Joy Division, before committing suicide, linking the film to the theme of suicide in the play.

As discussed in this chapter, it seems that the character of the patient uses intertextual elements, either in the form of thematic references or quotations, to express herself. The intertextual elements bring forth themes that seem to be essential to the play, such as the states of sanity and insanity and the disconnection between the body and the mind. Certainly, from what has been analyzed both in this chapter and the previous ones, the themes mentioned above seem to form the crucial issues that bring all of the patient’s discourse together. Both of these themes emphasize fragmentation and a sense of division in the patient, making it possible to argue that the text does represent the fragmentation of the patient’s mind in both textual and visual form and in its content.

6. Conclusion

In this thesis I have explored the themes of medicalization, anti-psychiatry, psychotherapy, fragmentariness of the self and the textual form and content, and the failure of psychiatric practices in *4.48 Psychosis*. I have analyzed the play on the basis of theories both on medicalization and anti-psychiatry, psychotherapy, and on postmodern theories on the nature of texts, mostly of form and unity. Uniting different types of theoretical resources has allowed me to better examine and analyze the play which in itself is endlessly complex, ambiguous and challenging to the reader. My initial research question of how the mind-set or psyche of the character of the patient is affected by her mental illness and the psychiatric and psychotherapeutic treatment she goes through in the play remained strong through my research process, although the more I analyzed *4.48 Psychosis*, the more plausible ways of reading the play seemed to emerge.

I would argue that the most significant finding of this thesis is presenting the possibility of reading the character of the patient as belonging to a gender minority, because this opens a whole new way of analyzing the play, both its textual content and the eventual fail of psychiatry in the case of treating the patient, as discussed in chapter 5.3. This kind of queer reading of the character of the patient has not been presented before in an academic context, although Kane's plays have previously been examined from queer perspectives (especially *Cleansed*). I claim that reading the character of the patient as a transwoman provides the reader with more ways to interpret the play than the typical, genderless reading that is mostly applied to it. Besides the obvious benefit that comes from new interpretational possibilities, it is particularly important to note the queer aspects (gender minorities, non-heterosexual characters) of a text whenever possible. As there are so few characters in literature that are not cisgender, pointing out the possibility of a queer reading like the one in *4.48 Psychosis* adds the text to the list of LGBTQIA[4] literature. As this list of literature is not

[4] The acronym LGBTQIA is used when referring to sexual and gender minorities. The letters come from the words lesbian, gay, bisexual, trans* (trans with an asterisk is used as an umbrella term for sexual minorities), transgender or transsexual, queer or questioning, intersex and asexual or ally. There is some variation as to what the letters are seen as referring to, and to avoid confusion I have gathered here all of the most typical ways to interpret the letters. However, it is good to note that the acronym is not as self-explanatory as it seems, for example, one might wonder why some people interpret the letter a for allies, as they do not belong to the minority groups the acronym is used to refer to.

profusely long, it is important to address queer themes when they are unquestionably present or plausible ways of reading, as literature and literary characters are easily relatable with, and therefore can help people belonging to sexual or gender minorities cope with their experiences, for example, minority stress or discrimination. Since gender is essentially an important social category, the understanding of the patient's gender adds important knowledge to her character, as the aspect of the patient's gender has been ignored or dealt with a sentence or two in most academic texts considering *4.48 Psychosis*.

My main object of analysis has been the character of the patient and how the psychiatric interventions, such as psychotherapy and psychotropic treatment, affect her sense of self. From the analysis provided in chapter 4.2.1 it can be noted that the psychiatric tests used to scan her mental states have an essential role in the play, and the patient's own statements often blend to these tests. Besides the influence the tests have on the patient and her self-evaluation of her mental state, the patient is highly affected by the psychotropic drugs that are prescribed to her. Almost all of the eight drugs that she tries have negative side effects on her, and as the ninth drug is offered, she refuses treatment and tries to kill herself. As mentioned in chapter 4.2.2, the prescription medicine is one of the clearest examples of how medical authority is portrayed as being dubious in the play. The chapters 4.2.1 and 4.2.2 provide essential information on how the medicalization of mental illnesses has affected the life of the patient, as both the psychiatric tests and the medicine she has been prescribed are forms of treatment resulting from the process of medicalization of the depression which she suffers from.

