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Sarah Kane's World of Depression: The Emergence and Experience of Mental Illness in *4.48 Psychosis*

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_Abstract

Fictional narratives of mental illnesses often focus on individual experiences of pain, anxiety and suffering. As such, narratives depict the experiences of illness in a holistic way, revealing the embodied, situated and intersubjective — in other words, *emergent* — nature of psychiatric disorders. They are thus able to create a different kind of understanding of mental disorders than medicalizing strands of psychiatry that tend to reduce mental illnesses to biological dysfunctions of the brain and the nervous system and thus ignore how disorders straddle the brain, the body and the environment.

In this article, I discuss how the experiential world of depression is constructed and conceived of in Sarah Kane's play *4.48 Psychosis*. Kane's depiction of severe, psychotic depression is in line with phenomenological accounts of the illness, in which depression is understood as an emergent phenomenon that gives rise to alterations in the embodied being-in-the-world of the subject. The text refers to common cognitive-affective experiences and folk-psychological understandings of the mind and employs different intertextual, narrative and poetic strategies to convey the phenomenal world of depression to its readers. In addition, Kane emphasizes that to treat depression a deeper understanding of this 'state of emergency' is needed than what medicalizing psychiatry is able to provide.

1_Introduction: "At 4.48 when depression visits"

> After 4.48 I shall not speak again
>
> I have reached the end of this dreary and repugnant tale of a sense interned in an alien carcass and lumpen by the malignant spirit of the moral majority
>
> I have been dead for a long time[1]

British playwright Sarah Kane (1971–1999) described her last works of fiction as "texts for performance."[2] In them, she moved towards a form of expression in which the materiality of the text, language and (inter)textuality had more and more significance over events and plot. This development reaches its peak in her last play, *4.48 Psychosis*,[3] which focuses on the experiences of a person who suffers from psychotic depression.[4] The narrating I constructed in the play cites feelings of overwhelming sadness, social and corporeal alienation and loss of affectivity that ultimately lead to a feeling of being dead, and these experiences drive the narrator towards suicide. The play can even be understood as a suicide note addressed to its audiences — or, as Kane's agent Mel Kenyon put it, "I pretend that [*4.48 Psychosis*] isn't a suicide note but it is. It is both a suicide note and something much greater than that."[5] Through her ambiguous text,

Kane produces a situation of outmost *emergency* — one that taps into the experiences of the play's readers and spectators.

The play is divided into fragments of monologues and dialogues, which can be understood as twenty four short scenes. Kane, however, breaks the conventions of a playtext by offering no stage directions.[6] The fragments are composed in a poetic narrative form[7] that draws its signifying power from, for example, typographical experimentation, alliteration and rhyme, gaps and silences, and literary allusions and intertexts — or "literary kleptomania,"[8] as the narrating voice suggests. The places, events and characters of the play are left open to interpretation, and readers and spectators are invited to fill the gaps.[9] As Alyson Campbell has noted, Kane's play creates a demand for the audience "to set active meaning-making aside; to allow the a-signifying power of the work to take over."[10] The play thus evokes experiences of a shattering mind by engaging the emotions and experiences of its audience, as well as their understanding of the human mind.[11]

4.48 is often discussed in relation to Kane's own experiences of severe depression, her eventual suicide a few months after finishing the play and the political ramifications of the text. Critics pay attention to the ways audience members are situated as witnesses of mental illness and failing mental healthcare. They discuss how the play challenges psychiatric knowledge by imitating medical discourses and by revealing problems in therapeutic relationships.[12] Meanwhile, less attention has been paid to the literary devices and narrative techniques through which the experiential world of mental breakdown is enacted and which highlight the *emergent* nature of mental disorders.

My essay brings together the two concepts, *emergency* and *emergence*. Emergency, evoked by severe mental illness, can be seen as the dominating theme or mood of Kane's playtext. Emergence, on the other hand, refers to a process whereby a complex system arises through interactions among smaller systems and yet is different from them. I use the concept especially to illuminate the play's account of mental disorders as phenomena that are connected but not reducible to neurochemistry and physical structures of the brain.

