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Reappropriating Shakespeare's 'Mad' Women:

Creating Positive Representations of

Mentally Ill Women Through

Solo Performance

by

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A thesis

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Committee Approval

To the Graduate Faculty:
The members of the committee appointed to examine the thesis of Jessica Sager find it satisfactory and recommend that it be accepted.

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This thesis is dedicated to the memory of
Rachel M. Miller
Cousin, friend, and heroine

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Thesis Abstract - Idaho State University (2019)

Reappropriating Shakespeare's 'Mad' Women:

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This thesis explores the research and creative processes behind the creation of a one-person play that addresses mental illness. It examines stigma against people with mental illnesses and how theatre can be used to fight this stigma. The concept of the 'mad genius' and its inaccuracies are also explored. The author then explains her rationale for creating a metatheatrical, one-woman show about mentally ill women playing 'mad' Shakespearean characters while fighting their own psychological battles. She outlines the research processes that went into the creation of each character. The thesis concludes with plans for refining and producing the one-act.

Keywords: Madness; mental illness; mad women; Shakespeare; theatre; one-person show; monodrama; solo; representation; stigma; Ophelia; feminism

Introduction

In this thesis I will discuss my creative and research processes in writing *The Mad, Bad Women of Shakespeare* (hereafter abbreviated as *Mad Women*), a monodrama that reveals the struggles of actresses with mental illnesses. My aim in writing this play was to create realistic characters affected by mental illness while also representing Shakespeare's 'mad'/suicidal heroines in a positive, feminist light. The need to write (and eventually perform) *Mad Women* came from my own experiences with mental illness as well as a desire to combat the stigma mental health sufferers face. In addition to my writing process, I will also address my plans for rehearsing and producing *Mad Women*.

Review of Literature

In this brief review of literature, I will go over my main sources as well as a few that, though cited only once or twice, were invaluable. The work of Corrigan and his colleagues (*The Stigma Effect*; *Challenging the Stigma of Mental Illness*) offered invaluable information on the problem of stigma and how to fight it. The anthology *The Stigma of Mental Illness - End of the Story?* edited by Gaebel et al., contained numerous helpful articles on many aspects of stigma. When it came to theatre's ability to reduce stigma, articles by both Knifton and Kosyluk et al. provided recent statistics. Łukowski's *New York Times* article provided me with much-needed figures from recent Edinburgh Festival Fringes. *Mental Illness in Popular Media*, edited by Rubin, helped me understand the representation of mental illness in theatre from both contemporary and historical perspectives.

Creativity and Mental Illness, edited by Kaufman, provided many articles offering different points of view on the possible link between mental illnesses and creativity. Saltz's *The Power of Different* offered evidence of a link while also advocating proper treatment of

symptoms; Kyaga's *Creativity and Mental Illness* provided a history of the 'mad genius' myth from the ancient Greeks onward.

My main sources for structuring *Mad Women* were *The Power of One* by Catron, *Creating Your Own Monologue* by Alterman, *Creating Solo Performance* by Bruno and Dixon, and both of Kearns' books on solo performance. Later chapters in these books also informed my plans for producing *Mad Women*. *Solo Performance,* edited by Stephenson and part of the *Critical Perspectives on Canadian Theatre in English* series, offered diverse views on making solo performance, including advice on how to represent marginalized groups. Sandahl's "Why Disability Identity Matters" informed my representation of mental illness within *Mad Women*.

For the history of mental illness/madness, my general information came from four major sources. Porter's *Madness: A Brief History* helped me gain a general historical knowledge of the subject and was an excellent quick reference. *Madness in Civilization* by Scull offered a more detailed history when needed, as did de Young's *Madness*. Pulitzer Prize-winning journalist Powers' *No One Cares About Crazy People* included an in-depth and passionate account of mental illness and its (mis)treatment in modern times. For more specific research, Gregory's *Actresses and Mental Illness* was invaluable and, in addition to providing historical information, helped inspire a character in *Mad Women*. Showalter's *The Female Malady* and "Representing Ophelia" provided information on nineteenth century theatre and the treatment of neurasthenia and hysteria. Finan's *Drunks* provided historical information for the creation of Pam, an alcoholic character in *Mad Women*.

When it came to representing and interpreting Shakespeare's heroines, I used many sources, but three were indispensable. Kordecki and Koskinen's thorough and inspired scholarship made *Re-Visioning Lear's Daughters* a joy to read as well as a strong influence on

Mad Women. The anthologies *The Myth and Madness of Ophelia*, edited by Kiefer, and *The Afterlife of Ophelia*, edited by Peterson and Williams, offered a myriad of perspectives on the heroine that helped me create and justify my own interpretation.

For medical research, I used the Mayo Clinic's website because of its accuracy and convenience. I also used the National Institute of Mental Health (NIMH) and Centers for Disease Control's (CDC) websites, as both are trusted government sources. Lastly, I used the latest edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5), which is published by the American Psychological Association, to double-check some information. I also used the Mayo, NIMH, and CDC websites to find statistical information. The U.S. Food and Drug Administration (FDA) and Welch's article provided necessary information on the drugs used to treat ADHD.

I will end this review of literature with a note on terminology. In this thesis, I use 'madness' and 'mental illness' in different contexts. I use 'madness' as a term for mental illness and/or unconventional behavior in historical times; I use 'mental illness' when referring to modern psychiatric disorders.

Media and the Stigma of Mental Illness

In his book *Ghost Light*, Chemers asks "Why this play now?" (108). By writing and performing *Mad Women*, I hope to fight stigma against people with mental illness. Stigma is a major problem that has actually been getting worse (Corrigan et al. 11). As Finzen says "The suffering because of the stigma, prejudices, defamation, and accusations becomes a second illness" (29). Much of our knowledge about mental illness comes from the media (Krupchanka and Thornicroft 130). Unfortunately, the media has not traditionally been good to sufferers of mental illness. In news media, "the very few crimes that are committed by those with diagnosed

mental illness are too often sensationalized and heralded as exemplary of all of those with mental illness" even though mentally ill people are more likely to be crime victims than perpetrators (Saltz 7). Entertainment as well as news media has "created a vast storehouse of negative imagery" of both psychiatry and the mentally ill (Stuart 505). From psychopaths to mad geniuses to 'funny' obsessive compulsives, mentally ill people are often represented as "different, dangerous or laughable" (Ellis 189).

This is not a recent phenomenon. As Rudolph and Kaplan say: "Throughout history ...portrayals of the mentally afflicted have been generally exaggerated, and do not reflect the reality of most people coping with mental illness" (7). While these negative portrayals are hurtful in and of themselves, people with mental illness have more to fear than seeing an uncomfortable stereotype on T.V. There is evidence that these negative portrayals worsen stigma (Henderson 86), which is unsurprising, considering that media is the only exposure neurotypical audiences have to mental illness without knowing a person who is openly mentally ill (Little Fenimore 157).

According to Corrigan et al., stigma affects people in three different ways. It affects *what* people think about, *how* they think about it, and how they behave towards the people who are stigmatized (58). In addition to suffering the unfair judgements of others, people with mental illness are also susceptible to self-stigma, believing that they are dangerous, lazy, or any of the other negative stereotypes perpetuated by our culture.

Stigma is more serious than hurt feelings. Stigmatized people are likely to "be discriminated against and excluded from many forms of social exchange including employment, housing, financing, relationships, health services, and parenting" (Little Fenimore 157). Parents are afraid that a diagnosis of mental illness "will inhibit their [children's] future success and

potentially doom [their children] to unhappiness" while many adults remain silent about their symptoms instead of seeking help (Saltz 8). According to NIMH, almost 20% of American adults suffer from mental illness ("Mental Illness"), but only half ever receive treatment ("Statistics"). Mental illness is also "a risk factor for landing in jail" (Varney).

The Fight Against Stigma and Theatre's Role in It

How do we counter stigma? Corrigan believes that solutions "should rest solely in the agendas of people with lived experience harmed by these stigmas" (xvi). He points out that the "war against racism is led by people of color, against sexism by women, and against homophobia by the LGBTQ community" (99); people who suffer from mental illness, however, have not traditionally led the charge against stigma. Instead, changes have been spearheaded by "providers and administrators" (99). Frequently, "physicians and allied health colleagues" have been allowed to "dominate decisions about mental health treatment and psychiatric care" (Corrigan et al. 8). Hubert warns that "historians have presented an incomplete and potentially inaccurate picture" (16) by ignoring the voices of people with mental illness.

Yet according to research, person-to-person interactions between people with mental illnesses and neurotypical people are one of the best ways to combat stigma; it is difficult for people to hold on to stereotypes after meeting others who have "overcome their psychiatric disabilities" (Corrigan et al. 65). "Person-to-person interaction," Corrigan asserts, "is the way to decrease the stigma of mental illness" (189). As he points out, "[y]ounger generations have been able to throw off homophobic ideas...*not* because they learned in high school health class that sexual orientation is genetic and not chosen" but because "courageous gays and lesbians came out forty to fifty years ago" (189).

People who 'come out' as mentally ill are of course taking a risk. Finzen writes that "finding people beyond the closest family circle who they can trust without fear of being abused or rejected is apparently one of the most difficult social challenges for people recovering from mental illness" (38). There are benefits to coming out, however. Hiding one's mental illness causes anxiety (37), while people who have "disclosed some aspects of their experience" with mental health problems often feel "enhanced personal empowerment, self-esteem, and confidence in the pursuit of their life goals" (Rüsch and Xu 456). Furthermore, the support of peers is "an important resource in challenging self-stigma," or the stigma that mentally ill people sometimes feel against themselves (456).

One way for people with mental illnesses to combat stigma and reach out to peers is by sharing their stories through theatre. Bobby Baker, a solo actress, found that people within the mental health system were being "delivered to rather than having any say in what they wanted or needed" (108), so she decided to create a one-woman show called *Mad Gyms and Kitchens*. Increasingly, theatre artists are taking charge of the narratives around mental illness. The "call for 'nothing about us without us' has particular resonance for theatre artists who have both experienced mental illness and seek to represent that experience," writes Johnston, especially since such artists face "a long history of stigma and stereotypical depictions" in media (222). Positive stories help combat stereotypes while also making it easier for audiences to empathize and identify with mentally ill people (Little Fenimore 157). A wide variety of stories shows that people who struggle with "the same illness lead very different lives" (Corrigan et al. 66). Knifton elaborates on the benefits of art:

> The arts explore rather than inform, creating new possibilities, allowing us to create and challenge dominant discourses and beliefs…. Arts explore the human condition. By

> considering everyone's mental health identities we can undermine the dehumanization and label of absolute difference necessary to perpetuate stigma. Stigma is emotional rather than rational (274).

Studies show that stories by and about people with mental illness *do* make a difference. The Scottish Mental Health Arts Festival was created in response to high rates of suicide and mental health problems amongst the Scottish population (Knifton 270). In thirteen years the annual festival has grown to include more than 300 events and 25,000 attendees ("About the Festival"). Attendees left the festival with "more positive beliefs about stigma, acceptance, and recovery" and were less afraid of people with mental illness (Knifton 281). Audience members were also more likely to seek help for their own mental health problems (282). The most impactful events were those that featured "[m]eaningful contributions from people with experience of mental illness as artists, subjects, or in panels" (282). Pre- and post-show surveys given to audience members at a *This Is My Brave* production, in which storytellers shared their experiences with mental illness, revealed "a decrease in stigma, improvements in beliefs about recovery and empowerment, and greater willingness to seek treatment" (Kosyluk et al. 276).

Theatre's portrayals of madness have evolved, perhaps more quickly than in other media: "Where insanity once haunted tragic figures and the antics of crazed characters enlivened comedy, many plays on the modern American stage consider mental illness" in a more complex light (Rudolph 165). An article published on the National Alliance on Mental Illness's (NAMI) website suggests that the musicals *Dear Evan Hansen, Next to Normal,* and *We Have Apples* "may help you better understand yourself and others" (Hurwitz). *Next to Normal* defies simple explanations and stereotypes by "[w]eaving together a range of attitudes and beliefs about [the] causation" and treatment of mental illness (Rudolph 176) and "resist[ing] the impulse to

define mental illness and the psychiatric profession with broad strokes," portraying both the benefits and negative side effects of medication (177). Offstage, groups such as the Alliance for Inclusion in the Arts and Entertainment Assist try to ensure equal opportunity and access to mental health resources for actors. In recent years the Edinburgh Festival Fringe has included many shows dealing with mental illness. In 2017, 52 shows at the Edinburgh Festival Fringe addressed mental illness; in 2018 the number was still strong at 42 (Lukowski).