Besides examining the character of the patient, I have analyzed the character of the doctor, whom I found to be quite unprofessional, misleading and even harmful to the treatment and recovery of the patient. Although the success of therapy lies much on the patient themselves (statistics from Asay and Lambert, presented in chapter 3.1 and further discussed in chapters 4.1 and 4.1.2), I would argue that the character of the doctor was an essential part as to why the therapy did not work for the patient, besides the argument presented in chapter 5.3 that offers gender

dysphoria as the cause of her depression. As analyzed in chapter 4.1.1, the doctor behaved unprofessionally, mislead the patient emotionally, and did not understand the difference between the theories of psychiatry, psychology and psychotherapy and their patient, therefore not truly understanding her but rather trying to conform her to the theories they knew. Here we are faced with Masson's ideas that therapists are harmful to the process of therapy because they are not able to make the distinction between theory and reality, and because they are after all only human, each carrying their personal prejudice and faults (Masson's critique presented in chapter 3.2).

Altogether, it seems that the character of the patient did not benefit from her medical treatment at all, as she seems to be in anguish throughout the entire play. Psychotherapy did not help her, and neither did drugs. Though have I argued that in the therapy witnessed in *4.48 Psychosis* the doctor is the main reason for its failure, the reader does not have the possibility to review the therapy she did with her previous doctors, and because of this the reader might be left wondering if the character of the patient is one of those unlucky ones that simply cannot benefit from psychotherapy. However, it is evident that the character of the doctor did nothing to aid the process of therapy on their part, which is why they could be considered one of the reasons of its failure.

As some of treatment the patient receives in the play, mainly the psychiatric tests discussed in chapter 4.21, are not analyzed in the play itself, this leaves the process of analyzing the results and diagnosing the patient for the audience or the reader. This results in a possibly uncomfortable, in-yer-face-style position to the ones who are left to analyze these results, as here the medical power is transferred from the character of the doctor to the audience or the reader. As the medical power is transferred, so is the responsibility that comes with it, resulting in a unique position in which the failures of medicine can be felt by the audience or the reader both from the perspective of the patient and the perspective of the medical professional.

On the subject of fragmentation, *4.48 Psychosis* has a lot to offer. In this thesis I have examined fragmentation from three different angles: the fragmentation of the text and its

implications on the play, the fragmentation of the mind, the mind/body divide the patient suffers from, and the fragmentation of a text as a whole through the idea of intertextuality. Generally, *4.48 Psychosis* is certainly one of the most fragmented plays to exist. The fragmentation in the play is essentially a postmodern feature, fragmentation without origin, which makes interpretations of the play a rather personal matter, as each person will try to interpret the play as their minds best seem fit. Still, it can be stated with certainty that the fragmentation in *4.48 Psychosis* is deeply related to the mind of the patient and the fragmentation she feels about herself. Content-wise, the text is full of contradictions and division between the body and the mind and sanity and insanity, and this is clearly reflected in the form of the play. As the source of the discourse, which is mostly the character of the patient, is so profoundly fragmented it can be but expected that the text be highly fragmented as well.

As noted before in this conclusion, *4.48 Psychosis* seemed to open up a reading after another when I started the process of analyzing the play. I think the play has many interesting possibilities for further studies, and I am particularly keen to recommend the possibilities of analysis on the LGBTQIA themes. Although this thesis provides a possible starting point for queer readings on the gender identity of the patient, this could be analyzed further. For example, one might want to apply theories on gender dysphoria or minority stress to the play and see what this could bring to the analysis. The play could also be examined for non-heterosexual desires, something which I mentioned previously in chapter 5.3. However, in general *4.48 Psychosis* has not been widely studied, so it would provide an excellent basis for almost any type of analysis one could see fitting to the nature of the play.

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