In what follows, I will look at Kane's play from the perspective of a reader who engages with the heterogeneous, collage-like storyworld and the shattering mind it depicts.[13] I will show how, in Kane's play, the human mind and mental disorders are understood and presented as emergent phenomena that are enacted through an interplay

between the mind and its social and material environments. This view goes against medicalizing psychiatric accounts in which mental illnesses are often reduced to problems of the brain and the nervous system. Rather, as phenomenological studies of illness have emphasized, and Kane's text illustrates, mental disorders should be perceived in the broader context of the human mind which is embodied and situated in the world. In other words, mental illness should be seen as an emergent phenomenon that straddles brain, body and world.[14]

In Kane's play, as well as in phenomenological accounts of psychopathology, the entire experiential world of the subject is seen as being altered by depression. In addition, both stress that to understand the emergent nature of mental disorders, one needs to explore the experiences of illness. I will begin by looking at the structure of the play and the ways the diagnosis of depression is constructed in it. Then, I move to Kane's representation of psychiatric reductionism and discuss the therapeutic relationship depicted in the play. After this, I will show how Kane challenges the reductionist view by evoking the emergent, situated and intersubjective experiences of depression. Finally, I will take a closer look at the textual and narrative devices through which all of this is enacted, and I will consider the consequences the play has for understanding mental disorders.

2_The Depressed Mind and the State of Emergency

Readers of *4.48* are guided by a cyclical narrative structure that gradually discloses information about the situation of the play's protagonist. The text is composed of a variety of different elements: First of all, there are fragments of dialogues, which seem to be either flashbacks of past patient-psychiatrist conversations or inner dialogues/hallucinations of the narrator. Secondly, these dialogic segments are surrounded by fragments of inner monologues and stream-of-consciousness, which seem to form the present time of the story. At times, however, the division between the dialogues and monologues is blurred, and it becomes uncertain whether one can separate the narrating I of the monologues from the patient and therapist figures of the dialogues.[15] In addition, as many interpreters have noted, Kane embeds citations from diagnostic manuals, self-help books and literary texts within the first-person narration.[16]

Despite the complexity of this work, it is very tempting to read the entire text as a product of one suffering mind. For example, Ken Urban has noted that multiplicity

"creates the uncanny sensation that the text is deeply monologic, the product of a singular, though divided, self."[17] Both its open form and strong evocation of affects and emotions make the text relatable and comprehensible, and many critics have pointed out that anyone who has experienced desire, love or pain is able to identify with the suffering of the play's protagonist.[18]

On the other hand, the destructive and pathological sides of these experiences also indicate that the text is a product of a mind that transgresses the borders of what is usually considered to be 'normal.' Kane herself said, while writing the play, that she tried to create a narrative form that would express the experience of a psychotic breakdown — the collapse of boundaries between self and other, and between self and the world:

> [The play is] about a psychotic breakdown and what happens to a person's mind when the barriers which distinguish between reality and different forms of imagination completely disappear, so that you no longer know the difference between your waking life and your dream life. And also you no longer know where you stop, and the world starts.[19]

In a way, the emergency of the mental breakdown is simulated for the reader, as the uncertainty of the events depicted becomes clearer and clearer. The form imitates the experience in which, as Kane says, "you no longer know where you stop, and the world starts" or in which the distinction between the self and the other disappears.[20] Kane uses literary devices like the blurring of speaking positions and narrative modes, shifts in the moods and tones of the text, as well as intertexts, allusions and references to medical discourses in order to reveal the instability of the boundaries between the self and the world. Psychotic depression is ultimately depicted both as a clinical condition and as a state that questions the relationship between self, body and their rootedness in the world. The text thus opens readers' eyes to the human fact of emergent situatedness in the world — a fact that we tend to ignore when not faced with states of emergency such as mental breakdown.

The worldly and intersubjective nature of depression is already indicated in the first scene. The play begins with a lopsided, almost haunting dialogue in which an unknown voice is questioning a silent other:

> (*A very long silence.*)
>
> But you have friends.
>
> (*A long silence.*)

> You have a lot of friends.
>
> What do you offer your friends to make them so supportive?
>
> (*A long silence.*)
>
> What do you offer your friends to make them so supportive?
>
> (*A long silence.*)
>
> What do you offer?
>
> (*Silence.*)[21]

This first scene frames the play with a painful experience of having failed in social relationships — or, more precisely, with a veiled (self-)accusation of not being able to offer anything to other people. The questioning voice could be understood as a hallucination of the protagonist, but later on the dialogue is repeated and it is hinted that it is a fragment of an actual patient-therapist conversation, recollected by the narrating I. In the monologues that follow, the meaning of the play's title is revealed: the I talks about a clarity that comes at night ("at 4.48"), hints ambiguously at suicide ("After 4.48 I shall not speak again")[22] and evokes a painful, unbearable loss that has happened in the past:

> Sometimes I turn around and catch the smell of you and I cannot go on I cannot fucking go on without expressing this terrible so fucking awful physical aching fucking longing I have for you. And I cannot believe that I can feel this for you and you feel nothing. Do you feel nothing?[23]

What is remarkable both in the 'silent dialogue' and in the monologues that depict longing and pain is that the protagonist's experiences are tightly connected to other people and to intersubjective emotions like love, longing and shame. The protagonist is introduced to readers through the suffering that characterizes her/his relationships to other people and her/his being-in-the-world. S/he does not appear as someone who is 'ill'; s/he seems rather to be heart-broken, alienated from others, and grieving.

On the other hand, different medical diagnoses are offered throughout the play. The protagonist suffers from "depression", as stated in the monologues, and "pathological grief", like one of the medical notes suggests.[24] "Psychosis" is cited in the title of the play, and the narrating I uses common metaphors of a psychotic breakdown, for example when s/he talks about her/his experiences of fragmentation: "And my mind is the subject of these / bewildered fragments;"[25] "my body decompensates / my body flies apart."[26] In psychiatric terminology, the narrative describes a major depressive disorder

that closes in on psychosis.[27] After the dialogical segments and fragmentary monologues of the first scenes, the I offers an almost hyperbolic list of symptoms that seems to authenticate the depression diagnosis:

> I am sad
> I feel that the future is hopeless and things cannot improve
> I am bored and dissatisfied with everything
> I am a complete failure as a person
> I am guilty, I am being punished
> I would like to kill myself
> I used to be able to cry but now I am beyond tears
> I have lost interest in other people
> I can't make decisions
> I can't eat
> I can't sleep
> I can't think
> I cannot overcome my loneliness, my fear, my disgust
> I am fat
> I cannot write
> I cannot love
> […]
> I cannot fuck
> I cannot be alone
> I cannot be with others
> My hips are too big
> I dislike my genitals
>
> At 4.48
> when depression visits
> I shall hang myself
> to the sound of my lover's breathing
>
> I do not want to die
>
> I have become so depressed by the fact of my mortality that I have decided to commit suicide
>
> I do not want to live[28]

The I names emotions and experiences which are commonly emphasized in diagnostic manuals: there is the depressed mood ("I am sad"), loss of pleasure ("I am dissatisfied", "I cannot love"), and the experiences of guilt and shame ("I am a complete failure," "I am guilty") as well as the thoughts of death ("I have decided to commit suicide," "I do not want to live").

When read or heard on stage, the detailed list creates an impression of deep subjective experiences. However, as readers and audiences with psychiatric knowledge might

notice, the list is actually an almost word-for-word quotation from a common diagnostic tool, Beck's Depression Inventory (BDI), used by clinicians in assessing the severity of depression. In BDI, the patient chooses experiences that are closest to her/his own from a multiple-choice list.[29] The narrating I, in other words, borrows expressions from medical discourse to convey her/his experiences. Later on, a description of the dominating experience is given in a repetitive fragment of stream-of-consciousness: "No hope No hope No hope No hope No hope No hope No hope."[30] Both in the 'borrowed' list of experiences and in the repetition that mimics the looping, depressed thoughts, the text evokes the most common experiences of deep, suicidal depression: sadness, loss of hope and loss of will to live — which all emphasize the emergency of the situation.

Clinicians and phenomenologists of illness widely agree that depression is an affective and cognitive disorder that influences one's moods and emotions as well as perception and memory. It distorts both past and present experiences and diminishes the ability to verbalize them. The future seems hopeless and life unlivable, as negative experiences take control. The risk of suicide is high.[31] What researchers and medical professionals disagree over, however, is the cause and treatment of the illness. The most common cure for depression in Western societies today is medical: antidepressants should alleviate the loops of hopeless thoughts and additional therapy should help individuals find new thought paths and alter the self-image that is centered on experiences of failure and hopelessness.[32] Drugs and therapeutic talk are also what the psychiatrist figure in Kane's play offers — though unsuccessfully, as the silent dialogue seems to indicate. Through the patient-psychiatrist encounters — whether they are imagined, hallucinated or 'actual' —, Kane offers an insightful critique of reductionist psychiatry in its failure to pay attention to the emergent, intersubjective and embodied nature of depression. In the following, I will take a look at this critique, before turning more closely to the experiences of depression and their meaning.