Actors' Struggles with Mental Illness and the 'Mad Genius' Myth

While many plays deal with mental illness, I have found few (with the exception of autobiographical shows) that focus specifically on *actors*' struggles with mental illness. One of my reasons for creating *Mad Women* was to reach out to fellow theatre-makers who may be dealing with mental illness. Furthermore, I want to challenge the 'mad genius' myth. The idea that "one cannot be creative, or extremely bright, without being at least a little insane" is still prevalent today (Powers 115), and it both discredits and endangers artists.

There have long been associations between artistic brilliance and madness in some form or other. The Greeks "believed that passion, not intelligence, was the source of creativity: poets received their ideas in a frenzy at moments when they were possessed by the Muse" (Berlin 6). It is important to note, however, that in ancient Greece the 'madness' of artists and seers was "clearly distinguished from clinical insanity" (Becker 6). In Plato's doctrine of divine madness, "the poet, who himself is devoid of talent, is seen as divinely inspired" (5), so while Greek poets were not considered regular madmen, they were not given credit for their creative effort, either.

The association between genius and madness was strong during the Renaissance but weakened during the Enlightenment. Renaissance Europeans believed that geniuses suffered from melancholia or *pazzia*, but, as in ancient Greece, the "separation between temperament and

clinical insanity was still forcefully upheld" (Kyaga 17). During the Enlightenment, genius was associated with creative people who were also "healthy and rational" (Becker 20). Porter concurs that Enlightenment poets "did not seek to don the mantle of madness," and while genius was valued, it was "found ...in balance and good sense" (80).

The Romantics are largely responsible for today's concept of the 'mad genius' (Becker 4). Unlike their predecessors, the Romantics emphasized "imagination over rationality" to the extent that they distanced themselves from "the mental qualities primarily associated with sanity" (Kyaga 19). For the first time, genius was associated with "*clinical* madness" (19, emphasis mine). Now "[t]rapped by their own logic," the Romantics were forced to see their mental illnesses as "inevitable" (Becker 14). They believed that "sickness and suffering fired with" drug and alcohol abuse were necessary in order to create great works of art (Porter 81). Psychiatrists at the time agreed that artists were "disturbed and perhaps in need of treatment" (81).

Even today, many people believe that the "severe pain of a disturbed mind" is typical of creative brilliance (Kaufmann and Kaufmann 206). When artists believe that their suffering "somehow aid[s] creativity," that their mental illness is a price that must be paid for talent (Kinney and Richards 313), they may avoid treatment and endanger themselves. Famous artist suicides during the last century have only "reinforced this sentimental view of the Artist as tragically insane" (Powers 122).

As an artist who enjoys her work while *also* striving for good mental health, I have a vested interest in disproving these ideas. Conversations with colleagues, not to mention my personal experience, made me doubt that the 'mad genius' myth was accurate. I was loath to believe that living in misery and possibly dying young were necessary to artistic success. Rather,

I was inclined to believe actress and teacher Uta Hagen when she wrote that "a correctly functioning actor should, ideally, be the healthiest, least neurotic creature on earth" (59).

I was initially dismayed to find that many scientists believe a link between mental illness and creativity *is* possible, if not certain. As I continued my research, however, I learned that the connection is "tenuous, at best" (Nusbaum et al. 400). The data linking mental illness and creativity are correlational; they "suffer from the problem known in statistics as the third variable," meaning that there might be another, currently unknown variable that accounts for higher instances of mental illness in creative people (Djikic and Oatley 282).

Most importantly, amongst the work I read there was strong agreement that creativity *does not benefit* from the symptoms of severe mental illness. While artists may be at "greater risk" for some types of mental illness, there is also evidence that their work is "not enhanced by severe forms of these disorders" and indeed "creative work seems *virtually impossible* during episodes of full-blown mental illness" (Carson 261, emphasis mine). Findings suggest that "*better functioning* individuals who carry genetic liability for certain major mental disorders...tend to have a creative advantage" while creative people with severe mental illness usually have "their most creative periods...at times when they experience either mild symptoms" or are free of symptoms (Kinney and Richards 296).

So while there may be a link between creativity and mental illness, artists are not endangering their talent by seeking professional help. Rather, they are taking care of both their personal *and* professional interests. Even Saltz, whose book *The Power of Different* argues *for* viewing mentally ill people as gifted, says that "individuals with brain differences are far more capable of displaying their spark productively when their symptoms are moderated via appropriate treatment" (12).

This research leads me to believe what I have long suspected: That creative people with mental illness must work *harder* in order to create. That is, they must deal with the myriad symptoms of their illness and attempt to seek effective treatment *while also* dealing with the self-doubt and job insecurity that typically come with being an artist. A recent report by Victoria University "suggested mental health problems are widespread and have more to do with insecure and harsh working conditions than romantic ideas of misunderstood genius or workers' existing illnesses" ("Mental Health Woes").

Even artists with regular employment and/or health insurance may be hesitant to seek help, however. Becker states that "the association of creativity and madness may essentially be seen as a kind of role expectation" for artists (20). The idea that mental anguish is *good* for one's art persists today. Furthermore, audiences are not always appreciative of an artist's struggle *through* mental illness in order to create work. When an audience believes the 'mad genius' myth, "the prevailing way, maybe even the *only* way, to appreciate and appraise the creativity and genius of the [artist]....is through the prism of madness" (de Young 25). Just as the ancient Greeks discredited their artists of any effort or talent, so madness or mental illness is used to discredit, or at least distort, the work of today's artists.

Nusbaum et al. argue that the amount of evidence for a link between mental illness and creativity is "disproportionate to the amount of popular interest" and scientific argument around the subject (399). Judith Schlesinger, who argues against a link between mental illness and creativity, states that we "would all do better if great creativity were celebrated, rather than diagnosed" (72) and I agree. Why focus on a person's illness or the chemistry of their brain when we can focus instead on the immense effort put into a book, a piece of music, or a performance? But, "regardless of time, place, or cultural difference" many people - including artists and

audiences - have believed and continue to believe in the "existence of an intimate connection ...between original creativity and mental illness" (Becker 18). As long as that is the case, advocates will need to fight stereotypes to win the respect of audiences while also convincing artists that seeking help will not harm their creative processes.

The One-Person Show

By creating a play about actors struggling with mental illnesses, I hope to celebrate "*achievement* as well as suffering" (Gregory 9). I chose the one-person show for several reasons. First and foremost, I wanted the play to have the best possible chance of being produced. Professional theatre companies are more likely to produce one-person shows: "With only one actor salary and significantly reduced costs for touring transport and accommodation, the one-person show offers the possibility of optimizing one's revenue against expenses," Stephenson writes (viii). The same principle applies to traveling on my own without patronage. Without salaries to pay, I have a better chance of making a profit or at least breaking even.

In addition to low costs and greater portability, the solo format seemed most appropriate for the show I wanted to create. I want to challenge the audience's perceptions about mental illness while also reaching out to audience members who suffer from illness themselves. Bonney writes that "the solo show expects and demands the active involvement of the people in the audience" (xiii). Furthermore, the audience of a solo show has a greater impact on the actor than in any other genre; without any other actors on stage, the audience becomes the actor's other. There is an exchange of energy between the audience and performer: "their presence in the room can trigger not only new levels of performance but ...new material" giving both audience and performer "great power and great vulnerability" (xiii). My hope is that this vulnerability will make both the audience and myself more open to new ideas while also empowering every

audience member who has ever suffered from mental illness. The intimacy of a one-person show and its "quieter revelations" (Stephenson viii) is appropriate for both my deeply personal subject and my performing style. *Mad Women*'s combination of genres, from traditional monologues to short dance numbers, will be more acceptable within a one-person show than in another kind of production.

The one-person show "not only tolerates but thrives on the coexistence of the illusion and reality of improvisation" (Bonney xiii) and has increasingly become "a hybrid of ...theatrical forms" (Kearns *Getting* 8). It will also be an excellent opportunity for me to grow as a performer. In addition to the challenge of holding an audience by myself, I will get to play some of the greatest characters ever written. Solo performer Kearns puts it well when he says: "No one was going to cast me in the way I could cast myself" (*Getting* 60).

There is, of course, the danger of becoming egotistical: "The possibility for performer self-indulgence is never far removed from the one-person show" Gentile warns (202). I hope, however, that the assistance of collaborators will keep me safe. My need to communicate with audiences will be another defense against arrogance. "If the solo performer has something valuable to impart ...how can the artist not be of service to a larger purpose?" asks Kearns (*Getting* 5).

I have such a message. Given my struggles with anxiety and depression, I have long felt a responsibility to speak out on mental health issues. But when I tried to write about mental health in the past, the work was too personal, which made sharing and workshopping painful. The objectivity I needed in order to take feedback and improve my work was impossible. I shelved the work until one of my professors suggested that I should write and perform a one-woman show for my thesis project. Knowing that such a show would require passion and a strong

message, I immediately decided it would be about mental health issues. I felt that I was ready to tackle my personal experiences and share them with the world through an autobiographical monologue.

I was wrong.

In order to turn personal experiences into public entertainment - and it *is* entertainment, no matter how serious it is - an emotional distance and sense of resolution is needed. In order to write about and eventually perform my story, I needed to see it as that: a story. Kearns asks aspiring solo performers: "Are you doing a solo show instead of going to therapy?" (*Solo* 53). By using purely autobiographical material, I was getting dangerously close to therapy. I realized that I needed to tell the story through other characters. Catron reminds us that "storytelling must be entertaining. It must be *fun*" (113). I was not ready to write a purely autobiographical script, much less make it *fun.*

The Structuring and Creation of *Mad Women*

While reading Showalter's "Representing Ophelia" for a class assignment, I was outraged by how the Shakespearean heroine had been used to justify and enforce romantic ideas about women's madness. My need to challenge the elegantly mad Ophelia gave me the idea of creating a metatheatrical script about the portrayal of mental illness in theatre. Specifically, the script focuses on women with *real* mental illnesses as they try to play madwomen from Shakespeare's plays. I felt this format would give me a voice I was ready to use while still raising awareness about mental illness. Plays "can be narrowly autobiographical - primarily and closely focused on the individual performing self - or they can be multifaceted, splitting the autobiographical self into many selves" (Grace 100). While each character in *Mad Women* shares aspects of my own struggles with mental illness, each woman's personality and illness is also significantly different

from my own. Furthermore, I think *Mad Women*'s mix of real-life issues and metatheatrical fantasy will help it stand out. There are many wonderful plays about people struggling with mental illness. There have also been many solo performances of Shakespeare's work, most famously those of John Gielgud and Ian McKellen (Young 83). I have not found mention of any one-person plays that address mental illness in Shakespeare's work, however. There is a play called *Shakespeare's Mad Women*, and although the three-character play explores "why female characters are reduced to no more than 'mad women,'" the dark comedy differs greatly from *Mad Women* ("Shakespeare's Mad Women"). I hope that *Mad Women*'s combination of Shakespearean monologues, advocacy, and the supernatural will help draw audiences.

Though I had some previous playwriting experience, I had never attempted a solo show before. There are a limited number of books on the subject, but those I did find were invaluable. Given the scarcity of literature on the subject, it was difficult to find a subgenre or style with which to describe my one-person show. I found a term I preferred in Alterman: In a *character-driven, fictional monologue* "the actor/writer creates multiple characters to express a theme, display a lifestyle, or tell a (sometimes) imaginary story. In many cases the characters have a common connection" (5). This perfectly describes *Mad Women*. The common connection is strengthened by the character of Ruby, whom I will discuss soon, as well as my being the only performer onstage.

