s1047706
How Theatre NEMO and Anthony Neilson use drama to challenge perceptions of mental ill health in Scotland 2003-2010.

MSc European Theatre
Graduate School of Languages, Literatures and Cultures
University of Edinburgh
August 19th 2011
Abstract

Despite a continued interest in the study of power-relations and discourse following Michel Foucault’s work on psychiatric power in society, there has been little attempt to examine the representation of mental illness in literature and culture as anything other than an artistic trope. This thesis examines the specific ways that performances have engaged with mental health discourses in Scotland since the passing of the Mental Health (Care and Treatment) (Scotland) Act 2003. By reading Anthony Neilson’s The Wonderful World of Dissocia and Theatre NEMO’s Does Anyone Know in the light of Scottish policy discourse, the thesis draws attention to the potentials and limitations of performance as a medium for engaging with the issues facing mental health service-users. This includes the impact of physical presence in performance and the risks of falling into conventional, stereotyped views of madness. By doing this, the thesis exposes the extent to which the power-relations within the mental health system are related to mental distress, as well as the ways that transformational strategies in performance can have a positive impact in revealing and challenging these power-structures.
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Introduction

Power relations constituted the a priori of psychiatric practice [...] what was essentially involved in these power relations was the absolute right of nonmadness over madness. (Foucault 1997: 48)

This statement summarises Foucault’s view of psychiatric power and the position of the mentally ill subject in modern medicine and culture. Foucault’s work addresses madness as a feature of society, moving knowledge about (and hence power over) madness out of a strict medical paradigm and into a broader social context. In doing so, it allows us to draw together two themes which have previously been held at arms length from each other – the actual experience of madness by those diagnosed with a mental illness, and the position of madness as a trope within social discourse and culture. The language of psychiatry is a ‘monologue by reason about madness’ (Foucault 2001: xii) that excludes other discourses, discourses Foucault seeks to reinstate. However, despite the prevalence of literary and cultural criticism based on Foucault’s ideas of power, there has been little attempt to address the question of mental illness as a feature of contemporary society, or to examine the relationship between artistic representations of mental illness and cultural assumptions about the meaning of madness.

Building on Foucault’s work, and that of other researchers in the fields of performance, disability, and madness studies, this thesis will examine the ways in which drama, broadly defined, has been used in Scotland to intervene in public discourse surrounding mental illness since the passing of the Mental Health (Care and Treatment) (Scotland) Act 2003.

This will be achieved by comparing two case studies, Anthony Neilson’s play The Wonderful World of Dissocia (both its premiere in 2004 and its 2007 revival), and the short film Does Anyone Know, produced in 2008 by the Glasgow based charity Theatre NEMO after a 10-week programme in the high dependency unit of Edinburgh Prison. Despite the differences between the immediate contexts
of these two productions, both are embedded within the framework of the Scottish Executive’s *National Programme for Improving Mental Health and Wellbeing*. The first performances of *Dissocia* were specifically connected, both through funding streams and within publicity materials, to the *National Programme*, and Theatre NEMO’s work appeared regularly in Scottish Executive reports as a positive example even before there were any concrete funding links (see e.g. McLellan 2006: 33).

In order to sketch the contexts of policy and public discourse, the first chapter will provide a critical assessment of Scottish mental health policy since 2003, placing it within the context of broader mental health discourses, and assessing its position within contemporary constructions of mental illness. Once this framework has been established, the second chapter will discuss the representative strategies employed in both performances, their physical and discursive treatment of service-users, and their representation of power dynamics within psychiatric settings. Building on this analysis, the final chapter will discuss the relationship between these performances and the discourses and constructions identified in chapter one.
1 – Contexts: Policy and Discourse

When we speak of mental illness a huge variety of different words, images, and concepts come to mind. We might have friends who have suffered, to a greater or lesser extent, from diagnosable conditions such as anxiety or bipolar disorder; newspaper headlines are lurid with descriptions of acts committed by ‘psychos’ and ‘maniacs’ (see e.g. Haywood 2010; ‘Daily Mail Reporter’ 2011). On a more mundane level, how many of us have heard the expression ‘I’m a bit OCD’, or ‘I’m so depressed’ from the mouths of people who have no formal medical diagnosis? We might think of Sigmund Freud and his Oedipus complex; see images of nineteenth century asylums with burly attendants and straitjackets. This parade of neurotics and psychotics, madmen, killers, and friends gives some idea of the complex issues associated with speaking about mental illness.

This being the case, before we examine the uses made of mental health discourses by Theatre NEMO and Anthony Neilson, and the specific interventions made by individual performances, it is necessary for us to examine in detail the contexts into which they are intervening. This will be done by focussing on the central discursive frames employed by policy makers and mental health bodies alike: the ‘bio-medical’ model of mental illness and the idea of ‘stigma’. Through this analysis, it is possible to get an idea of the discursive position occupied by service-users in Scotland.¹ In uncovering the range of constructions available, this chapter will also examine how organisations employ these constructions in order to further their own agenda. Since these different (and often conflicting) agendas have the interests of different groups at heart, to explore these areas is also to explore the power relations latent in the language of mental health.

¹ This thesis will use the term ‘service-user’ throughout to designate people who make use of mental health services available in Scotland. Although contentious, since it acts as an umbrella term bracketing otherwise disparate groups of people, it remains neutral as to the factors which lead to an individual using these services, unlike ‘patient’, ‘survivor’ or ‘mentally ill person’, all of which imply a preconceived judgement as to the service-user’s relationship to those services.
The analyses presented in this chapter will be based on policy documents published by the Scottish Executive, placed within the broader context of publications originating in the charity and academic sectors. Policy documents are particularly important when examining contested areas such as mental health, since they occupy an unstable position, both constructing and constructed by existing discourses. Lydia Lewis characterises the position of policy documents within the specific context of Scottish mental health policy as follows:

Policy documents […] should also be considered worthy of analysis in their own right […] The policy discourses contained within such documents are […] constructive of practices as they are implemented and also as they come to be promulgated in public spheres and to infuse the language used in specific public policy or service areas.

(Lewis 2005: 86)

Placing policy documents within their wider contexts can help develop a comprehensive picture of conceptions of mental health in twenty-first century Scotland. In addition, using these contexts to critique policy documents can draw attention to the specific purposes they are intended to serve. Newspaper and television reports will not be considered here, despite their centrality as mediators of policy and statements by mental health bodies. This is because they add a level of complexity for which there is not space within the current discussion, which is concerned with the ways in which specific bodies engage with the public through their own publications. In addition, the networks involved in Scottish mental health policy making are complex enough that, even without the added question of their presentation in news media, what follows represents only a rough sketch of the discursive field (see Smith-Merry et. al. 2008).

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Bio-medical constructions of madness – uses and limits

As made clear by writers such as Gach (2008), Szasz (2002), and Double (2006), the idea that what used to be called ‘madness’ has now been identified and categorised into various ‘mental illnesses’ with specific physical causes (the ‘bio-medical model’), remains a contentious one. Scottish Executive mental health policy, however, is grounded in language that sees ‘mental health’ as an uncontroversial, scientific entity. From the titles of documents such as the National Programme for Improving Mental Health and Well-being: Action Plan (Scottish Executive 2003),3 to the allowance under the Mental Health (Care and Treatment) (Scotland) Act 2003 that a ‘medical practitioner’ has the power to obtain an ‘emergency detention certificate’ against the will of the patient (Part 5), the language of health and illness places authority over ‘madness’ squarely within the medical profession. Partly in recognition of the complexities identified above, 2005 saw an attempt by the Executive to broaden the conception of ‘mental health’:

What people understand by mental health and well-being are influenced by age, class and gender, as well as by people's experiences, expectations, and cultural and religious beliefs. […] There is general agreement that mental health is more than an absence of mental illness. […] The definition of mental health as a 'positive sense of well-being' challenges the idea that mental health is the opposite of mental illness. (Myers et. al. 2005: 18)

The more holistic framework provided by the addition of mental well-being notwithstanding, mental illness remains a staunchly medical category in this account, despite controversy surrounding diagnostic labels in psychiatry (see e.g. Mirowsky & Ross 1989; Wakefield 1997), while non-medical aspects are relegated to the open and conceptually vague category of mental well-being, a category whose limits are defined against mental illness. Mental well-being is a continuum between content and

3 Subsequent references incorporated in the text.
discontent, just as mental illness is a continuum between eccentric neurosis and disabling psychosis, but the imposition of a diagnostic label creates a caesura between discontent and illness. While this definition of mental well-being prevents health being defined as a ‘lack of illness’, it emphasises the idea that mental illness is defined as a diagnosable ‘lack of health’: a diagnostically significant deviation from an established norm.