3_The Psychiatric Voice of Reason

> -I don't despise you. It's not your fault. You're ill.
> -I don't think so.[33]

In Kane's representation, the psychiatrist-figure sees the protagonist's depression as an illness that has its origins in the functioning of her/his brain.[34] Even though the borders

between the psychiatrist and the patient are ultimately blurred, Kane takes time to depict how this reductionist view disregards the experiences of mental distress and reduces them to a mechanical, biochemical flaw. She uses three particular narrative strategies to illustrate the problems of medicalizing psychiatry: (therapeutic) dialogues; the use of what I will call 'drug-induced narration;' and the use of medical notes as means of narration.

With regard to the dialogues between the therapist and the patient figures, the therapist's main methods of treatment seem to be to either to offer drugs or to try to 'reason' with the patient in order to prove s/he is mistaken in her/his experiences and ways of thinking:

> -Have you made any plans?
> -Take an overdose, slash my wrists, then hang myself.
> -All those things together?
> -It couldn't possibly be misconstrued as a cry for help.
> (*silence*)
> -It wouldn't work.
> -Of course it would
> -It wouldn't work. You'd start to feel sleepy from overdose and wouldn't have the energy to cut your wrists.[35]

The therapist's strategy is to try to point out the flaws in the patient's plan instead of finding out *why* the patient feels like s/he does. While the therapist's pragmatic attitude to suicide can be considered humoristic, it also seems to lack empathy, as the discussion continues with a disagreement about the way the patient expresses her/his feelings:

> - […] I feel like I'm eighty years old. I'm tired of life and my mind wants to die.
> -That's a metaphor, not reality.
> -It's a simile.
> -That's not reality.
> -It's not a metaphor, it's a simile, but even if it were, the defining feature of a metaphor is that it's real.[36]

The dialogues show that the therapist and the patient are engaging in completely different discourses: one is a discourse of rationality in which the world is 'objective' and in which the use of tropes, metaphors or similes seems to be a form of delusion; the other is the patient's discourse in which s/he uses tropes to convey the complexity of her/his experiences. The dialogue quoted above also reveals that the patient is actually quite rational: s/he is able to discuss in abstract terms and make high-level cognitive distinctions. The problem is, rather, that s/he feels so tired that s/he cannot live ("I'm tired of life and my mind wants to die"). The experience is corporeal, and the expression

of feeling "eighty years old" offers a way to articulate this. Similarly, in a later scene, the therapist notices cuts in the patient's arm, demanding to look at them and reprimanding the patient for hurting her/himself. Again, the therapist fails to understand, as s/he is convinced that the patient has cut her/himself to "relieve tension." This clinical opinion, however, has nothing to do with the patient's experience — a fact that becomes clear in her/his reply: "Why don't you ask me *why*? *Why* did I cut my arm?"[37]

The main source of conflict, portrayed in these scenes, seems to be the therapist's lack of understanding: the inability to view the patient's experiences of distress as something that is not only caused by a malfunctioning brain or lack of reason but closely connected to her/his embodied being and relationships with others. The therapist continues to explain that "You are ill," and the patient keeps on refusing: "I am not ill. I am depressed. Depression is anger."[38] This conflict also reveals the gap between the actual experiences of the patient and pathologizing labels like "mentally ill" or "depressed." The patient is suffering, tired and wants to die. S/he understands that s/he is depressed and needs help, but at the same time psychiatric diagnosis and descriptions miss her/his experiences and their meanings.