Mad Women consists of short vignettes, each of which contains a Shakespearean monologue followed by a monologue I have written. Each Shakespearean heroine is paired with an 'advocate,' an actress who is dealing with her own mental health problems. "When working on an evening of character monologues," Alterman advises, "each monologue can be thought of as a separate block and should be worked individually" (69). Thinking of each character's story

as a mini-play allowed me to break the writing into distinct portions. I did not combine the vignettes into a script until each was in final draft form. Each character required specific research, which I will detail later in this thesis, but there were some elements I considered for all six characters. Conflict, says Catron, "makes clear the play's thought, its intellectual meaning" (155). I chose distinct conflicts and objectives for each character before I began writing. Alterman reminds writers that both short and play length monologues should have "an obstacle, objective, and an arc" (29). This simple advice reminded me to give *each* of my characters a full arc. Ruby's arc covers the entire play, but the other women have mini-arcs. To keep the play from becoming monotonous, it was important to me that each woman's arc was distinct. "What is the character like at the beginning of the piece? By the end? What is the specific route that causes the changes that occur in him?" Miller asks (23). Pam, for example, starts out as an optimistic young woman and ends up resigned to obeying her fiancé and taking care of her abusive father. Anne has a far more subtle arc. She starts with the need to tell *her* story, not the media's, of obsessive-compulsive disorder, and while her personality does not change, her self-esteem enjoys a boost.

In one of his exercises, Catron asks "What abstract forces are in opposition? What concrete, specific forces?" (92). While writing each vignette I was determined to consider both the *abstract* forces of mental illness as well as the *concrete* forces, which were usually symptoms and/or an individual or culture's response to them. The concrete forces are most visible in the text, especially for Laura, Anne, and Amy. Whether they are experiencing symptoms of their illness during their monologues will be up to me as the performer. Violet, on the other hand, is clearly struggling with her symptoms, while Pam uses one of her symptoms (excessive drinking) as a tactic.

Another way I tried to distinguish each of my heroines was by giving her a clear other. For a long time I considered having a character who talked to herself or practiced talking to someone else while alone. Alterman points out that an actor talking to herself or to an imaginary being might say things she would not say in front of others (3); it would have given me more creative freedom. As an actor, however, I prefer to have a clearly defined other, and so each of my heroines speaks to real, albeit unseen, characters. I tried to reveal each other through the heroines' reactions to them as Bruno and Dixon advise (88). Some others are more clearly defined within the text than others. Pam's fiancé and the young reporter who interviews Anne both have strong reactions to what the women are saying and need to be appeased or reassured. In every vignette, I kept in mind that the character *needed* to speak because of her situation (Catron 24), that these women would not reveal such personal details about themselves without strong motivation.

"I wouldn't want to do a solo play about a lady with whom I wasn't totally in love," wrote Julie Harris, who played Emily Dickinson in *The Belle of Amherst* (Harris 6). While I tried to make each heroine in *Mad Women* distinct, I also gave each admirable traits that I would enjoy playing. The great monologist Anna Deveare Smith "gives each character an individualistic rhythm and style" (Catron 77), and I tried to do the same. I enjoy Anne for her bluntness, but I also appreciate Amy's formality and timidness at the top of her monologue.

I chose Shakespearean monologues in part because I wanted to narrow my scope of research and writing. By choosing Shakespeare, I also ensured I would have excellent material that most audiences would be familiar with. Finally, as my research on Ophelia revealed, Shakespeare's work has had a long and at times disturbing relationship with psychiatry. Since my goal is to reappropriate mad characters, Shakespeare's work, so often (mis)used in

representing the mentally ill, seemed like the best place to start. As for the heroines, I chose 'bad' heroines as well as 'mad' ones. That is, I chose characters who are generally considered weak (Juliet, Ophelia) or evil (Lady Macbeth, Goneril), with the one exception being Constance, who is from a lesser-known work, *King John*. So my challenge became to represent heroines who were frequently belittled, despised, or simply overlooked as strong and even admirable women. Thankfully, "Shakespeare's elastic plays have allowed for myriad presentations over the centuries, even differing feminist versions" (Kordecki and Koskinen 2), and I had both my own imagination *and* years of criticism to work with. In choosing each monologue I generally went with whichever best suited my purpose while also keeping language in mind. For example, Goneril has several monologues that could work for Pam, but the one I chose seemed more accessible to modern audiences than the other two. I also wanted a couple of famous monologues. While performing his *Ages of Man*, Gielgud found that audiences were impatient for the famous and "exciting bit[s]" (qtd. in Young 88) of Shakespearean monologues. I heeded his expert advice when possible.

My greatest fear in creating *Mad Women* was that I would misrepresent people with mental illnesses. Despite having suffered from mental illness myself, I feared presenting something that was inaccurate. After all, I have not experienced all the mental illnesses portrayed in *Mad Women*. What business do I have playing a character with bipolar disorder? Furthermore, what if my perspective was so different from those of other people with mental illnesses that the show became alienating? "The process of staging one life and one perspective also invokes problematic essentializing of this singular story," Stephenson warns (ix-x). *Mad Women* is *not*, however, the only play ever written about mental illness. My audiences will almost certainly have heard of musicals like *Next to Normal*; in some venues my play will be one of *many*

offerings that deal with mental illness. So, by offering my perspective in addition to others, I believe I am actually making it *less likely* for audiences to walk away with a single view of mental illness

Furthermore, it has been argued that one need not suffer from a *specific* illness in order to portray it. Disability is "a social identity and not just a physical condition," and this "explains casting choices in which a disabled actor is cast in a role in which his or her impairment significantly differs from the character's"; in other words, an actor's illness or disability can give her insight into the character's even if their disabilities are not the same (Sandahl 237). Though Sandahl is writing about physical disability, I believe the same principal can apply to the portrayal of mental illness. Knowing what it is like to suffer from a mental illness will give me a hook into every character I portray. Portraying illnesses other than my own may in fact be healthier for me as an actor.

Corrigan et al. have suggestions for telling life-stories about mental illness that are applicable to playwrighting as well. Stories about mental illness should not be unrealistically positive, nor should they be too negative (74). I achieve this through showing both heroines who succumb to their illness (or the treatment of it), heroines who are thriving in spite of it, and one heroine, Violet, who survives and raises a family but at great cost.

It is also important to show that the illness, or at least its effects, last "*beyond the relatively brief period of onset*" so audiences realize that this "is not just another short-lived emotional crisis" (Corrigan et al. 75). The long-term effects of my heroines' illnesses are clear: Laura has been ill long enough to be prescribed the rest cure; Violet's depression existed before she had her baby; Pam's alcoholism is hereditary; Anne 'came out' with her obsessive-

compulsive disorder several years ago; and Amy, an eighteen-year-old college freshman, has been struggling with anxiety since at least fourteen.

In his essay on the misrepresentation of disabled characters in literature, Sklar warns that "with the possible exception of semi-autobiographical narratives," the writer "is *not* the other whom he wishes to represent, and this makes the effort to portray the emotions and thoughts of another speculative, at best" (237). Given my experience with mental illness, the work *is* semi-autobiographical, though only very loosely. Still, I have been careful to avoid using stereotypes to create my characters. Rather, I have drawn on scientific information as well as my own experiences. Through the workshop process, I hope to gain feedback from other people with mental illnesses so I can address any problem spots I am currently unaware of.

The last precaution I took against misrepresenting mental illness was *not* offering diagnoses for any of Shakespeare's heroines nor, with the exception of Anne and Amy, explicitly stating my advocates' illness. For the advocates it was partly a matter of historical accuracy: Laura and Violet would not have been given the modern diagnoses of bipolar II and depression, while Pam would not have admitted to being an alcoholic. Anne and Amy, on the other hand, *need* to reveal their diagnoses in order to achieve their goals. I chose to be vague when possible because Corrigan warns that diagnostic labels put people with mental illness "in a class that is qualitatively distinct from the norm" (145). Even Anne and Amy get to say a few words before diagnosing themselves, giving the audience a glimpse into their personalities before there is a chance to put labels on the characters. As for the Shakespearean characters, Scull warns that we "run enormous risks of misconstruing history when we project contemporary diagnostic categories and psychiatric understandings back on to the past" (15) and I believe this applies to past literary figures as well as historical ones.

The Characters

The first character my audience will encounter is Ruby, a mysterious being who remembers (and vicariously experiences) everything that has ever happened in the theatre. We later learn that the theatre is called *The Ruby*; Ruby is the personification of the theatre itself. Her purpose is to create an overarching storyline that connects the actresses and their experiences over time. Having all of these events take place in one theatre will hopefully highlight how frequently people suffer from mental illnesses and give audiences a sense of seeing a small piece of the whole. Ruby also provides connective tissue between each story and justifies the changing of mood and costume. She 'becomes' each of the actresses through a brief dance sequence, and each vignette ends with her transformation back into herself.

Ruby is my alter-ego within the piece. An alter-ego "serve[s] as a medium to transport the actor-creator into the physical environment of the play" and allows the "private self" to be "physically present within a performance through a public self" (Dundjerović 161). Ruby is so named because the ruby is my birthstone.

As an otherworldly being, Ruby does not suffer from human illnesses. She does, however, feel the same emotions as the actors in the theatre. The feelings from the women suffering from mental illness confuse Ruby, as there is not a clear 'reason' for them to feel the way they do. As she mentions in the script, feelings of disappointment from aspiring actors and audition nerves can be uncomfortable, but she understands them as part of life in the theatre. She realizes that the ill actress' emotions have a more insidious source, and it has always bothered her to some extent. Now that her own future is uncertain, Ruby revisits the actress' stories in hopes that they will give her some clue as to how to deal with her new-found sense of mortality.

Aside from Ruby, there are five 'advocates,' each of whom has a corresponding character from Shakespeare. The purpose of each advocate is to speak for both herself and the character, putting a human face on a mental diagnosis or disorder while also speaking to the struggles of the woman she plays onstage. Each advocate required a unique research methodology because each has a different mental illness and several live in historical time periods.

My first vignette takes place in 1895. During the 1800s, theatre and mental illness became entwined. Asylums and their patients became theatrical, and many - including physicians - looked to the work of Shakespeare to explain mental illnesses. In the mid-1800s, Shakespeare was the most cited "authority on insanity and mental functioning" (Reiss 769). While there are many examples of madness (real, imagined, and feigned) in Shakespeare's plays, it was Ophelia's madness that received the most attention from physicians. Some saw Ophelia not as a fictional character, but as true-to-life example of women's mental illness:

> Shakespeare's depiction of Ophelia's madness was held by some nineteenth-century medical practitioners to reflect the reality of mental illness in women, and the popular image of Ophelia - flower bedecked and downcast - occasionally featured as an illustration in medical textbooks (Gregory 24).

Nineteenth century images of Ophelia had "begun to infiltrate reality" and "define a style for mad young women seeking to express and communicate their distress" (Showalter "Representing" 231). When mad women did not behave like Ophelia, asylum workers "imposed the costume, gesture, props, and expression of Ophelia upon them" and took pictures (231).

Photography caused mental health care to become even more theatrical. Bethlehem Hospital may have seen up to 19,000 tourists a year in the 1800s (Corrigan et al. 6), but Jean-

Martin Charcot (1825-1893) took the theatricality of mental illness - specifically, women's mental illness - to a disturbing new level. The French doctor "advanced his career ...by staging spectacular demonstrations of his ability to hypnotize and control patients" (Hunter 1). Charcot's patients were "coached in their performance for the camera" and even "instructed to play heroines from Shakespeare" while under hypnosis (Showalter "Representing" 231). The photographs of Augustine, one of Charcot's patients/models, seemed to imitate the "exaggerated gestures of the French classical acting style, or stills from silent movies" (Showalter *Female Malady* 152-54). To his credit Charcot *did* believe that hysteria "attacked men and women alike" (Scull 278), but "[i]t was not the male hysterics who drew the audience to Charcot's clinical demonstrations...but the attractive, scantily clad women" (280).

As for Ophelia herself, the "wild, emotional, and erotic visual representations" of her madness became "more pronounced" during the nineteenth century (Kiefer 12), and at the time "madness was identified with femininity" (16). As both a woman and sufferer of mental illness, I was horrified by this objectification of mad women and its strong sexual overtones. I became determined to reclaim both Ophelia and the Romantic/Victorian madwoman as part of my play. Showalter points out that while we "have so many remarkable pictures of Victorian madwomen," we have "so few of their words" (*Female Malady* 97). In creating Ophelia's advocate, Laura, my hope is to give the 'madwoman' some of her words back.