Although this diagnosis-based approach to psychiatry focuses around the idea that ‘there is a boundary between the normal and the sick’ (Double 1990: 473), this boundary is problematic, since, despite professional challenges to its utility, it marks the point at which medical, political, and legal authority can be specifically exercised over the individual. Their personhood is compromised and they become a ‘patient’, a ‘service-user’, a ‘mentally ill person’ who is denied legal rights over his or her own body. However, other conceptions of ‘mental well-being’ exist which challenge this boundary. The MIND booklet How To Improve Your Mental Wellbeing rejects the bio-medical model of mental illness, pointing out that ‘despite the huge amount of time, money and effort that has been spent in the search for the genes or the biochemical changes that cause mental disorders, none has been discovered’ (Rowe 2002: 6). This rejection of bio-medical orthodoxy leads to a very different conception of recovery:

The trick is to say to yourself, ‘I don’t think much of myself, but from now on I’m going to act as if I’m my own best friend. I’m going to be kind to myself, look after myself, and stop criticising myself and putting myself down.’ Acting as if you’re your own best friend will lead you to become that (7).

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4 The language in which ‘disability’ is discussed is a contentious area. Despite some challenges to the idea that ‘mental illness’ qualifies as a disability, this thesis will use the term ‘disabled people’ to describe the way in which ‘our society is constructed by people with capabilities for people with capabilities and it is this that makes people with impairments incapable of functioning’ (Finkelstein 2002: 2. Emphasis in original). Within this framework, mental health service-users are also ‘disabled people’ when their experience of mental distress prevents their functioning in a way socially codified as ‘normal’.
Within this construction, the service-user has the power to improve their own mental well being or, at the very least, is a unified person whose distress arises from concrete thought processes. This ‘person-centred’ approach can be traced back beyond the birth of bio-medical psychiatry, but found perhaps its most influential expression in R. D. Laing’s *The Divided Self* – a text that contributed to the birth of the so-called anti-psychiatry movement in the 1960s (and indirectly to NAMH’s transformation into MIND).\(^5\) In his early writings, Laing challenges a tendency towards ‘depersonalisation’ within mainstream psychiatry and psychoanalysis:

> How can one demonstrate the general human relevance and significance of the patient’s condition if the words one has to use are specifically designed to isolate and circumscribe the meaning of the patient’s life to a particular clinical entity? (1990: 18)

MIND’s approach is based on a similar consideration of the human context of the individual’s experience:

> Seeing someone’s problems solely as an illness that requires medical treatment is far too narrow a view. It discourages people from thinking about the many different influences on someone’s life, on their thoughts, feelings and behaviour, which can cause mental distress. It may also prevent people from exploring the various non-medical treatment options that are available. (Stewart 1993: 2)

Laing prefaced the first edition of his book with the comment ‘it is to the existential tradition […] that I acknowledge my main intellectual indebtedness’ (1990: xi), and the focus on individual freedom and context implied by MIND’s account, as well as the influence of anti-psychiatric ideas in the charity’s development, suggests a similar intellectual connection to existentialism. Through their concentration

\(^5\) The history of MIND and its predecessor NAMH (National Association of Mental Health) is a complex one, involving a major change in direction that coincided with its 1972 name change. For an account of this change, and its relationship to anti-psychiatric discourses, see Crossley, 2006: 112-127.
on the complete psychological and social context of mental illness, both Laing and MIND suggest a unified view of service-users involving an active approach to recovery.

Despite the absence of any direct challenge to medical orthodoxy, Scottish Executive policy is not limited by a simple application of the bio-medical model, but contains elements grounded in ideas similar to those of MIND, although in a complex and problematic way. The Action Plan does not provide a specific definition of mental health or illness, and the absence of a definition before the briefing paper ‘Concepts and Definitions’ (Scottish Executive 2004) suggests broad acceptance of the bio-medical model with its attendant difficulties. However, a comparison between the Action Plan and the Mentality report What Works (Mentality 2002), on which the Action Plan is based, reveals a telling omission. The ‘Priority Areas’ identified in the Action Plan correspond almost exactly to the chapters of What Works (see Fig. 1.):

<table>
<thead>
<tr>
<th>What Works Chapters</th>
<th>Action Plan Priority Areas</th>
</tr>
</thead>
<tbody>
<tr>
<td>Early Years: Children and families</td>
<td>Priority Area A: Early Years</td>
</tr>
<tr>
<td>Young People in School</td>
<td>Priority Area B: Children and Young People</td>
</tr>
<tr>
<td>Young People in Community Settings</td>
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<tr>
<td>Primary Care</td>
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</tr>
<tr>
<td>Workplace</td>
<td>Priority Area C: Improving Mental Health and Well-Being in Employment and Working Life</td>
</tr>
<tr>
<td>Older People</td>
<td>Priority area D: Improving Mental Health and Well-Being in Later Life</td>
</tr>
<tr>
<td>Communities and Neighbourhoods</td>
<td>Priority Area E: Improving Community Mental Health and Well-Being</td>
</tr>
<tr>
<td>People with Mental Health Problems</td>
<td>Priority Area F: Improving the Ability of Public Services to Act in Support of the Promotion of Mental Health and the Prevention of Mental Illness</td>
</tr>
</tbody>
</table>

The chapter ‘Young People in Community Settings’ spans Priority Areas B and E, and ‘Primary Care’ is partially covered by Priority Area F. The major difference stems from the way that the Action Plan’s
priority areas systematically deny personhood and autonomy to those service-users suffering from chronic or disabling mental illnesses. While *What Works* accepts the existence of ‘People with Mental Health Problems’ (there appears to be a deliberate decision by Mentality not to refer to ‘mental illness’ except when citing secondary literature), the *Action Plan* refers specifically to the ‘Prevention of Mental Illness’, but not to the treatment of those *already* suffering mental distress, or the ability of service-users to engage with their own process of recovery. The document which details the position of service-users in the *National Programme*, the report *Delivering for Mental Health*, was produced largely by NHS Scotland (Scottish Executive: 2006). Although this division of responsibilities is understandable, the absence of chronic mental illness from the *Action Plan* further emphasises the division between ‘healthy’ and ‘ill’. Indeed, the body of the *Action Plan* is devoted to policies based on a holistic framework of mental health:

> Older adulthood can be a time of considerable change, some positive – more leisure time, travel opportunities, some negative – loss of work, bereavement, lower income, reduced social contacts, increased social isolation, poorer health, ageism, fear of violence, increased risk of depression. (9)

This combination of the bio-medical model of mental health with the more wide-ranging concept of mental well-being provides specific advantages as a model for government policy. Bio-medical constructions challenge the idea of mental illness as personal weakness, while the model of mental well-being allows the Executive to claim policy can ‘prevent’ mental illness – something a stricter application of the bio-medical paradigm, in which medical practitioners have unique expertise in treating a biologically grounded ‘brain disease’, would preclude.

The limitations of scientific knowledge relating to mental illness allows a combined construction within an ‘evidence-based’ policy structure, but this pragmatic combination of approaches is not an unproblematic solution. The extent of the compromise this entails is clear from the fact that the *Action Plan* focuses on policy as the means to ‘prevent’ mental illness. In a Scottish Parliament
debate in 2003, Alan Ingram MSP stated that ‘we cannot divorce the health improvement agenda from the state of our national health service, especially with mental health’ (Scottish Parliament 2003). Although it therefore seems strange that the Action Plan only touches slightly on the question of mental health in a clinical setting, this disparity is consistent with the necessity for policy to be seen favourably at the ballot box. As Ingram says, ‘politically, not nearly as much kudos is to be gained from devoting resources to mental health as from devoting them to, say, cancer or coronary care’ (2003). The uncertain etiology of mental distress, combined with the social exclusion of service-users, means that investment in improved mental health services, both acute and community based, provides limited political returns. Conversely, the framework of mental well-being allows voter-friendly issues such as ‘speeding and drug dealing’ (Scottish Executive 2003: 9) to be tackled under the auspices of improving mental well-being.