In addition to the dialogues, Kane uses drug treatment and medical notes to emphasize the problems inherent in psychiatric care. The patient is afraid that drugs might affect her/his thinking and (literary) work, but ultimately agrees to try them. Soon after, the text loses its temporal structure, turning into fragments:[39]

> abstraction to the point of
>
> unpleasant
> unacceptable
> uninspiring
> impenetrable
>
> irrelevant
> irreverent
> irreligious
> unrepentant […][40]

The words follow each other by the logic of alliteration and negation (ab-, un-, un-, ir- , ir-, un-…), as if untethered from a conscious mind. The list is typographically arranged in sections, and the spaces in between create an impression of expressive difficulty, or of a great effort that is needed in forming thoughts:

> drowning in a sea of logic
> this monstrous state of palsy

> still ill[41]

In these 'drug-induced' segments of narration, the narrating I disappears altogether and, finally, psychiatric discourse takes total control in the form of medical notes: "Symptoms: Not eating, not sleeping, not speaking, no sex drive, in despair, wants to die."[42] As the list of impersonal notes continues, the readers are faced with heterogeneity of different kinds of new symptoms, like weight loss and rashes:

> Setraline, 50 mg. Insomnia worsened, severe anxiety, anorexia, (weight loss 17 kgs,) increase in suicidal thoughts, plans and intention. Discontinued following hospitalization. […]
>
> Zopiclone, 5.5mh. Slept. Discontinued following rash.[43]

In addition to the original symptoms, numerous side effects arise from the testing of different drugs, ranging from physical changes to severe disorientation and suicidal plans. A voice, which imitates but at the same time breaks the discourse, emerges to comment on this:

> Lofepramine and Citalopram discontinued after patient got pissed off with side [e]ffects and lack of obvious improvement. […]
>
> Mood: Fucking angry
> Affect: Very angry.[44]

For a few moments, expressions that appear to belong to the patient ("pissed off", "fucking angry") control the discourse, until the notes turn again into neutral, medicalizing description: "Thorazine, 100mg. Slept. Calmer."[45] The notes and changes in register thematize the way all experiences — whether they are caused by drugs or whether they are just normal emotional reactions to unpleasant situations — become viewed as pathological symptoms. The list finally ends with a passage that reveals the arbitrariness of medical treatment — and covers a suicide attempt with a witty parody of drug talk:

> 100 aspirin and one bottle of Bulgarian Cabernet Sauvignon, 1986. Patient woke up in a pool of vomit and said 'Sleep with a dog and rise full of fleas.' Severe stomach pain. No other reaction.[46]

The clashes between the psychiatrist (and psychiatric discourse at large) and the patient advocate understanding the experiences of illness and viewing them in context. The

patient makes this explicit: "Don't switch off my mind by attempting to straighten me out. Listen and understand […]."[47]

Kane's text reveals how, in the medicalizing, reductionist view, the human mind and human experiences become easily reduced to merely treatable, mechanical objects. Drugs not only treat symptoms but also change the patient's sense of self. The problem, then, is that the embodied and situated experiences, interpersonal relationships and the subject's embeddedness in the world — and thus the emergent nature of illness — are ignored. In addition, in some cases drug treatment makes the situation even worse by causing side-effects that are just as crippling as the disease — which is precisely what the patient fears at the beginning of the play, and what ultimately happens.[48] As the therapeutic encounters, the drug cocktails and medical notes attest, sometimes treatment fails, or even creates new problems. It seems that as long as the experiences of depression and their emergent nature are not understood, it is impossible to find a cure — medical or other.

4_The Emergent World of Depression

> a consolidated consciousness resides in a darkened banqueting hall near the ceiling of a mind whose floor shifts as ten thousand cockroaches when a shaft of light enters as all thoughts unite in an instant of accord body no longer expellant as the cockroaches comprise a truth which no one ever utters
>
> I had a night in which everything was revealed to me.
> How can I speak again?[49]

Kane's representation of the mind-in-a-world resonates with a current 'enactivist' understanding of the mind, according to which the human mind and its environment co-emerge. Enactivism perceives the mind as a product of action in a specific environment: it is a process, something that is done, and the interaction between the mind and the environment shape both.[50] In normal life, people quite automatically differentiate between the self and the world, but the enactivist account suggests that experience is actually structured by bodily dynamics and one's interaction with the world. In fact, different marginal experiences such as psychosis (as well as dreams, out-of-body experiences, etc.), which break the barriers between the mind and the world, reveal how utterly intertwined the self, the world and others are. In addition, according to the enactivist view, the sense of 'self', as well as the experience of 'interiority' of the mind, are dependent on the capability to be bodily attuned to the world and on one's sense of embodied unity and coherence.[51]

Throughout the play, the patient-therapist dialogues and medical notes that mimic, exploit and modify psychiatric discourses are contrasted with another discourse, which could be characterized as a phenomenal discourse or 'psychotic stream-of-consciousness'. In these fragments, which form a part of the monologic strain of the text, the grammar is often broken, images take control and meanings become strained: "a consolidated consciousness resides in a darkened banqueting hall near the ceiling of a mind whose floor shifts as ten thousand cockroaches […]." In a way, Kane's storyworld is trapped inside a depressed, psychotic mind. The material and social world around it disappears.[52] But at the same time, the mind evoked in the text is very much connected to its surroundings and to other people — and this happens not only through the cultural and scientific discourses used in the text, but also in the passages that create the seemingly solipsistic narrative of psychotic depression.