The greatest challenge in creating Laura and her take on Ophelia was sifting through the vast amounts of information about the character and the actresses who have played her. Every story about Ophelia is also part of "the history of her representation, reflecting each era or culture's characteristic constructions of women's roles, madness, and essentialized notions of femininity" (Peterson and Williams 2). The more I researched Ophelia and thought about Laura,

the less I wanted *either* of them to be completely, unambiguously mad. Hamlet's madness, or lack thereof, "has been discussed in innumerable books, critical reviews and dissertations" (Davis 34), but critics take Ophelia's madness for granted. Lopez states:

> ...no critic, as far as I know, has ever suggested that Ophelia might be merely *acting* mad because she perceives and is interested to enjoy the freedom that histrionic insanity provides Hamlet. ...What if Ophelia is imagined to *adopt* an antic disposition in order to provoke her brother to take revenge upon Hamlet for the death of Polonius or force Hamlet to prove his love for her, now that he has freed her from the tyranny of her father? (38)

While I appreciate Lopez's theory, I disagree with the motivations he gives Ophelia. Coursen points out that Ophelia is "however unwillingly, a central player in Elsinore's game of espionage," one who becomes "a teller of truths ... [and] represents a danger to the kingdom" (53). What if, I asked myself, Ophelia's madness was a form of self-defense? Coursen says "I am surprised that no [film] director has ever had Claudius signal the dispatch of Ophelia - perhaps even handing a parchment to Gertrude, containing her 'willow' speech" (58), and I agree that Ophelia's death might not be a suicide or accident, but murder. So, the Ophelia I portray in *Mad Women* is distressed but not mad, and her pretty death by drowning is highly suspect.

Ophelia's advocate, then, is less sick from her mental illness than from society's treatment of it. Though not explicitly stated in the script, Laura suffers from bipolar II and has had one hypomanic episode that alarmed her brother. A person with bipolar II disorder has had "at least one major depressive episode and at least one hypomanic episode" but not a manic episode ("Bipolar Disorder"). Laura's symptoms have been infrequent, but combined with her choice of profession, which was not considered respectable at the time, they are enough to justify

a diagnosis and treatment. I originally intended to have Laura diagnosed as hysterical, but during my research I found a more appropriate diagnosis. In the nineteenth century, the "newly emerging professional class, the 'brainworkers'" were diagnosed with an illness called neurasthenia (de Young 18). The disease covered a wide range of symptoms, and it was considered a "*privilege*" of the "cultured and affluent class" (19), but only for white males. Women were also diagnosed with neurasthenia but were treated with the rest cure. The rest cure was "not particularly well-suited" for men but recommended for women, for whom "brainwork" was considered dangerous (20). During the rest-cure, "the patient was isolated from her family and friends, confined to bed, forbidden to sit up, sew, read, write, or to do any intellectual work" (Showalter *Female Malady* 138).

We now know that exercise helps *reduce* symptoms of some mental illnesses, specifically depression and anxiety ("Depression and Anxiety"); the sedentary lifestyle promoted by the rest cure would probably worsen mental illness as well as bore the patient out of her mind. Being forced to lie still all day and stay away from her beloved theatre would have been torture for Laura.

Laura's escape is inspired by a true story. In her essay "Representing Ophelia," Elaine Showalter describes an eighteenth century incident where "Susan Mountfort, a former actress at Lincoln's Inn Fields who have gone mad after her lover's betrayal...escaped from her keeper, rushed to the theater" and took over the role of Ophelia (225). The actress died soon after the performance (225). Mountfort, who had been a "good Ophelia" when sane, supposedly "render[ed] the character overwhelmingly vivid" that infamous night (Wingate 284). I could not find any contemporary accounts of the incident, and so have chosen to take it with a grain of salt.

The idea stuck with me, however, and inspired Laura's last act of defiance. Terrified by the rest cure's effect on her mental health, Laura needs to play her heroine one more time.

How Laura plays Ophelia is inspired by another real-life actress. Mrs. Patrick Campbell, who experienced the rest cure before playing Ophelia, disconcerted Victorian theatregoers and critics. The typical way to play Ophelia had been embodied by Ellen Terry, whose character seemed "all the more genuine and womanly for having gone mad" (Conti 146). Campbell's Ophelia, rather than being an "emblem of prettiness and pathos" was instead "vacant, depressive, [and] 'beaten'" (Gregory 27). Campbell made Ophelia's madness "horrific" rather than pretty (35). While most criticized her performance, George Bernard Shaw praised Campbell for depicting Ophelia as truly mad and was "impressed by the dramatic effectiveness of the scene" (32-3). Gregory's suggestion that Campbell was playing the rest cure fits my idea of Laura's Ophelia. My advocate loves her heroine not because they are both mad, but because they are both oppressed. Laura, by becoming an actress, has "fail[ed] to adhere to the limits imposed by society" and therefore "risk[s] annihilation, including the annihilation of the self though psychiatric incarceration." (Hubert 21). Even without her mental illness, Laura might have ended up in an asylum anyway for daring to break Victorian convention.

I was originally going to end this vignette with Laura being lobotomized or dying from electroconvulsive therapy, but neither fate would have been historically accurate. The first human trial for electroconvulsive therapy was conducted in 1938; the first lobotomies were performed in the 1930s (Scull 312-13). Asylums were growing overcrowded at the end of the nineteenth century, however. As the problem worsened, drugs were administered, not to treat, but to "pacify, sedate, and stupefy" patients (Porter 120). The end of Laura's vignette, which will

include historical information on the projector, reveals that after her condition worsened she was sent to an asylum where she died of a drug overdose given her by an orderly.

My second advocate is Violet, a young mother living during the 1920s who is playing Constance from *King John*. The character began as something of a stereotype: In the original draft, her struggle with depression ended in suicide. Given the slew of criticism against both entertainment and news media's portrayals of suicide, I wondered if a depiction in *Mad Women* might endanger rather than empower audience members. Suicide.org has a long list of media guidelines, including many *do nots,* for reporting/portraying suicide in a way that will not encourage others to kill themselves (Caruso). As I looked back on my personal experiences as an audience member, I realized that most of the media I consumed that dealt with mental illness featured either a suicide or suicide attempt. Considering that *all five* of the Shakespearean heroines portrayed in *Mad Women* are suicidal, it seemed excessive to have one of my advocates die that way as well. I began to ask myself: Do we really need another theatrical suicide? And am I the right person to write it? I decided to address suicidal thoughts in two monologues (Violet and Amy's), but none of my characters would *die* by suicide. Instead, one of my heroines would die from poor medical care (Laura) and another from her symptoms (Pam). This way, I could avoid the controversy of suicide without ignoring it altogether while also reminding audiences that suicide is not the only way mental illnesses can kill.

After deciding that my 1920s heroine would be a survivor, I turned to my personal experiences and observations to create the character of Violet. I began thinking about the many people with depression who do *not* kill themselves, particularly people who lived before there was safe and effective treatment. I began to wonder how they survived and passed for normal while fighting a devastating illness. Obviously the severity of depression would be a huge factor

in both survival and quality of life. I read about dysthymia, which is a "more moderate form of chronic depression" and learned that people who have it "experience cycles of low and even despairing mood, but tend not to be utterly incapacitated by it" (Saltz 111). The Mayo Clinic refers to it as persistent depressive disorder, noting that while the symptoms are chronic, they vary in severity ("Persistent"). This would allow Violet to participate in day-to-day activities while experiencing mild episodes but would also explain the severe depression she feels during the vignette. It also explains her hope that life will get better.

Violet's refusal to seek help is explained by her time. The asylums were jam-packed (Porter 120). Experimental treatments in at least one hospital involved removing patient's teeth (de Young 183-85). Violet would have heard of Freud, whose *Interpretation of Dreams* was published in 1900 (Porter 192), but not necessarily agreed with his ideas. Even if talk therapy appealed to Violet, she might have been too embarrassed about her condition to seek help. Furthermore, the idea of being taken to an asylum and 'treated,' away from her beloved husband and son, frightens Violet enough to keep her from reaching out to anyone.

Symptoms of dysthymia include "[s]adness, emptiness" and "[h]opelessness" ("Persistent"). Violet's connection to Constance, based on their shared loss (Constance's *actual* loss and Violet's *sense* of it), seemed appropriate based on both my research and personal experiences of depression.

My next heroine is a young woman portraying Goneril from *King Lear*. Though Lear himself is the character most often associated with madness in that play, it is easy to argue that the entire family has psychiatric problems. From Lear's loyalty/love test to the elder daughters' rejection of their father, I saw the play as a cycle of abuse ending in the destruction of the entire family. This immediately made me think of alcoholism and the toll it takes on families. After

looking at the text of *King Lear*, I decided Goneril was the best heroine for this show as her monologues show the distress of a put-upon daughter and are fairly modern sounding. Her advocate, I decided, would be the daughter of an alcoholic who is slowly succumbing to alcoholism herself.

I am not the first person to link alcoholism with Lear and his family. Kordecki and Koskinen suggest that "[o]ne possible source of Lear's erratic, aggressive action" could be "years of alcohol abuse" (30-1). They go on to posit that "mental illness...and drinking could haunt the Lear family line" (31). In addition to their thoughts on alcoholism, I am indebted to Kordecki and Koskinen for their insights on the Lear family. They argue that "the actions of all three daughters, like those of most of the men in the play, are a result of Lear's erratic and irresponsible behavior in the first scene" (2). They state that *King Lear* "does not 'show' us these women [Goneril and Regan] as monsters; it demonstrates how the world forces women into roles that others perceive as monstrous" (19).

Like this re-visioned Goneril, my *King Lear* advocate, Pam, has been through "years of enduring [her] father's emotional mood swings and abusive alcoholic antics" (37). She thinks she has found escape in the theatre, and so she has ...for a while. Later she turns to her fiancé, a sober but overbearing man who insists she leave the theatre.

In order to put even greater pressure on Pam and liken her situation to Goneril's, I set her story in the 1950s, "when rigid images of the 'ideal woman' dominated cultural consciousness, strictly binding women to standards of unrealistic perfection as mothers, wives, and homemakers" (Lavin 14). As woman nearing thirty, Pam is under tremendous pressure to please her fiancé and conform to the 1950s ideal before it is too late. Like Albany, Pam's beau sides

with her father. In trying to keep up with the demands of the men, she sinks deeper into the alcoholism that is starting to emerge during her monologue.

A person with a family history of alcohol use disorder or a history of trauma is at a higher risk of becoming an alcoholic ("Alcohol Use Disorder"). Already predisposed to the condition, Pam lives during a time when seeking help would have been very difficult. Even today, "alcohol and substance abuse [are] viewed [the] most negatively" of all mental diagnoses (Corrigan et al. xix).

In the 1950s, the situation was worse:

> Even after the founding of Alcoholics Anonymous (AA) in 1935, which proved that many drunks want to stop drinking, the major institutions of American life refused to help them. Hospitals would not admit alcoholics, turning away even those in need of emergency care. Most doctors, psychiatrists, and psychologists would not accept them as patients...The federal government finally recognized alcoholism as an illness in the 1960s, but many people were not convinced (Finan 2).

Even some early AA groups restricted membership in the fear that bad behavior would endanger the entire group (196); alcoholic women were judged "more harshly than men" and often assumed to be prostitutes (206). In 1970, almost twenty years after Pam's vignette, "the overwhelming majority of AA members were [still] middle-aged white men" (252). Even if Pam had acknowledged her problem, it would have been difficult for her to get help.

Historically, "actresses have been seen as particularly vulnerable to the lure of drugs and alcohol" for multiple reasons (Gregory 60). I chose instead to show Pam as happy and fairly stable in the theatre; it is by trying to conform to the 1950s standards of perfect wife and

daughter that Pam dooms herself to alcoholism. Pam's closing dance was originally going to end with her dying in a car crash. Corrigan cautions advocates not to "unintentionally worsen the stigma of substance use when trying to erase the stigma of mental illness" (71). Given public feeling about drunk driving, I thought it would be more sympathetic for Pam to die of pancreatic cancer caused by drinking rather than behind the wheel.