**Anti-Stigma Discourses and Mental Health Policy**

The problems of stigma and discrimination are central to policy discourse and discussions of mental health more generally. The Scottish Executive has devoted a large amount of time and money to addressing the problems of stigma surrounding mental ill-health (See Myers et. al 2009). That such a campaign is necessary (or at the very least was necessary during the period under consideration) can be seen from the results of the first *Well? What do you think?* survey of attitudes towards mental health. The executive summary which introduces the report shows that, although people express broadly positive and tolerant attitudes towards service-users, a significant proportion of the Scottish population has a much more negative opinion:

> While the attitudes of almost half the people interviewed placed them in the two most tolerant groups, one in five expressed opinions that placed them at the other end of the spectrum. (Glendinning 2002: 4)
Indeed although attitudes towards mental illness are broadly positive, this changes when presuppositions about the suitability of service-users for various tasks are examined. In a 2009 YouGov survey reported by the ‘Time to Change’ campaign, 56% of respondents said they would not employ a candidate who disclosed a mental illness, despite considering them the best person for the job (Stringer 2009), suggesting that service-users are only viewed positively within a very limited framework.

Erving Goffman’s classic discussion of stigma provides a possible explanation for these findings. If, as Goffman argues, ‘stigma’ represents ‘a special discrepancy between virtual and actual social identity’ (Goffman 1986: 3), then it is a mark that resides within the individual. Challenging stigma does not remove the mark, but provides a new social category into which bearers of the mark can be placed to remove the ‘discrepancy’. Seen in this way, the results of the Well? survey, rather than representing positive attitudes towards mental illness, suggest that there is a conceptual category into which service-users can be placed, akin to the ‘sick role’ described by Parsons (1951). There is evidence for this within the Well? survey itself: responding to vignettes depicting individuals with the symptoms of stress, depression, and schizophrenia, ‘very few respondents thought that Robert or Shona should live alone, whatever the symptoms described. For the person suffering depression or stress, living at home with family members was a popular option’ (Glendinning 2002: 10). This fits with Parsons’ idea that the sick role entails obligations ‘to want to “get well”’, and ‘to seek technically competent help […] and to cooperate with him in the process of getting well’ (Parsons 1951: 437): essentially giving up the right to independence for the duration of the sickness. This reading is supported by the findings of the 2009 British survey of Public Perceptions of Disabled People.

Looking specifically at the results relating to mental illness, the level of comfort felt fell steadily as the service-user was placed in more responsible situations or closer proximity to respondents. 79% of people said they would be comfortable interacting with a service-user in a sports team, but only 39% of people expressed comfort with the same person as their MP. It is also worth noting that, even in the
scenario with which people felt most comfortable, the figure of 79% is markedly less than that reported for physical disability (97%) (Staniland 2011: 38).

These findings represent a challenge to the assumption that it is somehow more difficult to justify discrimination on the basis of ‘disease’ than inherent psychological flaw. In a discussion of the relationship between stigma and the bio-medical model, A. K. Thachuk characterises the thinking underpinning this assumption as follows:

[L]ikening mental illness to physical illness legitimizes the individual’s experience of helplessness, undermines the assumption that those with mental illness are simply weak-willed, and increases accessibility to health-care services. (2011: 143-4)

She goes on to refute the claim that the body is ‘morally neutral’ (156), that grounding mental health discourse within a bio-medical framework is a ‘talisman to ward off stigma’ (144). Indeed, it is worth noting that a seminal work dealing with stigma deals primarily with stigmatization associated with physical rather than mental conditions. Neuro-muscular disease, polio, muscular dystrophy and other physical conditions are represented, but not a single essay is the work of an author suffering from mental distress (Hunt 1966), suggesting that physical disability bears just as much stigma. Even etymologically, a ‘stigma’ is a mark of difference, even if, as Hélène Cixous argues, that mark denotes something more ambiguous than mere inferiority (2005).

Petra Kuppers, discussing disability in the context of performance, draws attention to the impact of constructions of disability, whether physical or mental, on disabled people, grounding her analysis in the physical basis of the category ‘disabled’:

Disability as a social category is not the same as race or gender, but it shares important aspects with the ways of knowing difference. All three terms relate to differences that are constructed as binaries and as biological, and that come with heavy weights of
Excess meaning: like race and gender, disability structures people into separate
categories (2003: 5)

Emphasizing the biological, physical model of mental distress draws social understanding of it closer
to that of physical disability. This is problematic, as ‘the act of ascribing ‘disability’ to a person is not
value-free’ (5). Although the social model sees individuals as ‘disabled’ by the failure of a society
constructed by people with capabilities to recognize the rights of people with impairments, the social
roles available to disable people in broader public discourse are more limited, and include the ‘heroic
cripple’ and the ‘stoic invalid’.

This raises a further problem with the Executive’s use of stigma as a conceptual framework. To
make a functional distinction in policy between service-users, whose needs are met through medical
policy, and people who are not service-users but may have poor mental wellbeing, whose needs can be
met though social policy, is to inscribe service-users with a mark of difference. Although not
immediately visible, unlike the ‘signs […] cut or burnt into the body’ from which the term ‘stigma’
originates (Goffman 1986: 1), this mark nevertheless results in different treatment for those who bear
it, as demonstrated by the 1996 MIND report Not Just Sticks and Stones (Read and Baker 1996).
Indeed, following Goffman’s definition of stigma cited above, as well as T. J. Scheff’s ‘labelling
theory’ of mental illness (1966: 69-100), it becomes clear that constructions based on stigma affect
service-users’ self-image as well as how they are seen by others. The interaction between Goffman’s
account of stigma and the labelling theory proposed by Scheff makes it clear that an absolute category
distinction between ‘service-user’ and ‘non-service-user’ is unhelpful in reducing negative treatment
of those with labels. Not only does the distinction re-enforce negative assumptions, it also encourages
service-users to ‘play up’ to their labels, reducing their social participation to a level consistent with
their assumed social identity. By using stigma as a framework through which to challenge negative
treatment of service-users the Scottish Executive is with one hand marking service-users out as
categorically different from other distressed people, while with the other investing money in
programmes which aim to convince the public that there is no essential meaning in such a mark of difference.

If stigma is a limited, though widespread, concept for assessing the barriers to social participation experienced by service-users, what is the alternative? Liz Sayce (1998) draws together a wealth of studies that reveal the level of abuse and discrimination suffered by service-users, from the necessity of disclosing mental health diagnoses to acquire a US visa, to the experience of having dog feces put through the letterbox. She argues that discrimination is a more productive campaigning framework than stigma, which is limited for the reasons outlined above. Her conclusion is as follows:

Terms such as `discrimination’ and `exclusion’ are more likely to help us conceptualise and plan this work than `stigma’ – although the main issue at stake is that we should root thinking and practice in an analysis of unfair treatment. The significance of this for the lives of service-users transcends any narrow discussion of terminology. (342)

As well as making the pertinent point that questions of language are only secondary to the actual experience of service-users, Sayce’s conclusion makes it clear that the terminology in which these experiences are conceptualised has a marked impact on the policy approaches taken. The key advantage of Sayce’s focus on ‘discrimination’ is that it places mental health discrimination within a human rights framework, taking as its basis the idea that service-users deserve to be treated in the same way as those without a mental health diagnosis, regardless of differences.
2 - Performance in Action

The representation of mental distress in dramatic performances is limited by a number of factors. One of the main limitations is the fact that the contexts in which it is produced have a decisive influence on its reception. The specific performances under discussion here exist in a discursive and economic situation affected by the Scottish Executive policy discussed in the previous chapter, and the constructions employed in policy also manifest within the performances. The second problem, also affected by the discursive context, is that all representations are mediated through the physical bodies of the actors. This chapter will examine the physical strategies employed in both Dissocia and the work of Theatre NEMO, identifying potential problems and examining the solutions posited by both groups.

Physical Representations

The bio-medical model roots mental distress in a (theoretically, if not practically) detectable physical change in brain chemistry. This conceptual focus on the physical interacts with an expectation that disordered minds are externally reflected in disordered bodies: the conventional images of the strait-jacket and padded cell, exemplified by the writhing, moaning inmates of Charenton in Peter Brook’s RSC production of Weiss’s Marat/Sade. This tendency is emphasised by Petra Kuppers:

A general problem with working towards an aesthetic that tries to find spaces for the unknowable is that the ‘other’ too quickly becomes fixed into otherness […] it is too easy to allow the spectators to see the performers as ‘mad and to see the traces of that ‘madness’ evidenced on their bodies. (2003: 130)
As a result, any attempt at sympathetic stage representation of service-users must tread a fine line between grotesque stereotypes and a failure to identify the action on stage as deriving from mental distress.