Passages like the one quoted above portray the mind as dispersed within the material world via language that brings together concrete and metaphorical objects and spaces. The passages also challenge the very structures of language. The mind *is* the world — it is a ceiling, a floor of cockroaches that gives way to light, and these objects and spaces evoke a new meaning, "a truth which no one ever utters." After this 'psychotic' flash of a mind conflated with the world, the text moves to the more structured interior monologue of the I (indented on the page), who now doubts her/his ability to express these experiences: "I had a night in which everything was revealed to me. / How can I speak again?"

Kane alternates between different narrative modes and typographical settings to create an impression of different perspectives; moving from stream-of-consciousness that conflates the mind to its surroundings to an internal monologue, which returns the speaking I to its place as the agent of the monologue. The fragments about cockroaches, ceilings and revelations are directly followed by a passage that retains the I but evokes an ominous feeling of unknown others surveilling her/him:

> and they were all there
> every last one of them
> and they knew my name
> as I scuttled like a beetle along the backs of their chairs[53]

Again, the self is seen in an environment, now in a space inhabited by other people. "They" could be the doctors or the whole world which has "secret knowledge" about the I. The scene is delusional, as it breaks with our folk psychological understanding

of physical being, but it is metaphorically accurate when thinking about the protagonist's experiences of psychiatric treatment. The segments resemble what phenomenology of psychosis has called *Stimmung*: a strange mood or a moment before actual psychosis in which the surrounding world takes on a new meaning.[54] While the whole play is framed by the distressing dialogues between the psychiatrist and the patient, the idea of psychotic clarity of the world, which comes at night, is the motif of the monological segments.

Phenomenological accounts of mental disorders emphasize the connections between the subject's situatedness and embodied being-in-the-world, one the one hand, and the sense of coherence and reality which characterize 'normal' experience, on the other.[55] In mental illnesses, the structuring experiences of being-in-the-world have been altered, causing something similar to what Kane described as "no longer knowing where you stop, and the world starts."[56] The experiences that Kane's protagonist cites throughout the play are very much in line with phenomenological descriptions. The protagonist's being-in-the world is characterized by different kinds of experiential changes: altered bodily experiences, affective detunement, loss of the feeling of being alive, and heightening of negative emotions (especially of emotions that connect human beings to each other, like sadness, guilt, and shame).

In what follows, I will take a closer look at these experiences and the ways the emergent nature of mental illness is evoked. First of all, there are changes in the sense of embodiment — in the way the subject is corporeally situated in the world. Phenomenologist Thomas Fuchs has described severe depression as reification or corporealization of the lived body. In depression "the body does not give access to the world, but stands in the way as an obstacle."[57] The body is supposed to function as a mediator to the world, but in depression it starts to feel like an alien object. According to Fuchs, "all this literally means a *corporealization*, in the sense of resembling a corpse, a dead body."[58] Or, as Kane's monologist puts it: "I have been dead for a long time."[59]
In psychosis, on the other hand, the mind becomes disembodied — a mind without a body.[60] Either there is an immaterial mind, as the speaking I describes:

> I will drown in dysphoria
> in the cold black pond of my self
> the pit of my immaterial mind[61]

Or the body is there, but separated from the self:

Here I am
and there is my body

dancing on glass[62]

Near the end of the play, as the psychotic experiences seem to grow stronger, Kane emphasizes the painful experiences of being distanced or separated from one's body that characterize psychosis. But dualist experiences can also be found in the monologist's earlier complaints about being "fattened up" as well as in reference to the act of cutting oneself: both depressive corporealization and psychotic disembodiment rely on a heightened division between the body and the mind.