Anne, a leading lady with obsessive-compulsive disorder (OCD), is by far the most autobiographical of all my mad women. A few months ago I was cast in a production of *Macbeth*; during rehearsals, I often watched the sleepwalking scene. As rehearsals progressed, the actress' movements became more violent; she would rub her hands against the floor as though trying to tear her skin off. I inevitably remembered my childhood germ phobia and the feeling of contamination that came with it. While I do not see Lady Macbeth herself as obsessive-compulsive, the idea of an obsessive-compulsive actress portraying her (and, consequently, having to fight the 'mad genius' stereotype) appealed to me.

According to the Mayo Clinic's website, OCD "features a pattern of unreasonable thoughts and fears (obsessions) that lead [one] to do repetitive behaviors (compulsions)" that interfere with daily life while causing "significant distress" ("Obsessive-Compulsive"). A common symptom of OCD is fear of contamination, which can result in excessive hand washing.

Many of Lady Macbeth's behaviors are similar to that of a person with OCD: her "obsessive attention to a particular detail"; the "[i]mmersion in a world of fearful fantasy" (Davis 42); her habit of "furtive and compulsive writing" (Salkeld 112). A 2013 article on exposure therapy in *Nature*, entitled "Cleaning Damned Spots from the Obsessive Mind", states that Lady

Macbeth could be suffering from mental contamination, which "is a feeling of internal dirtiness caused by a psychological or physical violation" (Rachman 7).

Unlike people with OCD, however, Lady Macbeth is the violator rather than the violated. The imaginary blood does not come from a person who attacked her physically or mentally but rather from her own victims. People with OCD often have unwanted thoughts, including thoughts that are "[a]ggressive or horrific" ("Obsessive-Compulsive"), but they *do not* act on those thoughts, whereas Lady Macbeth's ghosts are the result of *actual* crimes. These significant differences show that even if Anne *wanted* to use her illness as inspiration there would be severe limits to its usefulness as well as psychological danger to the actress. As I demonstrated earlier, good mental health is almost certainly beneficial to creativity. For the 'mad' actress, "work stands as a mark of resilience" but, as Anne discovers, "a mark the significance of which ...is repeatedly discounted" (Gregory 36).

Catron suggests "developing characters who have distinctly unusual or even eccentric qualities that make them colorful" (141). Anne's blunt yet garrulous speech and Southern dialect are meant to both surprise and delight. In a serious show, humor is desperately needed. Anne has a difficult story to tell, but her humor and heart will hopefully make it more palatable. I was also careful to make Anne's story and symptoms distinct from my own so I will not feel as though I am merely playing myself.

As well as giving myself a voice to advocate for other people with OCD, I also used Anne's vignette to address an issue that has long troubled me. Earlier in this thesis I made clear my views on the concept of 'mad genius.' Anne is the only character who addresses this issue directly in the show, and I chose her because depictions of OCD as a 'gift' are particularly frustrating for me. Not everyone with OCD has the same experiences, of course; perhaps some

people do benefit from it. I, personally, have found representations of OCD on shows like *Monk* (Breckman) and *The Big Bang Theory* (Lorre and Prady) problematic and difficult to relate to. In my experience the illness has been a distraction rather than a mixed blessing or quirk. With Anne I hope to offer another perspective on OCD.

Amy, an eighteen-year-old college freshman, has the final vignette in the current version of *Mad Women*. Like the heroine of the first vignette, Laura, Amy suffers less from mental illness than from improper treatment. As with my other modern heroine, Anne, Amy is a semi-autobiographical but distinctive character. Like Amy, I was diagnosed with attention-deficit/hyperactivity disorder (ADHD) when in reality I had OCD, an anxiety disorder. The medications I was given worsened my illness; unlike Amy, I was able to get medical help before the situation escalated to the point of a suicide attempt. While my experience was rare, it was not unique. About five million Americans age twenty-five and under are on medication for ADHD (Welch). According to the CDC, 5.2% of U.S. children ages two to seventeen were taking medication for ADHD in 2016 ("Data and Statistics").

Yet an analysis showed that "1 out of every 486 patients who started on an amphetamine developed psychosis that required treatment with antipsychotic medication" (Welch). According to the FDA, Ritalin (another drug used to treat ADHD) can cause "stroke and heart attack in adults" as well as psychiatric problems ("Medication Guide"). People who "are very anxious, tense, or agitated" are warned not to take Ritalin. Amy suffers from generalized anxiety disorder. Symptoms can include twitchiness, irritability, and nervousness ("Generalized"), so it is not unreasonable to imagine she might be misdiagnosed with ADHD. Even people who *have* ADHD may have other mental illnesses; according to the CDC, approximately one out of three children with ADHD *also has anxiety* ("Data and Statistics").

Having personally witnessed (and suffered from) doctors' eagerness to label mentally ill children and teenagers with ADHD, I felt obligated to bring awareness to the potential side effects of ADHD medication - especially on people with other disorders that can be mistaken for ADHD. I also wanted to address suicide directly at some point during the play. It was important to me to portray a *survivor*, not a victim, as there are already many portrayals of suicidal characters in theatre and film. Amy uses *Romeo and Juliet* to remind her classmates that, unlike Juliet, they can seek help. A recent production of *Romeo and Juliet* by the Utah Opera did something similar. The theatre addressed concerns about teen suicide by using the show as an opportunity to "start discussions about warning signs, stigma and other aspects of mental health" and had advocates and information tables in the Capitol Theatre's lobby (Means).

Amy's story came in part from my own experiences with misdiagnosis. It also came from a desire to defend a masterpiece that I have often seen maligned. My own students have complained about how terrible they think *Romeo and Juliet* is; trashing the play seems commonplace for high school and college students. I believe that it is Romeo and Juliet's (and Paris and Tybalt and Mercutio's) untimely deaths, rather than their star-crossed love, that create the real tragedy. In 2017, suicide was the "second leading cause of death for people 10 to 34 years of age" and the tenth leading cause of death in the United States overall ("Suicide"). Some of the reasons for suicidal thoughts listed on the Mayo Clinic's website include: "loss of a loved one"; "Feel[ing] hopeless...socially isolated or lonely"; "Hav[ing] a family history…. of violence" ("Suicide and Suicidal Thoughts"). Maybe Romeo and Juliet are not so unusual - or pathetic - after all, considering that all of these risk factors are present in their lives.

Rehearsal, Workshopping, and Production

When I first started this project, my hope was to perform the completed script before graduation. After realizing how much research and energy was needed to create the script, I cut down. However, I do have a detailed plan for designing, rehearsing, workshopping, and eventually performing *Mad Women*. During the course of my research I came up with several ideas for expanding the number of characters in *Mad Women* as well as an alternate, multi-actor version.

In order do *Mad Women* - and, even more importantly, its audience - justice, my first goal is to get into better shape. "Do you trust your voice? Do you trust your body.... Do you trust your ability to capture an audience?" Kearns asks (*Solo* 11). Right now, my answer would have to be no and, due to an upcoming surgery, the answer will be no for a while.

During the approximately two weeks I will need to heal, I hope to begin sound and visual design for *Mad Women*. Specifically, I need to find evocative transition music that is either in the public domain or that I can obtain permissions for. The transitions out of character and back to Ruby should be relatively simple, as I intend to use classical music or, depending on the vignette, no music at all. The transitions *into* each advocate will be more difficult to obtain since each needs to be evocative of a specific time period.

In addition to music, I will also need to gather public domain pictures. Some, such as the idealistic 1950s images that accompany Pam's descent into alcoholism, should not be difficult to find on Creative Commons. Others, such as pictures of Victorian asylum patients, may require more time and effort to obtain permissions.

Alterman suggests only using elements such as song and dance if they "add something not already said" in the script (70). He adds that while many solo performers use projections, it is important not to "overdo" it (70-1). Given the historical context of my first three vignettes, I

believe music is essential for setting the time. The projections are the best way to evoke time and mood while also giving the audience necessary historical information. The dance transitions are an elegant way for me to embody the actresses' stories without 'telling' what happens.

Once I am recovered, I will resume my fitness routine, which includes core strengthening and endurance building that will be invaluable for dance. I will also seek a voice instructor; until I find one, I will continue to do vocal warmups as usual. Specifically, I need to work on my projection, as that is a weakness of mine and I may have no control over acoustics and sound levels in the venues where I will perform. Catron suggests working on "vocal dynamics" (188) and avoiding "the dull monotone and its weary companions, monovolume and monotempo" (189), so I will also work on vocal variety.

Once I am physically and vocally strong enough to perform, my next goal is to begin workshopping the vignettes. "The more you share your work, the more feedback you will get," Bruno and Dixon remind performers (20). This will include everything from performing in front of friends to open mic nights at artsy bars and cafes. Alterman states that many solo performers choose to rehearse their pieces in beats (84), and open mic nights will be a great opportunity to do this. By practicing in front of small audiences before working with collaborators, I will figure out as much as possible on my own and avoid wasting my collaborators' time later on. Acting solo requires a performer to be "keenly tuned in [to the audience] without losing focus or sacrificing the flow of the story" (Kearns *Getting* 48-9), something which I anticipate having some trouble with, as my tendency in multi-person plays is to lock onto my others. Early exposure to small audiences will help develop my rapport.

In addition to practicing and refining my vignettes, I will also begin choreography as soon as I am strong enough. Given my past experience with classical ballet, modern, tap, and

other dance styles, I expect to accomplish most if not all of the choreography on my own. If I become stuck on one piece, or if injury becomes a concern, I will hire a choreographer to work problem areas. I will also hire a choreographer if there are any difficult new steps I need to learn.

As soon as I have a full show (projections, choreography, and polished vignettes) together, I plan to begin working with a director or, since I plan to be somewhat itinerant for the next few years, directors. As tempting as it is to 'self-direct,' most of my sources warn against it. "Most performers in one-person shows…. make at least one major concession in their passion for autonomy. They rely on the advice of a good director" McDougall states (4) and, as a first time solo performer, I am disinclined to go against this practice. In order for *Mad Women* to thrive, my director *must* be someone who "understands and appreciates the work" without being a yes man (Alterman 83). Additional feedback is necessary to make my play as entertaining and accessible as possible; however, as a person with a mental illness, I am wary of my voice being lost in the process. Ideally I will find a reputable director who has also experienced mental health problems or disability. At the very least, he or she must be familiar with the subject.

"Have you begun to make a list of directors and designers ...whom you might call upon?" Kearns asks (*Solo* 11). As of now, I have several acquaintances in mind, including some directors I have worked with before. Whom I work with will depend on where I am living, however, so it is too early to pick someone. Alterman advises self-directors to "at least allow directors ...to drop in on occasion and see a rehearsal or two, and get their response" (84). While I do not intend to self-direct, working with multiple directors may be the best route to go depending on how much I travel. Before working with a director or directors, I will create a contract. Bruno and Dixon recommend writing "a brief job description or contract for anyone

you are working with" (219). I hope to work with early career directors who want a unique experience and are willing to work without a fee.

The other option I have considered is directing the piece myself and casting an actor to perform the show. In spring 2019, I directed a classmate and friend, Kimberly Flowers, in a scene from the one-woman play *The Belle of Amherst* by William Luce. The scene work gave me a taste of directing one-person shows, and while I would prefer to perform *Mad Women* myself, I would not be opposed to directing it, either.

Lastly, I will need to fund and produce *Mad Women*. For the next few years I hope to supplement my precarious theatre-maker's income with other employment as needed. If I maintain a healthy savings, I will be able to fund *Mad Women*. Costs should be relatively low. I will need to invest in a projector and screen, but I believe I can purchase both for under $200. The costume and set pieces for *Mad Women* will be minimal. There will be one piece of clothing for Ruby to put on for each advocate, and these are items I can pull from my own wardrobe. Ruby's costume will be a simple leotard and possibly skirt. Aside from the screen, the set will consist of five folding chairs and a rack to hang clothes on.