An added complexity in the case of Dissocia is the fact that Lisa’s is not identified (or diagnosed) as mentally ill until the beginning of act II. This is part of the ‘particularly unusual structure’ (National Theatre of Scotland 2007) drawn attention to by Neilson. This structure, one of the major talking points in reviews of the play, functions by fracturing the expected narrative. Prior to the interval, the play is conventional fantasy quest in which the protagonist is transported from a contemporary, realist milieu into a fantastical realm. References to previous works increase the audience’s sense of familiarity as the song “Welcome to Dissocia” owes a structural and lyrical debt to “The Merry Old Land of Oz”, and the Scapegoat, in literalising and embodying a conventional concept, is a direct descendent of Lewis Carroll’s March Hare. Act II, however, reveals Lisa to be a psychiatric patient, her medication induced drowsiness standing in stark contrast to her position as ‘Queen Sarah’ at the close of act 1. Neilson acknowledges the potential problems of this shift, in terms of the representation of the psychiatric institution itself:

It is important to me, however, that this play does not seem biased against the notion of psychiatric treatment; on some level, such treatment is always about the suppression of individuality which already loads the dramatic dice somewhat […] For example […] to omit a window would hint at an unacceptably inhumane environment.


However, despite, or perhaps because of, his desire to avoid prejudicing the audience against psychiatric treatment (an understandable concern, in the light of those reviewers who saw the play as a manifesto for a return to the medication-free treatments of R. D. Laing), less care is taken the physical

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6 All subsequent references to this edition.
representation of Lisa as a service-user. As noted above, there is a tradition of representing madness onstage through a concentration on frantic action, whether that be actually represented, or implied through the presence of straitjackets and padded walls. This trope also appears in *Dissocia*. In scene six of act 2, we find Lisa ‘*dancing manically around the room, on the bed, everywhere*’. Even if we overlook the medically inflected term ‘*manically*’, we are still left with an image of the service-user as physically out of control. Despite the fact that Lisa is finally subdued with ‘*as little contact as possible*’, the image is fundamentally no different to that of the madman in need of restraint (78): tranquilizing drugs replace physical bonds, but the conceptual resonance is the same. Indeed, this lack of self-control begins to undermine the ability of audiences to relate to Lisa as a complete, valid, human self. In the *Handbook of Self and Identity*, the ‘self’ as is repeatedly cited as a key difference between human and non-human animals:

> Perhaps the greatest benefit of the human capacity for self-awareness is that it allows people to control their own behavior in ways that are not possible for animals that do not possess a self [...] One of the most notable things about human beings that distinguishes them from all other animals is their ability to self-reflect, to form images and ideas of what they are like, to ponder important questions about themselves, to seek outcomes that are congenial to their sense of self, to exert deliberate control over themselves, and to engage in other acts of selfhood. (2003: xii)

If possession of a self, and the deliberate exercise of that selfhood, is a defining distinction between humans and other animals, a representation of service-users based upon an inability to fully exercise selfhood is essentially dehumanising. Service-users are again characterised by lack and absence, a representation which re-enforces patterns of discrimination. As Goffman says, ‘by definition, of course, we believe the person with a stigma is not quite human’ (1986: 5).

Theatre NEMO, to an extent, is able to avoid this conceptual minefield, especially in their live-action work; the bodies through which ideas about service-users are mediated are the bodies of
service-users themselves. The short film *Does Anyone Know* (Theatre NEMO 2008) directly challenges images of mental distress reflected in uncontrolled movement. The focus of the piece is directly on language, opening with text on a black background, and with the voices of the performers heard before their bodies are seen. When we finally see the actors, they are isolated in space, lit by a single light, superimposed on a black background. The light and the background remain in place, but the images of the performers fade in and out depending on who is speaking. This focus on speech and presence, emphasised by the measured, slow, rhythmic delivery of the script, implies physical control, a contrast to the alternating catatonia and disordered movement of Lisa in act 2 of *Dissocia*.

![Image: Does Anyone Know](image)

**Fig. 2.: Does Anyone Know**

However, the bodies of the performers are not unproblematic. The design of the film, fading the actors in and out while the background remains constant and the voices echo, gives an impression of the body as transient and unstable. In this representation, the bodily integrity of the service-users is assailed by the issues that they discuss (see Fig. 2.). Unlike *Dissocia*, in which Lisa suffers from a straightforwardly medical condition, *Does Anyone Know* presents a dialectic picture, placing service-
users within a social context which aims to render both their crimes and their mental distress explicable, positioning them as unified bodies and minds under threat from external influences.

These differences are partly due to the differing aims of the performances. While *Does Anyone Know* was the result of a project whose aims were not primarily artistic, seeking rather to ‘increase participants’ self-esteem, confidence, communication and interpersonal skills’ (Theatre NEMO 2008: 1), *Dissocia* arose from Neilson’s interest in a combination of dramatic and social issues – in mental health, but also in improvisation and the spectacular potential of theatre. In much the same way as the language used on stage is citational, bearing inevitable intertextual relationships to previous plays and works of literature, the physical gestures used by actors also conjure images of their previous uses. As a result, it is significant that Neilson’s choice of actress to play Lisa was Catherine Entwistle, with whom he had worked on a 1994 Edinburgh Festival Fringe show called *The Woman in the Attic*; a piece whose title evokes madness through its suggestion of Brontë’s madwoman. As Entwisle said in an interview with *The Herald* newspaper prior to the 2007 revival of *Dissocia*, Neilson ‘knows I can do mad, so that probably helps’ (Cooper 2007). This expectation of recognisable stage madness, the ability to ‘do mad’, draws attention to the traditions within which theatrical representations of madness exist. These traditions are emphasised by the visual reference to Sigmund Freud in the character of Victor Hesse – Freudian psychoanalysis is tied in the public imagination to the stock figure of the female hysteric, (although a contextual essay in the programme argues that this association is largely unfair (Cramer 2004: 6)). These factors, combined with the fact that Neilson has been pigeonholed as part of the ‘In-Yer-Face’ movement (Sierz 2001) and has said ‘I want people to experience something first and then talk about it afterwards’ (Cavendish 2004), to an extent determine that the physical representations of madness in the play will be based around excess.

**Concepts and Constructions**

As well as the physical representations of service-users, ideas about mental illness are also represented through the language used in these productions. *Dissocia*, perhaps because it is only addressing the
central question of ‘why people who are mentally ill find it difficult to take their medication’ (Cavendish 2004), does not challenge the more fundamental conceptions of mental health available in cultural discourse. From the moment we see the watchmaker Victor Hesse who ‘bears more than a passing resemblance to how we imagine Sigmund Freud’ (6), the play is full of jokes, both visual and verbal, based on the preconceptions of the audience about mental health. Even the name of the play itself is a nod towards the DSM-IV’s classification ‘dissociative identity disorder’, despite Neilson’s insistence that the play is ‘not aiming at depicting a particular mental state’ (Cavendish 2004). These jokes, and the reliance on preconceptions, are a result of Neilson’s writing technique of ‘group-dreaming’, so that ‘the play will move in the same way the mind does, through association’ (Cavendish 2004). By allowing these preconceptions to interact, the play offers a challenge to the consistency of existing narratives, especially by making them into jokes, as with the ‘insecurity guards’. However, one of the problems of humour is that it is constantly ambiguous. The play relies on the images the actors already had of mental health, mediated through Neilson’s own writing process. Christine Entwisle (Lisa) makes it clear that, although much of Neilson’s work is heavily workshopped, it is not ‘devised’ work:

You do lots of improvising, you read the scripts, you say ‘I don’t think that works as well as that’, so there is a sense that you are helping the process along. But, ultimately Anthony will go away and come back and write whatever he wants to write and it may as well have nothing to do with anything anyone has said. (Reid 2007).

The model of mental health that emerges from this process is largely in accordance with the biomedical model. Indeed, when we enter the hospital, we are presented with a measured, largely unproblematic view of effective medication and a mechanical view of the process of recovery, as Lisa moves through stages of sleepiness and non-compliance towards the point at which she takes the medication herself. This mechanised construction was emphasised by the set design:
The hospital room was enclosed in a box, the front of which was clear perspex. This necessitated the use of radio mikes for the actors’ dialogue. This allowed them to act on a much more intimate scale and was very effective (74) (see fig. 3.).

**Fig. 3.: The Wonderful World of Dissocia, Act 2.**

We are given an indication of some of the more problematic aspects of the medication, as Lisa asks for ‘lighter’ pills, because ‘these ones make me feel really dopey’ (81), but this is not a serious engagement with the question of medication side-effects – something that might be expected in a play attempting to delineate reasons for non-compliance. Indeed, by the end of the play, the side effects have vanished completely, without any apparent change in medication, as Lisa says she feels ‘Fine. Good, actually’ (85). Despite the nuance provided by the mechanistic, impersonal representation of the institution, and some references to medication side-effects, Dissocia constructs a view of medication very much in accordance with its own metaphor about the Sirens: ‘they know that if they sail to them their ship’s going to get all smashed up. But they think it’s worth it, you know – for the song.’ (88). Medication is the safe, open sea through which Lisa (a figure for service-users in general) must navigate, away from the beautiful but dangerous lure of psychosis and Dissocia.

By contrast, Does Anyone Know places mental distress in a broader context, and in doing so complicates the picture. The second section of the film deals specifically with the question of
medication and bio-medical interventions. Beginning with one character saying ‘doctor, I feel really low’, the disembodied voice of the doctor prescribes ‘10 milligrams,’ the starting dose of many antidepressants. However reasonable this might be, the extent to which a psychiatric diagnosis can impact medical treatment is explored, as the doctor’s reaction to a patient saying ‘doctor, I’ve dislocated my right shoulder’ is to increase the dose to ‘20 milligrams’. This continues as the section builds to its climax, the disembodied voice increasing the dose over and over again, each prescription bleeding into the next through an echo effect added to the audio. The section ends with the old joke ‘Patient: Doctor, everyone keeps ignoring me. Doctor: Next please’, recontextualised so that it becomes a comment on the invisibility of people doubly excluded from society by their categorisation as both service-users and convicts.

This is the key to Does Anyone Know’s performance of mental distress – the desire to place it in a broad social context. The opening of the third section, which initially seems to be questioning diagnostic categories, signals this project:

Some are not really causes, but just symptoms, and we misdiagnose a sickness for a symptom of the real sickness. The cause and the effect are often interchanged.

Opening the section with the word ‘some’, but providing no way for the audience to know ‘some of what’ immediately introduces ambiguity. The monologue is spoken directly to the camera by an actor filmed close up, a contrast to the full- or three-quarter-body shots used previously, and this increased focus on the face provides greater immediacy and intimacy. The ‘real sickness’ being discussed is the relationship between poverty, crime and ignorance, rather than any recognised form of mental distress. Using the language of mental illness to segue into a discussion of poverty draws attention to the interaction between social and medical models of distress. This strategy chimes with observations made about the mental health system from within psychiatric hospitals. In a report produced by Theatre NEMO, a member of staff working in a psychiatric hospital described service-users as ‘individuals caught and entrapped in institutions that can cower [sic] the human spirit’ (Butts, 2011: 1).
The effectiveness of Theatre NEMO’s approach can be seen by comparing sections of *Dissocia* and *Does Anyone Know* which employ a similar dramatic concept: a bureaucratic department for recovering lost things. In both cases, the bureaucracy in question is reminiscent of Monty Python’s ‘Argument Sketch’ – dysfunctional, unhelpful and pedantic (Chapman 1972). In *Dissocia*, Lisa visits the ‘Lost Lost Property Office’ – where the person in charge waits to be brought the Lost Property Office, which has been lost (55-6), and later reveals that the whole section has been an elaborate set-up to prevent Lisa from completing her quest. In *Does Anyone Know*, a character looking for the ‘Lost Purpose Department’ arrives instead that the ‘Department for Lost Causes’ and is led in a circular conversation through various departments before being told ‘there’s no purpose in your being here’, and directed back to the Department for Lost Causes. Both these scenes associate mental distress with loss, while emphasising the bureaucracy involved in being a service-user, but while *Does Anyone Know* provides a poignant image of the mental cycles associated with mental distress, *Dissocia*’s less focussed, more humour-based scene adds to the ‘losses’ suffered by Lisa without addressing her earlier infantilisation: she is described in the stage directions as ‘*a child who has senselessly broken her toy*’ (5) – a fundamental loss of adulthood.

**Dramatic Physicality and Psychiatric Power**

The positioning of the service-user within *Dissocia* and *Does Anyone Know* can be usefully considered in relation to Michel Foucault’s work on psychiatric power. Although, as Porter (1990) has shown, Foucault’s account of the ‘great confinement’ at the start of the nineteenth century is historically unsupported, his broader thesis about the exercise of power over the ‘madman’ provides an essential framework for the consideration of power-relations within contemporary psychiatry. Foucault’s best-known work on psychiatric power is his first book, *Madness and Civilisation* (2001), however, perhaps his most concise statement can be found in the course summary ‘Psychiatric Power’. In it, he maps the position of the psychiatric patient, drawing attention to the fact that a psychiatric diagnosis (a statement of diagnostic ‘truth’) disqualifies the patient from ‘any power and any knowledge
concerning his illness’ (1997: 49). For Foucault, the moment of diagnosis removes the service-user from their position of autonomy and brings them under the auspices of psychiatric power – an imposition of structures of understanding that take no account of the actual experience of madness, since this experience is invalidated at the moment of diagnosis.

Lisa, in act 2 of Dissocia, feels the force of this power acutely, as her experience and actions are discredited by her diagnosis and position inside the hospital – the seat of psychiatric power. The set design reflects the psychiatric gaze – Lisa’s hospital ward is at once a place of recovery and a place of observation, and each audience member is placed in a position of power over Lisa by virtue of their silent, unseen observation from behind glass. In Laing’s terms, she becomes an object described by medical terminology, and this position is only slightly complicated by the audience’s knowledge of the contents of her psychosis. The impact of this gaze, an example of the panoptic gaze described by Foucault in Discipline and Punish (1995: 195-230), is continually emphasised throughout act 2. Nurse 3 makes this explicit in her threatening comment ‘now don’t be creeping around cos I’ll be watching’ (77), and scene 10 draws attention to the audience’s voyeurism, consisting solely of Nurse 1 looking through a window in the door and leaving the curtain open – all who pass the ward can now see in.

However, although these representations may make the audience question their complicity in the power being exercised over Lisa, this attention is not clearly focussed, due both to the unproblematic view of medication discussed above and the fact that the preconceptions about mental illness raised through the character of Lisa’s sister Dot are not comprehensively challenged. Dot views Lisa’s failure to take her medication as ‘selfishness’ (82), and is presented as the ‘every-person’ beloved of British tabloid newspapers: a mother concerned about her mortgage and what ‘people’ will think. Indeed, she is happier to view her sister as an archetype of ‘madness’ than a coherent, individualised person:
[Y]ou’re just going to have to take the consequences. We can’t all be floating around with our heads in the clouds, playing the guitar and being ‘artistic’. The sooner you get that through your head, the better. This is the real world (83).

Although Dot herself is a two-dimensional figure, she also demonstrates the ways in which a psychiatric diagnosis removes power from the service-user, not just in relation to medical power, but also in relation to every other ‘sane’ human being. As Dot says, ‘you can’t blame’ people for thinking that Lisa’s ‘some sort of nut-case’ (82) – this is a standard category for psychiatric patients. Indeed, the democratisation of psychiatric power throughout the ‘sane’ community can be seen in the number of reviews which offer (differing) diagnoses of Lisa’s condition, a point to which we will return in chapter three. The conversation with Dot undermines Neilson’s stated aim for the play, as, by failing to challenge the views presented, it allows unsympathetic audience members a ‘get out clause’ – Dot’s views, inscribed on Lisa from a comfortable position of sanity, deny any need for Dot to be sympathetic by making Lisa totally responsible for her actions, not ‘ill’ but ‘selfish’. The ease with which her experience, as opposed to Lisa’s, can be universalised is suggested by Michael Billington’s review for the Guardian newspaper:

Amanda Hadingue as [Lisa’s] confused sister and Jack James as her partner convey the helplessness of those struggling to come to terms with mental illness in loved ones.
I shall remember the play for this kind of attentive human detail rather than for its attempt to take us into the essentially private, unreachable world of Dissocia.

(Billington 2007)

Neilson has failed to ‘capture something overall about [mental illness]’ (Fisher 2004) – for Billington, it has instead reinforced the strict delineation between madness and sanity. However, there is an extent to which the responses to the 2007 revival of the play were always circumscribed by the enthusiastic response to the first production. As Christine Entwisle says ‘critics like to have something to react to
and of course because Scotland though it was really fantastic, the critics here say “well, the Scottish critics say this, but we think…” (Reid 2007).