I will need to hire someone to run the projector and sound cues, but that will be a very brief time commitment. As for travel, I intend to work in local venues until the show gains momentum. I will submit the work to nearby fringe festivals; given the number of shows about mental health at Edinburgh, it is reasonable to assume American fringe audiences might be interested. In addition to fringe festivals, I hope to find more atypical venues for my work. Gentile lists "coffee houses, bookstores, cafes, bars, libraries, museums, prisons, medical centers, private parties, [and] lofts" as possible playing spaces (205). Traveling for work will ideally allow me to tour the show without spending extra money. If *Mad Women* begins to turn a profit,

I will consider taking it on the road. My ultimate goal is to bring *Mad Women* to both the Edinburgh Festival Fringe and the Scottish Mental Health Arts Festival. If the current trend continues, there will be many other shows about mental illness at Edinburgh but, given that the Festival Fringe hosts more than 3,500 shows (Lukowski), I think there will be room for one more.

In order to advertise *Mad Women*, I will rely heavily on social media. The show will have its own Facebook account as well as Twitter and Instagram feeds. I also plan to reach out to mental health advocacy groups, such as NAMI, who may support my work by promoting it. Kearns warns not to "be too reliant on reviews to bring in an audience" (*Solo* 53). Considering the variety of shows that festival audiences have to choose from, I have no intention of relying on reviews at all. My long-term advertising will consist of regular social media updates and outreach to national/international advocacy groups. As soon as I know the locale of each performance, I will reach out to that area's media and look for local support/advocacy groups to reach out to. Once I arrive at the festival, I will hand out business or postcards (depending on which I can afford) and tell everyone I meet about the show. I also intend to use each performance as an opportunity to improve the show by asking for audience feedback at the end.

"Define your potential audience but don't limit yourself," Kearns advises (*Solo* 32). Obvious target audiences include thespians and people dealing with mental illness, by which I mean loved ones and medical professionals as well as patients. Fans of Shakespeare are also target audiences, though I will need to be clear in my advertising to avoid disappointment that the show is not *all* Shakespearean monologues. Depending on how the show develops, I may change the name to *The Mad Women of the Ruby*, which would solve that problem. Since the point of my show is to raise awareness and fight stigma while also entertaining, I hope people

who do *not* fit into any of these groups will come too. I hope that feedback from my open mics and early shows will help me find more ways to appeal to wider audiences.

While I want to receive positive and constructive feedback, I am well aware that I may receive very negative, possibly even cruel, feedback. As much as this frightens me, I must keep Corrigan et al.'s advice in mind: every tough audience question is a chance for me, the performer, to give an answer "that threatens their stigmatizing attitudes" (90).

Additional Characters and Multi-Actor Version

As *Mad Women* continues to develop, I hope to include more characters. During the writing process, I had an idea for a 1970s advocate for Isabella from *Measure for Measure*. This character would fill in the historical gap between Pam and Anne. She would be a young woman whose brother, a Vietnam veteran, is suffering from PTSD. What no one knows is that the actress is also suffering from PTSD after being raped by someone she thought was a friend. During one of Isabella's monologues she breaks down and tells her director what happened. There are "higher prevalence rates (approximately one-third to one-half)" of PTSD "among individuals exposed to rape, combat, and genocide" (Lehrner et al. 100), so exploring two of these issues through one family's experience seems appropriate. I decided to wait on this vignette because it occurred to me months after the others did, severely limiting my time to research and gather resources. Secondly, rape and PTSD are both highly sensitive subjects, and rushing this sequence is not worth the risk of misrepresenting survivors. So, I am shelving this idea until I can give it proper time and attention.

The second character I hope to add did not occur to me until *very* late in the process, and her 'disorder' will be the most difficult, and possibly controversial, to portray. Her vignette will also be the last in the complete *Mad Women*, revealing Ruby's fate and offering a gleam of hope.

This last advocate will be 'neurodiverse,' diagnosed with either autism or ADHD, and her monologue will be comedic and male. Neurodiversity is

> the notion that conditions like autism, dyslexia, and attention-deficit/hyperactivity disorder (ADHD) should be regarded as naturally occurring cognitive variations with distinctive strengths that have contributed to the evolution of technology and culture rather than mere checklists of deficits and dysfunctions. (Silberman 16)

This is obviously a controversial statement. Are some 'mental illnesses' societal, rather than biological, problems? In Shakespeare's comedies, many characters are thought to be 'mad' because of misunderstandings or deceptions. In the comedies, the truth eventually comes to light. My neurodiverse heroine will open with Sebastian's monologue from *Twelfth Night* before talking about her hope that one day people will accept her for who she is, pointing out that it is the way people treat her, more than the way her brain works, that makes life difficult. One day, she says, she will be an actress and perform on this stage, regardless of what people tell her she can and cannot do.

As a person without autism or ADHD, I of course have reservations about writing, much less playing, this character. I hope to talk to advocates, both those who want a cure and those who want to be left alone, before deciding if this character is even viable. I also need to decide how I personally feel about the neurodiversity movement before trying to write about it.

Finally, I have considered a multi-character version of *Mad Women*. Given the chance, I would like to do a reading, if not a full-scale production, with each character played by a different actor. It might be a good piece to do with acting students, as it offers challenging material but is also very short when divided amongst multiple actors. The end, of course, would have to change. My idea is that the last advocate would stand daydreaming in the theatre with

Ruby watching her. After her monologue ends, she is surrounded by the theatre's ghosts: Laura, Violet, and Pam each approach her, vowing that what happened to them will not happen to her. The other actresses then come out, offering additional messages of support. The lights would go down on the women standing together. Having a multi-actor show would allow for a greater representation of other marginalized groups - people who have been "harmed by multiple stigmas" (Corrigan 47) - than I am capable of by myself.

Conclusion

These additions are far in the future, however. For now, my goal is to produce the existing script for *Mad Women*, bringing it to as many audiences as possible. My hope is that, by empathizing with characters on stage, theatre-goers who are unsympathetic to people with mental illness will be forced to challenge their biases. Perhaps even more importantly, I hope to empower audience members who are personally struggling with mental illness by showing them positive, accurate portrayals of people facing similar issues. I hope to remind *all* audience members that, even if an illness enhances creative thinking, an artist with that illness must fight numerous battles every day just to survive, much less make art. My research on stigma and how to fight it support *Mad Women*'s chances of making a difference in audience perception. My research into mental health, as well as future plans for open mics and workshops, will protect the show from falling into inaccurate or stereotypical portrayals. Future collaborations will further refine the play, making it more entertaining and accessible to more audiences.

Lastly, *Mad Women* has been, and will continue to be, an empowering challenge for me as both a theatre-maker and survivor of mental illness. While creating *Mad Women* I realized for the first time how hard I am willing to work to bring a story to life. I also learned a valuable lesson about burnout and pushing myself *too* hard emotionally that I will carry with me into

rehearsals. In order to advocate for others, I learned, I must also take care of my own mental and physical wellbeing. Most of all, this process was a lesson in how theatre can bring hope and joy to even the darkest of subjects. Through writing and performance, I was able to address some very difficult issues and begin to make sense of them. I hope this will translate into my performance so that I can share some of this clarity and hope with audiences.

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Appendix A

Draft: *The Mad, Bad Women of Shakespeare*

A Monodrama by Jessica Sager

SETTING: A stage with a ghostlight. It is like every other stage in every other theatre: magical. Full of possibilities. A little wistful. Five chairs in a semicircle USC, or wherever works in the space. A costume rack is tucked into one corner. A projector screen behind and above the chairs. The stage is dimly lit with one spotlight DSL.

AT RISE: RUBY, the spirit of this particular theatre, glides onto the stage. The ghostlight winks out just as the stage lights come on (depending on budget/prop availability, the ghostlight may be represented by a projection. Or just start with RUBY's entrance.)

Soft music plays as RUBY connects with the stage. Her movements are balletic. She greets the room like a friendly cat, touching everything, brushing against corners. She takes her time before addressing the audience. She is in no rush. She is timeless...and yet….

RUBY

It's my anniversary today. (*beat*) Sometimes, it feels like a long time. They call me old Ruby, now, but what is "old" for…..ones...for...*beings* like me? There are others much older, I've heard of them. (*beat*) The people who love me most are having a party tonight. I don't know if it will make a difference, but it feels good. (*beat*) I wonder what will happen if they tear all this down. Or turn it into something else. Will I still be here? Will I change? Or will I just…. (*The thought is too strange, too uncomfortable for her to think about. She stands and begins moving about.*) I've been happy here. Many people have been. I think…. I think it is good, that I am here. I feel things, you know. Everything that happens here. And it all feels so good. (*beat*) Even the horrible things feel good. The saddest songs have their triumphant notes. Whatever

happens here, there's always that *other* energy, that actors' joy behind it. (*slyly*) Even the ones who say it's all *the method*. There's something noble in the effort of the actors and the suffering of their characters. Something that makes it hopeful. Tragedy is the most hopeful kind of play. Somebody else said that. I didn't make it up, but I know it's true…..

Of course, sometimes people are *really* sad here. I don't like that as much. All the people who get told "no." More women than men. I like the nerves, though, during auditions. They're so alive!

But sometimes I feel terrible things, and I *don't understand*. Something happens, sometimes, back there (*points backstage*) that doesn't up here. That we haven't ever shown up here. I see these women... hurting. And there's something that's the *same* about all of them, something, I don't know what. And I don't understand what they feel or *why*. I feel it, too, but I don't understand it. It doesn't make any sense, and that's what's so terrible about it. That's why I fear it. I….Until today, it was the only thing that scared me. (*she decides to tackle it.*)

The first time was when I was very, very young….

The projector reads 1895. Soft Victorian music plays as RUBY goes to the rack and pulls out a filmy white dress. She dances into it, becoming LAURA, a delicate beauty in her early twenties.

OPHELIA (*Hamlet*), as played by LAURA

LAURA

Please let me in. I… I know you must have heard some terrible things; I don't know what they said, but... I promise I won't tell anyone you let me in. I won't cause trouble. Please....I won't ask another favor of you again. I just need to get in....I just need to be in the theatre. It is important. Thank you.

OPHELIA

O, what a noble mind is here o'erthrown![1]

The courtier's, soldier's, scholar's, eye, tongue, sword,

Th'expectancy and rose of the fair state,

The glass of fashion and the mould of form,

Th'observ'd of all observers, quite, quite down!

And I, of ladies most deject and wretched,

That suck'd the honey of his music vows,

Now see that noble and most sovereign reason,

Like sweet bells jangled out of tune and harsh,

That unmatch'd form and feature of blown youth

Blasted with ecstasy. O woe is me,

T'have seen what I have seen, see what I see.

LAURA

You're right, I shouldn't have. Absolutely terrible. Not proper at all. But if I asked, you wouldn't have let me. Oh, do calm down! I haven't ruined you. They can't tell one weepy girl from another, God knows, and even if they could, why, you'd be a sensation! Real mad girl plays Ophelia!

That word bothers you, doesn't it? But why else would I be trapped in my brother's home, for weeks on end, with nothing to do? No work to support myself, not even a book – it would be too strenuous! He does it out of love, of course. He believes the stage is too strenuous, that it has shattered my nerves. Perhaps it has. Sometimes I *did* cry, and other times, well, you said I was

[1] All excerpts are from a public domain edition of *The Complete Works of William Shakespeare*, which is available on Project Gutenberg's website.

too ecstatic. You worried for my health. All I know is that since I left you, I've seen half a dozen doctors, and they'll all said the same thing. I'm in great danger, they say. I must never come back. No! Don't open that door. That's him. He's come for me, he'll take me home. I'll be lucky if that's where he takes me. I promise I'll go with him – I'll go quietly, like a good girl – and I'll stay away, forever. Or until I'm well again. But tonight, just tonight, please let me have this.
Yes, when I am well again....and tonight. Because....because it may be a long time. These cures...take time, that's what they say. So many new cures to try, it could take ...awhile....so let me have tonight. It will be....a fond memory, something to think of in the days to come. And you know how I love her. You always said I was the best. Different from the others. It's because I understand her – oh, the look on your face! Not her madness, just....her. Please. Please, let me go on. It's almost the final scene.