By contrast, Does Anyone Know engages with psychiatric power from the outset, communicating vividly the experience of existing in a subservient relationship to it. The design, reminiscent of an interrogation room with its single overhead light bulb, reminds the viewer that the speakers are not just mental health service-users, but also prisoners of the criminal justice system. While the subject is clearly visible, any figures outside the small, lit area are rendered invisible, producing a kind of inverse panopticon, where the actor is the focus of the gaze of any number of possible observers. This is the position of the subject of psychiatric power – alone, and under constant, unsolicited observation. This is emphasized by the submissive positions of the actors, shoulders slouched, hands lowered. Even their voices are subdued as they address the audience from their compromised position. The submissiveness of the actors’ postures can be seen as an expression of the ‘inability to take space’ noted by Kuppers in her work with service-users, and as such draws attention to the ‘lack of physical and mental privacy’ which characterizes life in institutions such as prisons and hospitals, in which the individual’s right to personal autonomy is removed and replaced by the demands of the institution – the extent to which service-users find ‘no space for themselves, their bodies, their movements in their social and physical environments’ (2003: 125) is the extent to which institutional power has acted on them. For Kuppers, this difficulty in asserting ones individuality is not purely a function of mental distress, but one which ‘seems to mirror their representational silencing or distortion in the media’ (125), and this reading is supported by the aspect of the actors in Does Anyone Know. As discussed above, the simple design draws attention to the individual actors on a physical level, but this challenge to images of service-users as hysterically out of control does not attempt to normalize their experience.

Beyond the physical manifestation of life under the institutional gaze, Does Anyone Know directly addresses the external forces acting on the individual. Playing on the referential instability of
the word ‘crazy’, to mean both ‘mentally ill’ and ‘angry’, the shift from ‘normality’ to crime and mental illness is expressed in the line ‘till you’re so fucking crazy you can’t follow their rules’ – the first instance of profanity in the performance. This elision of anger, crime, and mental illness, and the placement of ‘craziness’ at the point at which the social rule is transgressed, rather than the moment of diagnosis, serves to complicate the simple binaries upon which both psychiatric power and criminal justice are based: innocent/guilty, and sane/crazy. It is these binaries that allow power to be exercised over service-users, and which also maintain service-users in a perpetual position of dependence on the structures that remove their agency – the process of ‘institutionalisation’. In revealing them, Does Anyone Know also brings them into question. Part of the reason for Theatre NEMO’s work in prisons is a concern with the Scottish system’s has a tendency to elide distinctions between criminal justice and medical treatment, and the way in which this elision serves to remove all possibility for agency on the part of service-users. In the words of Theatre NEMO director Isabel McCue, ‘the creativity is being crushed in people’ (Carrell 2006).

The project outcomes, as described by the facilitators, bear witness to the effectiveness of the challenges offered by Does Anyone Know. The specific circumstances of the prison setting led to a degree of self-censorship, as ‘the numbers started to drop and we found out that there was a lot of bullying going on in the halls regarding the workshops’. Participation in the workshops represented a transgression of power structures within the prison, especially due to the fact that people within the high dependency unit were involved. Members of the prison community attempted to rebalance these structures, while the facilitators further undermined them through their recommendation that:

At least one member of HMP staff should participate fully throughout as a group member […] to underline and support the (intended) perception of inmates that they are part of a group which is not centered on their identity as a prisoner, but on their greater identity as an individual
Despite the initially negative reaction, the responses to the project itself (as opposed to the process of its production) were extremely positive: ‘the work of the group was held in great esteem by the individuals prison peers’. This shift in perception from discrimination against work that both transgressed institutional power and engaged with stigmatized individuals, to the acclaim given towards the finished product demonstrates the power of work which directly challenges attitudes built upon binary views of individual roles, especially within the physically limited space of a prison institution (Theatre NEMO 2008a: 2).
3 - Performance as Intervention

Having examined the representation of service-users and psychiatric power in *Dissocia* and *Does Anyone Know*, this chapter will place these representations within the context of the discourses identified in chapter 1, in order to assess the specific interventions being made, the way in which these performances have been appropriated, and the strengths and weaknesses of each representative strategy.

**Interventions**

The interventions being made by Theatre NEMO, in *Does Anyone Know* as well as their work more generally, challenge some of the more orthodox conceptions of mental illness. As discussed in chapter 1, Scottish Executive policy conceptualises mental health in a pragmatic way, which retains a diagnostic caesura between ‘discontent’ and ‘mentally ill’. By contrast Theatre NEMO, despite working with service-users in prison and hospital settings, resists the idea that ‘service-user’ is an absolute category. It was mentioned in chapter 2 that prison staff are encouraged to take part in workshops alongside prisoners, and Theatre NEMO’s community workshops are open to all, not just those who are diagnosed with mental illness. This focus on individuals as individuals cuts across binary distinctions between service-users and non-service-users, allowing those involved to experience treatment as coherent selves in an effort both to remove discrimination within the workshop spaces and also to provide an opportunity to challenge self-stigma.7

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7 ‘Self-stigma’ is the way in which negative social conceptions about a certain attribute can be internalised. Goffman describes the process as follows: ‘the stigmatized individual tends to hold the same beliefs about identity that we do; this is a pivotal fact. His deepest feelings about what he is may be his sense of being a “normal person,” a human being like anyone else, a person, therefore, who deserves a fair chance and a fair break’ (1986: 7).
This conception of the individual is drawn out in Does Anyone Know. As discussed in chapter 2, the design of the short film emphasises individual integrity, while also drawing attention to external pressures that contribute to mental distress and criminality. To an extent, this is in line with the framework put forward in the Action Plan, which envisions a ‘cross-cutting’ approach to improving mental well-being, an approach that sees many interconnected areas as important:

Being able to provide the basic building blocks of a good quality of life in local communities is an essential part of improving mental health and well-being. This involves the provision of good quality housing, quality built environments, environmental policies that have communities’ well-being at the core of their actions, good transport infrastructure, safe parks and recreational areas and facilities, cultural activities, play areas, clean sheets, responsive policing, tackling speeding and drug dealing. (10)

However, while the Action Plan focuses squarely on issues affecting a demographic likely to make their views known in public forums, Does Anyone Know presents a far more challenging picture of the kind of policy areas that might provide an effective solution to community mental health problems. Rather than the suburban milieu implied by the above extract from the Action Plan, Does Anyone Know dedicates much of its dialogue to a discussion of poverty and crime, and the ambiguities and contradictions that exist within policy and public discourse:

All that is given is not all that is gotten,
all that is needed is not at all what is wanted,
and so life goes.

All that is spoken is not all that is heard,
all that is said is not at all what is believed,
and so life goes, on and on and on.
Although this passage is ambiguous on its own, allowing it to resonate beyond a specific referent and suggest a generalised failure of communications, its relevance to policy can be seen from its position between a monologue discussing poverty, ignorance and policy, and a group piece dissecting the social factors making crime more likely. It draws attention to the problems of any kind of intervention, whether from above, as with policy, or within, as with the performance itself, while having a special point to make about the power of discourse to affect perception – however much groups such as Theatre NEMO or the Scottish Executive attempt to make interventions into public discourse, ‘all that is said is not all that is believed’. The idea that ‘all that is needed is not at all what is wanted’ acquires a special relevance in the context of Alan Ingram’s comments about the limited political returns available for mental health investment. The problems of policy implementation recognised by Does Anyone Know are clearly demonstrated in a report appraising public policy and mental health. This report examined theoretical frameworks and policy documents in combination with interviews with policymakers in order to assess the potential impacts of Scottish mental health policy:

Healthy public policy depends on effective intersectoral working between government departments, along with better use of research evidence to identify policy impacts. This study identified barriers to both of these […] In the case of social determinants of health, we conclude that an evidence-based approach to policymaking and policy appraisal requires drawing strongly upon existing theoretical frameworks, as well as upon research evidence, but that there are significant practical barriers and disincentives (Petticrew 2008: 314).

Some of these barriers owed to the fact that policy documents only rarely engaged specifically with mental health, but others were of a more practical nature, including problems caused by the ‘cross-cutting’ approach – the fact that ‘the political system is structured in such a way that departmental identity and allegiance takes precedence over an inter-sectoral perspective’ (319), and the lack of rewards for working together.
In addition to raising these issues, Theatre NEMO’s work challenges the assumption, latent in the Scottish Executive’s division of policy which places service-users under the policy remit of NHS Scotland, that the only treatments guaranteed to have a positive effect are bio-medical. It is not only the charity’s ethos that challenges this paradigm, but the effects recorded by medical professionals. A report produced from ‘observations and quotes’ by staff in psychiatric hospitals stated that they had seen ‘collaboration, stimulation, relationship building and enthusiasm which have endured in the lives of those involved beyond the period of the projects’ (2011: 2). This (qualitative) improvement was also observable in the project that led to the production of Does Anyone Know:

We can truly say this project was a huge success. All participants have benefitted from the project in terms of confidence, self-esteem, team work and skills and we believe that this experience demonstrates the positive effects of the workshops we provide.

(2008a: 2)

Although this is clearly signaled as the subjective opinion of facilitators with a vested interest in giving a positive impression of their services, their conclusions are based on the observations of prison staff, who ‘saw an increase of self-esteem and confidence within the participants, and […] the participants engaged as a whole and identified itself as a team.’ (2008a: 2)

The intervention being made by Dissocia is more specific, if less thoroughgoing. As discussed above, the play aims to address the question of medication non-compliance. In order to do so, it begins by individualising Lisa, before attempting to represent her subjective experience in a way with which the audience can empathise. The audience, although possibly aware that Lisa suffers from a mental illness due to information in the programme or other publicity material, are also initially encouraged to see her as ‘normal’ in comparison to the other characters – Victor Hesse, the ‘Insecurity Guards’ and the other inhabitants of Dissocia. This strategy aims to present Lisa’s decision as a rational response to a choice between mundanity and excitement. The emphasis on personhood again challenges the binary distinction between ‘ill’ and ‘well’, since, as Neilson says, ‘I want people to experience something first
and then talk about it afterwards’ (Cavendish 2004). The play’s intervention is given force by the fact that the audience is positioned in an active relationship with the events onstage. Neilson describes the nature of this relationship as follows:

The aim of *Dissocia* is modest; there will be no attempt to portray realistically what mental illness is like. How could I show you that? No, this is just an impression, the distant shape of mental illness as seen through frosted glass. Two halves of a puzzle, the solution lying in neither but in the space between them. That space, I hope, will be you. (Edinburgh International Festival Society 2004: 4)

There is a tension, however, between these two statements by Neilson, as he acknowledges that the experience he wishes his audience to talk about can never be the full experience he is attempting to represent. Indeed, this could be seen as an intrinsic problem with ‘a more experiential form of drama rather than that detached cerebral view’ (Fisher 2004) – the success of the intervention can only be measured by the extent to which the audience is able to relate to, indeed to share, the protagonist’s experience of mental illness. Neilson is clear that a cerebral understanding of the issues is insufficient – the audience must understand Lisa’s experience on a visceral level.

Chief among the strengths of *Dissocia’s* intervention is its high profile, which allowed it access to a far broader demographic than *Does Anyone Know*. Discussing playbills, Christopher Balme expands the concept of the theatrical institution:

By defining the public sphere, as opposed to the spectator or audience, as an object of theatre-historical research […] we can study the public theatre independent of the performance event. Theatre is thus much more than the sum of the individual performances; it consists of a complex set of institutional as much as artistic practices that need to be brought into historiographical focus (2010: 59).
Although 21st century theatres do not produce playbills, Balme’s conceptualization of the relationship between the theatre and the public as a series of ‘articulations’ (39) remains an illuminating framework. Balme’s caveat that ‘from the point of view of contemporary theatre and performance studies […] the theatre is largely separated from the outside world’ is based on the idea that contemporary studies take as their object the ‘aesthetic response to a performance or discussions of performances in the arts pages of newspapers’ (45). This is largely valid, but does not take into account the fact that articles appearing before the opening of a production, or at least early in a run, are calculated interventions on the part of the theatrical institution in the same way as the playbill, aiming both to communicate with and create an audience for the production. Indeed, since the communications surrounding the 2007 revival show that Neilson is concerned with precisely the ‘separation’ Balme identifies as problematic, it is important to draw attention to the idea of the theatre as institution, and marketing of productions to maximize audience numbers.

Despite the information available from newspaper articles and advertising material, too sharp a focus on these articulations can mask the intervention being made by the performance itself. In the programme, Neilson offers an extended criticism of the binarism within the mental health system:

It’s easy to classify people who are psychopaths or sociopaths, they do harm to other people. But what about the people who hang about in doorways, or go into shops shouting or moaning hideously; that’s when we get uncomfortable. They’re not really doing any harm, but they’re embarrassing us. Embarrassment isn’t a good enough reason for putting someone away, so we find other reasons. You go back to their house say, and it’s in such a state that it’s clear they can’t look after themselves. The main problem with the mental health system is it lacks subtlety; we’re only beginning to find that. We’re working our way to a situation where we can understand that each case is very individual and many elements need to be weighed up. If any system needs to be taken out of the hands of politicians, it’s the mental health system. There’s no big
policy initiative or eye-catching idea that can take on the whole problem. (Cramer 2004: 8-10)

This reading of the problems goes beyond the narrow focus of *Dissocia*, and identifies some issues that are, in fact, reproduced within the performance, such as Dot’s response to Lisa’s illness, discussed above, which is an example of the embarrassment described by Neilson. During the play’s 2007 revival, Neilson commented on an online review of his play that in order to generate interest ‘I unashamedly have to make bold statements to generate interest but some of my brasher ones should be taken more as debating issues than great offerings of wisdom’ (comment April 6, 2007 11:47 AM on Shenton 2007). However, this ‘bold statement’ is highly nuanced, drawing attention to similar issues to *Does Anyone Know*, issues which are invisible, or at least ambiguous, in the play itself.

**Appropriations**

In addition to the problems created by an over-reliance on other media, the advantages of this mode of communication with the public (and creation of a public) are complicated by the competing demands of commercial dramatic success. Scottish Executive support of *Dissocia*’s first productions at the International Festival, combined with the educational programme funded by the Executive, ensured that the majority of the mediations between the production and the public were squarely focussed on the subject of mental health. The 2007 revival, despite retaining the same cast, design and director, existed within a very different commercial context. Instead of the Scottish Executive, the majority of the revival’s funding came from the National Theatre of Scotland (NTS), whose associate director, John Tiffany, made the following comment about the organisation in it’s first year:

> Hopefully we won’t fall into the trap of becoming an institution. We have an opportunity to redefine what a national theatre is. What I like about the programme for our opening season is that it doesn’t feel too heavy. We are saying that Scotland is different to England in the way it wants to express itself (in Smith 2005).
This emphasis on drama not feeling ‘too heavy’ is clear in the press statements surrounding *Dissocia*’s revival. Much of Neilson’s public commentary in the run up to the 2007 tour concentrated on the ‘theatrical’ and populist elements of the play, in common with the NTS’s desire to present itself as ‘different to England’. As part of this, Neilson wrote a polemical article entitled ‘Don’t Be So Boring’ for the *Guardian* newspaper’s theatre blog, in which he compares ‘serious’ theatre unfavourably with musical theatre: ‘Musical theatre offers song and dance, of course; a certain unpretentiousness; a tangible sense of "liveness"; magic; and, most importantly, spectacle’ (Neilson 2007a). He returns to this theme in the foreword to the printed script of *Dissocia*, saying ‘that’s what we’ve got to do, in the “serious” theatre – we’ve got to have our flying car. We’ve got to reclaim the spectacle’ (2007: Foreword). In a promotional video on the NTS website, produced for the revival, Neilson’s comments deliberately move the focus of the publicity away from mental illness towards broader themes:

In one sense the play’s impetus is the subject of mental illness, but in fact it is about sensation and numbness, and that can be seen as meaning many things. It could be also an analogy for childhood and adulthood; it could be an analogy for creativity versus normality. Some people have even suggested that it’s like the difference between a drug or an alcohol hit and being sober, so in fact this battle between chaos and order is within all of us, whether we suffer from a mental illness or not. (National Theatre of Scotland 2007).

This change in focus coincided with an increased nuance in the representation of psychosis. Since no script exists for the 2004 production, it is difficult to identify what was added in order to ‘harden up’ the first act (Logan 2007), but given that a 2004 review sees *Dissocia* as ‘wonderful - private and cosy’ (Rampant Scotland) it seems likely that the offstage sounds of Jane being ‘beaten and anally raped’ (42) were at least less pronounced.