OPHELIA

There’s rosemary, that’s for remembrance; pray love, remember. And there is pansies, that’s for thoughts. There’s fennel for you, and columbines. There’s rue for you; and here’s some for me. We may call it herb of grace o’ Sundays. O you must wear your rue with a difference. There’s a daisy. I would give you some violets, but they wither’d all when my father died. They say he made a good end.

[*Sings.*]

He is gone, he is gone,

And we cast away moan.

God ha’ mercy on his soul

And of all Christian souls, I pray God. God b’ wi’ ye.

Once her monologue is over, Laura collapses into herself. Music begins to play. The projector reads: Women on the "rest cure" were forbidden to read or do other "strenuous" activities for more than fifteen minutes at a time. Sometimes they were forced to lie in one position all day. LAURA enacts this. On the projector: In the early 1900s, asylum inmates were given drugs to keep them quiet. At least a few deaths were due to carelessly administered doses. LAURA goes still. The white dress slips off her body, and she is RUBY again. RUBY gently, reverently lays the dress over one of the five chairs.

RUBY

She never came back.

20s jazz fills the room. RUBY slips into VIOLET's flapper getup. VIOLET is a sturdy, pretty woman in her mid-twenties.

CONSTANCE (*King John*), as played by VIOLET

CONSTANCE

Grief fills the room up of my absent child,

Lies in his bed, walks up and down with me,

Puts on his pretty looks, repeats his words,

Remembers me of all his gracious parts,

Stuffs out his vacant garments with his form;

Then have I reason to be fond of grief.

Fare you well; had you such a loss as I,

I could give better comfort than you do.

I will not keep this form upon my head,

When there is such disorder in my wit.

O Lord! my boy, my Arthur, my fair son!

My life, my joy, my food, my all the world!

My widow-comfort, and my sorrows' cure!

VIOLET

After her speech, Violet is smiling, putting on a convincing (if somewhat mechanical) show.

Thank you. Thank you so much. Excuse me, please....

As soon as she's alone, Violet collapses.

Damn! Damn, damn, damn!

She sinks to the floor, about to give in to tears. With effort, she pulls herself back.

It's this damn part....Talking to yourself, now, are you, girl? God, how am I going to do this for three more nights?

(*Looks at herself. Squares shoulders*) Your son is alive! Your husband adores you, and you're just goofy about him! What is wrong with you?

Oh! Dammit! Look, no! No, don't go get anyone. Just...stay a minute? Please, honey.

Yeah, I'm all right. I mean, I will be. It's just this damned role. I guess it's hard, since I have a kid and everything. I...I don't know, it just brings these....feelings up.

I guess I've always had them. Felt really weepy and tired sometimes. It got a little worse after the baby, but.....OK, it's been really bad. Constance....she doesn't help, I guess, but it didn't start with her. It just drives me nuts, though, because every night, there's this woman, and she has something real to grieve about, to lose her mind over....and I've got every reason to be happy, but sometimes I feel just like her.

What's wrong? What isn't....I just feel like crying all the time, like my best friend died or something, but nothing's wrong. Nothing except this thing inside me, and all I can think about is

how everyone dies and everything could go wrong. How I could lose everyone and everything. And then I hate myself, because I haven't lost anyone, I'm mourning *nothing*, I'm *wasting* all this time....And I sleep so much. He teases me about being lazy, says I need my beauty rest, and I'm almost mad at him, but....Of course he doesn't know! Promise you won't tell! That's the thing, he would try to help. I don't want to be a burden on him. He has enough to think about. Well, the war, for one thing. He doesn't talk about it, but I know he lost friends, and....and then there's his job, he's doing so well right now, the last thing I want is to hold him back....well, that's why I won't ask him.

Besides, what could he do? Sit at home and hold my hand while I blubber about nothing? It isn't always this bad. Usually it's just sort of in the background, waiting, but I can sorta hold it off. It just...pounces sometimes.

Now, you mustn't tell anyone, you hear? Don't you know what they do to people like – to people who can't control themselves? No, I won't go to a doctor. Next thing you know I'd be all doped up – or worse, packed off and locked up somewhere. No, they can't help me....but they might kill me trying!

What am I going to do? What I've always done. I just....I get by, OK?

Tomorrow, it will be better. It has to be. And if it's not, I...I'll smile, and make breakfast, and kiss him, and play with the baby and....and I'll just keep going. I'll lie down for a little if I need to. I'll be fine.

Because I have to be. Sometimes I want to....But no. I've got a son, and a husband, and it would be wrong to....nothing. It's never been this bad before. I think it'll get better. And if it doesn't....why, then I'll go to the doctor. Promise.

But I'll get better. You'll see. Anyway, we're starting a comedy next month, that'll help. And after this season I'm done – a proper wife, staying at home with the baby and the maid and all! Yes, well, only a few people know, but – see, it'll all turn out OK!

Violet smiles and nods her friend away.

Oh, God....please get me through this. I don't know what to do. Just make me well....Why did you give me all this, if I couldn't ever enjoy it?

She crumples to the floor. Music or a light shift cues the beginning of VIOLET's dance. She struggles to wake up, to get out of bed. Finally, she manages. The dance is a slow mime of day-to-day activities, all of which VIOLET struggles to get through. Family photos - a new baby, birthday parties, kids graduating high school, etc., flit across the projector. VIOLET, still exhausted, adjusts her routine to old age. Finally, she sits down on a chair. Her flapper getup slips off, and she is RUBY again.

RUBY

I guess she was OK. She died in her 90s...in her bed, asleep. That's what her great-granddaughters said. They came to visit here, they'd seen it in a photo album....They couldn't believe she'd ever been an actress. They said....they said she almost never smiled.

Obnoxiously cheerful 1950s music begins to play. RUBY reluctantly dons a dress and heels. She carefully places a glass of wine on one of the chairs. She is now PAM, an actress in her late twenties.

GONERIL (*King Lear*) as played by PAM

GONERIL

By day and night, he wrongs me; every hour

He flashes into one gross crime or other,

That sets us all at odds; I'll not endure it:

His knights grow riotous, and himself upbraids us

On every trifle. When he returns from hunting,

I will not speak with him; say I am sick.

If you come slack of former services,

You shall do well; the fault of it I'll answer.

Put on what weary negligence you please,

You and your fellows; I'd have it come to question:

If he distaste it, let him to our sister,

Whose mind and mine, I know, in that are one,

Not to be overruled. Idle old man,

That still would manage those authorities

That he hath given away! Now, by my life,

Old fools are babes again; and must be us'd

With checks as flatteries, when they are seen abus'd.

Remember what I have said.

PAM

Did you like it? Oh, I don't know. The last scenes are hard. (*sip*) You know, I don't really think she's a villain – no, honey, I don't! I think there's more to her than meets the eye, more than the director sees, anyway. I don't think it could've been easy, growing up the way she did – yes, I know, I know you think I take these things too seriously, but honey, this is my job!

Yes, I know. And I can't wait. But till then....just let me enjoy these last months, OK? Then I'm all yours. Yes, I *can* cook! Promise. (*big sip*)

Hey, honey, there's something I need to talk to you about. I got a letter today....from my dad. I know, I told you he was dead, I *thought* he was, but....well, he isn't. I thought I'd talk to you about it, since we're going to be married and (*sip*) – Well, he wants to come live with us! Now don't get upset! Of course I'm telling him no! I just....I wanted you to know about it, in case he shows up on our doorstep or something. (*brave smile. sip.*)

Oh, I expect he'll find someplace else to stay. He always did. We haven't spoken in years. He wasn't.... (*sip*) He wasn't home very much when I was small. I barely remember him. Well, I guess he provided for us...sometimes....why are you asking? (*sip*) Oh, come now, I'm not turning him out on the street! (*sip*) Like I said, he'll be fine. He always is. If he's still alive after all these years -

Of course I care! (*sip*) I just....caring for some people is hard, you know, and you've got to live your own life, and he's a grown man. He can care for himself, believe me.

WHAT? (*Recover. Pour.*) That's really sweet of you to offer, but I promise, he doesn't need to come live with us! No, no, I don't think mother will take him in, please don't tell her I said – because they weren't happy, OK? I don't want to talk about it! Just let me -

HE WAS A DRUNK. He. Was. A. Drunk. He *hit* me. He *left us* for weeks. Mom was the one who held everything together, Mom – I know he's my father! That doesn't mean I have to like him. That doesn't mean I have to clean up his messes. Please, don't let this ruin things between us. We're going to be so happy, and....

A long time. Longer than ten years. Not since I was.....not since I left home. (*sip*) He hasn't contacted me since then. Now he's only writing because he needs a place to stay, and -

Of course I believe in helping people! (*gulp*) But you don't know him, he'll just....yes, I know it's been a long time, but....No.

Look, please, let's talk about anything else. (*sip*) Did you really like the show tonight? I just love Shakespeare! Ever since I read *Romeo and Juliet* in high school, I just....You know I really love this, don't you? Maybe one of our kids will be an actor one day! The greatest actor, a real star! Don't you think? Honey? (*sip*)

You're angry at me, aren't you? (*sip*) What do you know? Your mom and dad are great, I bet they never.... (*sip*) Nothing, they're just really nice, that's all. I love them. I love you.

You can help me by forgetting this. You can help me by – meet him? I don't think we ought to. You...you're good, you don't know what people can be like, and he's so tricky.....Promise? OK, lunch. OK. Yes, we'll see.

Just a few more months, and all of this will be behind us!

Images of the "perfect" 1950s home life flit across the screen. PAM mimics the perfect housewife. Cooking, cleaning, tending the men of the family. She drinks the whole time. Suddenly, she clutches her abdomen and sinks to the ground. The dress slips off, and she is RUBY again. RUBY stands, begins to fold the dress as she did LAURA's, and realizes she is still wearing the heels. Grimacing, she folds the dress and lays it on a chair. Then she takes the shoes off - very carefully, as if they were made of glass - and hurls them off stage.

RUBY

She was *fine* here. (*beat*) People didn't stay as often, after that. They came and they went. The 60s were pretty crazy - lots of new shows! It was fun, but scary. There was a lot of hurting then, too. Now people just pass through. They do a couple of rehearsals, a few weeks' run, and then they're gone! I don't get to know them so well. There is one lady I remember….

Modern music begins to play. It is badass and dark. Enjoying herself, RUBY slips on a cape and crown. ANNE is a feisty Southern lady in her early 40s. Her accent is absent onstage. The projection reads 2010.

LADY MACBETH (*Macbeth*), as played by ANNE

LADY MACBETH

Yet here's a spot. Out, damned spot! out, I say! One; two. Why, then 'tis time to do't. Hell is murky! Fie, my lord, fie! a soldier, and afeard? What need we fear who knows it, when none can call our power to account? Yet who would have thought the old man to have had so much blood in him? The Thane of Fife had a wife. Where is she now?—What, will these hands ne'er be clean? No more o' that, my lord, no more o' that: you mar all with this starting. Here's the smell of the blood still: all the perfumes of Arabia will not sweeten this little hand. Oh, oh, oh! Wash your hands, put on your nightgown; look not so pale. I tell you yet again, Banquo's buried; he cannot come out on's grave. To bed, to bed. There's knocking at the gate. Come, come, come, come, give me your hand. What's done cannot be undone. To bed, to bed, to bed.

ANNE

All right, so, I don't usually do this, but seeing as how you're a student ... (*laughs*) you didn't expect the accent, did you? Don't worry, I'm not gonna give you a hard time about it. Now, twenty years ago I would've given you the lecture, do you think all Southerners are stupid and unsophisticated, etc. I used to be very defensive. Can you blame me?

So, what do you want to know? I guess I should start with my biography, how I got into acting, and so on. You'd like that, right? Well, first I want to set something straight.

If you did your homework, you know I came out two years ago. No, not that kind of came out – I like men, thanks, though I know plenty of nice women who're lesbians, nothing wrong with that.

No, I came out with a secret. Hadn't really thought of it as a secret before; it was just something I didn't want anybody to know. *Secret* implies you're actively hiding something, and by the time I got around to telling everyone, I was so used to hiding it didn't even feel like hiding anymore.