The media response to *Dissocia* also draws attention to the way in which psychiatric diagnosis has been democratized. Almost every review offers a diagnosis of Lisa (despite Neilson’s insistence
that he’s not presenting a realistic mental illness). The diagnoses offered range from Dissociative Identity Disorder, understandably the most common, to ‘manically psychotic’, offered by a reviewer from the *British Medical Journal* (McClure 2004). The ease with which theatre journalists pass clinical judgment on Lisa suggests their engagement with the production was limited – as Kuppers observes, ‘the diagnostic gaze reduces the presence of bodies to texts that need to be read and categorized’ (2003: 130). However, in the case of the *BMJ* review, the experienced medical practitioner, who is culturally sanctioned to impose a diagnosis, uses his position to make a largely unsubstantiated political point about public subsidy for the arts:

The Scottish Executive has not, by any means, collaborated in serving us a turkey, but has it spent taxpayers' money wisely? *Dissocia* has been an undoubted critical success, but the play's Edinburgh run did not sell out. Such a bold initiative fully exposes the political risk inherent in public funding of the arts. [...] It could all have gone horribly wrong. In view of the Scottish Executive's interminable series of public image blunders, is such risk taking a sign of departmental desperation? One wonders, respectfully, if our political masters might benefit from a visit to the shrink (McClure 2004).

McClure, the reviewer most qualified to comment on the medical aspects of the production instead focuses on his own views about arts funding, arguing that public money should not have been invested into the production as a result of the *possibility* of failure, notwithstanding the eventual outcome. This again draws attention to the inability of the producers of dramatic texts to control their receptions, as well as the degree to which dramatic productions can be used as springboards allowing commentators to discuss their own agendas.

Despite its lower media profile, Theatre NEMO has not escaped the risk of its work being re-conceptualised by other institutions. Chief among these institutions is the Scottish Executive itself. At Theatre NEMO’s 10th Anniversary Celebrations in 2010, Cabinet Secretary for Justice Kenny
MacAskill MSP used his speech to place charity’s work within the broader agenda of the Scottish Executive in the latter part of 2010:

[W]e need to challenge them to take responsibility, nobody makes you drink it, nobody forces you to inject it, at the end of the day the person who’s got to stand up and take responsibility is that individual […] we can motivate, mobilise those who currently are languishing in their home, depressed or whatever else, and we can make this a better country (MacAskill 2010).

This focus in this address on personal responsibility, coupled with a rhetoric which posits mental ill-health as personal weakness, is at odds both with the multi-faceted analysis of criminality and mental ill-health presented in Does Anyone Know, and the anti-stigma constructions employed by the Scottish Executive as a whole. Sarah Banks, discussing the ethics of social work in a neo-liberal economic milieu, notes a tendency towards ‘responsibilization’ in public services as a whole during periods of economic austerity, since ‘the focus on the individual service-user or family can also make it easier to locate blame and responsibility for the causes of problems with individuals, rather than with structural inequalities’ (2011: 15). At a time when the Scottish national budget is uncertain due to the austerity measures being put in place by the Conservative/Liberal-Democrat Coalition in Westminster, it makes sense that a senior cabinet minister would seek to direct the focus away from the Executive’s commitments to mental health and towards the role of the individual. The counterpart to this speech can be found in that of former Deputy Inspector of Prisons John McCaig at the same event, which focused on institutional problems in a manner more in line with Theatre NEMO’s analysis of the position of service-users. By stating ‘Theatre NEMO have shown that, for some people, the therapeutic and pill free option can be as beneficial, and extremely cost effective’ (2010), McCaig places his speech within the context of public austerity, while also engaging with the critique of bio-medical essentialism offered by Does Anyone Know.
Transformations?

Before we draw this discussion to a close by assessing the interventions made by these performances within Scottish mental health discourse, it is worth reminding ourselves of the sober note struck by Tamsen Wolff: ‘No matter how tempting, the urge to read theatre history as chock-full of thrilling, crafty efforts to overthrow the status quo needs serious scrutiny’ (2006: 10). The fact that both Dissocia and Does Anyone Know make explicit interventions into the discourse of mental health does not reduce the force of Wolff’s warning – both performances exist within a political and economic milieu in which there is often a direct connection between funding streams and perceived orthodoxy, and where the economic health of the theatre institution is at least as much a consideration as the artistic or discursive aims of individual playwrights and directors. With this in mind, it would hardly be surprising to find the concrete impact of these performances extremely limited.

Having acknowledged this, there is much that can be said about the interventions being made by Dissocia and Does Anyone Know. The most important way in which both performances conceptualise mental ill-health is through their engagement with the divide between health and illness, and the point at which this can be located. As discussed in chapter 1, the utility of mental health diagnoses is far from universally recognized, and some psychiatrists such as Double (2006) reject their use altogether. Dissocia is careful to avoid any specific diagnosis, and its emphasis on personhood rather than bio-medical frameworks works to complicate and destabilize the point at which a person can be identified as mentally ill. However, the play also presents bio-medical intervention as an unproblematically effective way of managing mental distress, and fails to comprehensively challenge the idea that medication non-compliance is, at least in part, due to selfishness. Does Anyone Know shares Dissocia’s ambivalence about the point at which mental illness can be located, through the inclusion of non-service-users within its workshops on equal terms, and its focus on the social contexts of mental ill-health. However, unlike Dissocia, it does not provide a framework through which the experience of service-users can be normalized. The success of the production, both in terms of the
impact on those involved and the broader shift in attitudes among the prison population (as far as these can be determined) suggests the strength of an approach which focuses on context and the experience of being a service-user, without either locating a specific point at which one ‘becomes’ mentally ill or denying that mental illness is a discrete experience.

The second important thematic issue which has emerged over the course of this investigation is the extent to which the performance of mental ill-health exists within a framework of either excess or lack – a conception of illness which can be traced back as far as ancient Greece (Porter 2002:36-43). *Dissocia* engages with this framework by placing its representation of Lisa within theatrical traditions whose aesthetics are based on excess – musical theatre and pantomime. Although this serves to normalize Lisa in relation to the inhabitants of Dissocia, it also determines that her experience will appear excessive when read against act 2, with its intentionally minimalist design. In addition, the conceit that explains her symptoms as the result of a missing hour emphasizes the construction of mental illness as a deviation from a well-ordered norm. *Does Anyone Know* does not attempt to ignore the prevalence of these constructions, but instead engages critically with them through its focus on the physical presence of the actors as possessing self-control in the face of institutional pressure. In doing so it encourages the audience to question the utility of constructions of deviance and disorder that erase the social and political contexts of mental distress.

The final conclusion that can be drawn from this discussion is that any intervention made in the form of a public performance will always be a contingent one. Not only can the communications between a theatre institution and its public be thought of as ‘articulations’ in which both parties contribute to the creation of meaning, but discussions of a performance can alter the effect and emphasis of the intervention being made. Although these shifting conceptualizations can be effected by newspaper reviews, they are more likely to occur as a result of governmental financial pressures that affect not only the creation of dramatic performances, but also the perception and representation of mental health in specialist and non-specialist discourses. This can be seen in the shift in emphasis
between the 2004 and 2007 runs of *Dissocia*, as well as in the way that politicians have used the work of Theatre NEMO as an example when discussing their own money-saving policies.

In treating the issue of mental illness within performance as a discrete object of study, placing these performances in the context of Scottish Executive policy and available discourses of mental health more generally, I hope to have gestured towards a productive avenue for the broader exploration of the representation of mental health issues in contemporary culture. Additionally, I hope to have drawn attention to the possibilities and limitations offered by performance as a mode for intervening in mental health discourse and helping to shape representation of service-users within the public imagination. There is scope for a much wider discussion of the work of Theatre NEMO, especially the complexities added by their animation workshops to the range of representations within their canon. A starting point for this work would be the film *Lost Property*, as this shares with *Dissocia* and *Does Anyone Know* a focus on the discourse of loss and the problems caused by an excessively bureaucratic mental health system. In addition, it would be illuminating to look at the history of drama and performance within Scottish prisons and hospitals using similar critical methods, as well as similar contemporary work such as that reported by Ho and Richard (2010). Indeed, performance continues to be used in Scotland to address the intersection between mental health and politics. For example, as part of the *Theatre Uncut* protest events in March 2011 David Greig wrote *Fragile*, which examines the extent to which service-users are marginalized when budget cuts have to be absorbed (returning to the issues raised by Alan Ingram in 2003). As long as the position of service-users within society remains marginal, work which interrogates their representation in media and culture, and which explores transformational strategies of representation, remains crucial.
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