Oh, sweetie, you look so confused! I'll just say it, then. I am mentally ill. I have a mental illness. O.C.D., to be precise. Obsessive. Compulsive. Disorder.

I'm not ashamed. I used to be, before I knew what was wrong with me. It's awfully....unsettling, having thoughts you can't control. They talk about "evil thoughts" in the Bible, you know, and some people think the thought is as bad as the deed. I disagree, obviously. We can't control our thoughts – I guess everyone has those moments, where you think about jumping off a cliff or driving your car off the road. It just doesn't happen often for most people; for me it's every day. It was scary as hell, before I knew what it was. Now that I know, I'm doing better....Knowing helps. That, and a damn good therapist. And a little Prozac.

But like I said, knowing helps. You can't get any other kind of help if you don't know. If you think there's something wrong with *you*, as a person, and not with your brain chemistry or whatever it is. Two years ago, I'd gotten to a really good place. So I thought I might help some other people by coming out with my story. It isn't easy being an actress, God knows, and dealing with this (*taps head*) makes it a hundred times worse. But I did it. (*laughs*) I guess I was just too stubborn to quit. Never thought I'd get this far, but I did, and if I did, so can other folks with brains like mine.

So I gave this interview, and do you know what people said? Not "wasn't she brave!" Not "gee, I guess my kid might have that OCD thing – maybe I should get help!" Not even "she's crazy," which I was prepared for AND expecting. Nope, they wrote "award-winning actress inspired by illness."

INSPIRED??? That's what I want to address with you tonight. There is nothing inspiring about praying twenty times a day. There is nothing inspiring about foul language going off in your head. And there is nothing, believe me, nothing inspiring about thinking someone has died *every time the phone rings*. But THAT is what this thing does to your brain. It's like you've been hijacked. And it feels crazy, it *is* crazy, but *you're* not. You KNOW it's bull, but that doesn't stop your heart from pounding. That doesn't stop the panic attacks. That doesn't stop you from wondering, will I get out of bed today? Will I be able to pay attention? Or is this the day....is this the day I actually cuss out my boss, like I've been afraid of doing for years? Is this the day that this thing costs me a friendship, or my job? Is this the day someone finds out.....that I'm not healthy, like everyone else pretends to be?

If I could go have this thing taken out, without any side effects, I would. But I can't, so I live with it as best I can, which has been pretty damn good. But now people say it inspires me. They act as though...as though I *owe* this thing, this monster inside my head, for everything I've done! Everything I've done in spite of it! You know, I had someone – not a director, thank God, just some obnoxious stranger – ask if my meds interfered with my work! Now that's just stupid and dangerous! I can't do anything when I feel like crap – why would I.....

I'm not angry at you, sweetie. I just get fired up. And oh, by the way, I'm *not* going to drive my car off the road or call you something nasty. Those are just thoughts. They distract me, and they make my life hell sometimes, but they aren't mine. They're just....They're not things I believe or want. OK?

There is one more thing I want to say. The worst thing they said was that it inspired her. And that just made me madder than anything. “Out, damn spot” indeed! Yes, I have been a hand washer, but no, that's not why I'm so good. It's....Well, I *get* her, as you say. She's....she's not obsessive

compulsive, that's for sure. And she's not a bitch – well, she's not *just* a bitch. She's guilty as hell, and I guess anyone would go crazy, cooped up in a castle, waiting for it all to catch up with you. You know, the play is very different from what actually happened. In the play she stays home like a good Englishwoman, but really they rode out with their men to battle. I think that's what drives her crazy – not the guilt itself, but knowing you reap what you sow, and she's stuck in that castle and can't even fight for whatever reason. You see, that's what I think about when I'm on stage. I don't think about myself, or *this*. *This* goes away when I'm out there. I'm just her.

OK, well, I hope you print some of that, though it's your choice, of course. I respect journalists, even if one or two of you have screwed me over. And by that I mean misrepresented, not slept with. Aren't you sweet? Well, you can never be too careful.

Now, what else did you want to ask me?

Oh, and one more thing. Lady Macbeth didn't commit suicide. She was murdered.

ANNE lets that hit. Music begins to play. The interview is over. ANNE begins to take off her garb, but tonight is a bad one. As she goes through her post-show routine, she does some things twice, three, four times. She gets frustrated. At one point maybe kicks the ground. She is able, with effort, to finish. She looks around her dressing room. Smiles, tired but proud of herself, a survivor. She takes off her black cape or dress. RUBY hangs up the garment.

RUBY

I liked her.

Modern music begins to play. RUBY struggles to put on nice, business like clothes - the kind a student would wear to impress their professor for a presentation. Or that an actor would wear for an audition. The projection reads 2019.

JULIET (*Romeo and Juliet*), as played by AMY

AMY

Hi, my name is Amy Smith, and....uh....I'm sorry, can I....may I please go again? Thank you. Thank you so much! Hi....OK, sorry, yes, breathe before the slate, got it, haha, thanks....Hi, my name is Amy Smith, and today I'll be portraying Juliet from *Romeo and Juliet* (*beat*) by William Shakespeare.

Amy very self-consciously takes a breath. Lets it out too soon. Takes another breath. At the top her acting is forced. She desperately tries to remember everything she learned in class. As the words and story take hold, she becomes more confident. The fear and playing of emotion turn to good, solid tactics. It may not be Tony-worthy, but there's something real and good behind it.

JULIET

Farewell. God knows when we shall meet again.

I have a faint cold fear thrills through my veins

That almost freezes up the heat of life.

I'll call them back again to comfort me.

Nurse!—What should she do here?

My dismal scene I needs must act alone.

Come, vial.

What if this mixture do not work at all?

How if, when I am laid into the tomb,

I wake before the time that Romeo

Come to redeem me? There's a fearful point!

Shall I not then be stifled in the vault,

To whose foul mouth no healthsome air breathes in,

And there die strangled ere my Romeo comes?

Or, if I live, is it not very like,

The horrible conceit of death and night,

Together with the terror of the place,

As in a vault, an ancient receptacle,

Where for this many hundred years the bones

Of all my buried ancestors are pack'd,

Where bloody Tybalt, yet but green in earth,

Lies festering in his shroud; where, as they say,

At some hours in the night spirits resort—

Alack, alack, is it not like that I,

So early waking, what with loathsome smells,

And shrieks like mandrakes torn out of the earth,

That living mortals, hearing them, run mad.

O look, methinks I see my cousin's ghost

Seeking out Romeo that did spit his body

Upon a rapier's point. Stay, Tybalt, stay!

Romeo, Romeo, Romeo, here's drink! I drink to thee.

AMY

Thank you.

OK, so, one down, one to go, haha. (*beat*) Right. For this assignment, as you all know, we were supposed to pick a character who we think is relevant to today. And I know what you must be thinking: what could possibly be relevant about stupid Juliet? I know it's everyone's least favorite

play. Everyone likes to talk about how stupid it is, at least that's what it seems like. But Romeo and Juliet does have a lot to teach us. Not about love, um, I think we can all agree that works out pretty badly, um, but about tragedy. People talk about how they're a couple of stupid, romantic teenagers, but what people seem to forget is....they die in the end. A couple of teenagers die, and how can that be stupid or silly or sappy or any of the things people say it is?

Teenagers still die for reasons that people think are stupid. Things like being bullied too much – people say, get a thicker skin. Or a bad grade – it wasn't that big a deal, their teacher says, even though we're told from birth that our grades are our future. And suicide is a BIG problem. It's the second leading cause of death for people our age! And, whatever anyone thinks of the reasons, teenagers dying from suicide – anyone dying in any way – is a tragedy, and I think we should respect this play. (*Beat. She has totally lost her audience. She decides to go off.*)

You know....maybe they're not so stupid, anyway. Imagine what it would be like, growing up hating the people next door. Or in the next palace or whatever. Knowing that they hate you. Seeing these people and their servants in the street all the time and knowing they hate you, would hurt you if they could. Wondering which of your family they're going to kill next, or which of them is going to be killed. Wondering if your dad or cousin or best friend will go to jail or be executed for fighting one of them. Imagine growing up like that. And not being able to do a damn thing, just everyone expects you to sit around and, I don't know, embroider, and then get married and have babies. And all you hope is that your husband lives far away so your sons don't grow up and kill people or be killed. (*beat*) And then you meet one of them, and he's nice, and it's just that instant connection, don't tell me none of you have felt it, that chemistry...he's not a monster, and he doesn't think you're a monster. You've met the only other person who's willing to forget about names and just be a human being. And maybe you can show your families a

better way, or maybe you'll just run away and never see any of their stupid faces again, but either way, there's a chance to be happy, to be free, to make your own choices for the first time.…And then it all goes to hell. It just keeps getting worse and worse, but you still hope...and then you wake up, still groggy from whatever crap the priest gave you, and it's your worst nightmare. The person you were going to spend your whole life with is lying there, dead, and you blame yourself, of course you do, even though it isn't your fault.

And then what can she do? Go to a nunnery after everything she's done, everything she's seen? Grow old and miserable, forgetting who she was? Wait for her family to come and kill her or marry her off or something equally horrible? Maybe it wasn't just Romeo. Maybe it was because, back then, she didn't have a choice. Dying was better than what would happen to her without a man who cared, who respected her.

Well, that's what I think. That's why people do it, isn't it – because they feel there's no other way. Because they feel hopeless. And even though there are choices – now – if you can't see that, well.... (*She is starting to get them back. But not completely.*)

I can see you texting! Will you just listen? This is important, I - *I've been there*. When I was fourteen, just like her. Oh, God, I didn't mean to say that. I....OK, this is happening. When I was fourteen, I took drugs. Nothing illegal, just the medicine my doctor told me would make me better. But it didn't. It made everything ten times worse. I felt....I felt the world shatter around me. Everything was going to go wrong. Everyone I loved was going to die now. Every person on the street wanted to kill me. Everything that could go wrong, everything that could hurt me, would. My skin hurt. *(beat*) It didn't work. And I scared myself just enough to go back to the doctor....The first time I told him I was scared, I thought something was wrong with me, he laughed. The second time, he gave me those meds....Now....he promised to keep it a secret. Of

course he couldn't, it was against the law, I guess, and anyway.....but he promised, and as soon as my parents came back in the room, he turned his back on me and told them: “Amy tried to kill herself.” I wanted to kill *him*. Their faces....Later, it turned out that this doctor – who, by the way, delivered me – it turned out he'd made a mistake. Wrong diagnosis. The “harmless” drug could, in fact, worsen anxiety – which is what I had. Have.

I'm OK now. (*Can't believe what she's done. Decides to go for broke.*) So all I'm saying is, it may seem stupid....when I first said, “I think I'm going crazy,” the doctor just laughed at me, told me I had ADHD 'if anything' – but what does that matter? What do the reasons matter, if someone dies? I was lucky, and I'm OK now – please, let me have one more minute – but all I'm saying is, we dismiss a lot of people, especially teenagers, because we think it's not a big deal. We think, they'll get over it. But sometimes they don't, and sometimes there's a lot more going on then we realize, then we ever ask about.....Well, obviously, that got a lot more personal than I meant for it to, but....I, for one, really respect Juliet, and I think we can do a lot better than portraying her as weak or stupid. That monologue I just did? She’s actually pretty badass. (*beat*) Anyway….She deserves better. (*beat*) We all do.

Thank you.

Amy scuttles away from USC. Lets out a massive sigh of relief as she takes off her “fancy” clothes. Sits for a moment to collect herself. Finishes undressing and is RUBY again.

RUBY

I think she’ll be OK. (*beat*) They’re talking now. That seems to help. (*beat*) I wish *I* could talk to somebody.

Oh, I want a hundred more years of this! (*looks around*) I want to see things get better. I want to see *them* get better. And I want to see what they do. These women who are hurting but have so much to offer...I want to be here for them. So they can keep talking. Here.

They were here. They spoke, and people heard them. Maybe some people even listened. And they laughed, and cried…. Here! With me! We were here. (***beat***) We existed. (***beat***) We were heard.

Lights begin to dim. A headline on the projector: Ruby Theatre shut down. A blank screen. Then: Ruby Theatre purchased by "Neurodiverse" troupe, set to reopen….

END OF PLAY