In addition to the embodied nature of the experience of depression, Kane renders mental distress as deeply entangled with intersubjective relationships. The monologist is connected to other people, especially to the therapist figure, and looks at her/himself through the eyes of others. Already in the first dialogue the patient is tied to other people in a very concrete way, as we saw earlier. Towards the end, just before the final monologue and the suicide scene, the text loops back to the silent dialogue of beginning, framing the narrative and tying the various elements together. One way to interpret the repetition would be to understand the scene as a traumatic memory that haunts the narrating I.[63] It emphasizes the protagonist's social relationships, supporting the interpretation which is hinted at throughout the text: the protagonist's suffering is caused by being abandoned by the therapist. ("I trusted you, I loved you and it's not losing you that hurts me, but your bare-faced fucking falsehoods that masquerade as medical notes.")[64] Near the end, the silent dialogue is repeated and continued, and the reader learns how the therapist ultimately refuses the patient's friendship: "I fucking hate this job and I need my friends to be sane."[65]

The patient/therapist dialogues form a persuasive narrative about the problems of therapy and the subject's entanglement with others. They highlight the tragedy of feeling abandoned and disconnected from others. However, the monologues between these dialogical scenes also complicate such issues and prevent the reader from drawing simple conclusions. As previously mentioned, it is uncertain whether the dialogic segments are actual dialogues or distorted memories (or even figments of imagination or hallucinations of the monologist). Even though it is repeatedly suggested that the monologist's pain is connected to therapy and to the loss s/he experiences, it is also uncertain who or what it is that s/he has actually lost: "[…] fuck my father for fucking up my life

for good and fuck my mother for not leaving him, but most of all, fuck you God for making me love a person who does not exist, FUCK YOU FUCK YOU FUCK YOU."[66] Such statements call forth the well-known psychoanalytical description of melancholy as mourning of an unidentified, loved object. The lost object is incorporated into the self, where it becomes a source of eternal sorrow, and the therapist in the play seems to have taken the place of this lost loved one.[67]

The monologist's experiences of shame and guilt can be understood as arising from painful self-other relationships. In phenomenological and psychoanalytical descriptions, shame has been viewed as an experience in which the self is positioned against itself. It fails to fulfill the demands of a loved, ideal other. Guilt, on the other hand, is understood as resulting from the transgression of social norms that are incorporated in the self.[68] For example, the dialogue about friendship can be read as a haunting self-accusation, and the therapist figure brings up the shame and guilt that is afflicting the self. Later on, the self-reproaches grow stronger, taking on delusional forms:

> -I gassed the Jews, I killed the Kurds, I bombed the Arabs, I fucked small children while they begged for mercy, the killing fields are mine, everyone left the party because of me, I'll suck your fucking eyes out send them to you mother in a box and when I die I'm going to be reincarnated as your child only fifty times worse and as mad as all fuck I'm going to make your life a living fucking hell I REFUSE I REFUSE I REFUSE LOOK AWAY FROM ME
>
> -It's all right
>
> -LOOK AWAY FROM ME
>
> -It's all right. I'm here.
>
> -Look away from me[69]

The experiences of guilt range from feeling responsible for mass destruction to people leaving a party because of the protagonist. The self-accusations then turn into violent threats.

The repeated command to "look away" crystallizes the painful divisions inside the speaking I, and the conflation of the identities of patient and therapist is finally confirmed, as the monological and dialogic strains of the text intermingle. What started as a monologue turns into a dialogue:

> -At 4.48
> when sanity visits
> for one hour and twelve minutes I am in my right mind.
> […]

> Why do you believe me then and not now?
> […]
>
> -It's all right. You will get better.
>
> -Your disbelief cures nothing.
>
> Look away from me[70]

Kane's text shows how depression facilitates random feelings of guilt and how grief over a loss can turn into an unspecific sad and depressed mood.[71] Rather than solely illnesses of the brain, mental disorders are deeply entangled with intersubjective relationships, bringing together the brain, the embodied mind and their environment.

As phenomenologist Matthew Ratcliffe puts it, in depression "the overall structure of one's relationship with the world has altered."[72] This change in one's being also explains the central paradox (and tragedy) of depression: wanting and not-wanting to die, or as Kane's monologist puts it: "I do not want to die / […] / I do not want to live;" "This is not a world in which I wish to live."[73] In this context, suicide appears to be almost a rational thing to do — and this seems to be the conclusion that the monologist makes at 4.48 in the morning. However, Kane also warns against drawing conclusions in which suicide would be seen as a solution. The complexity of depressive experiences is articulated once more in the final scene, just before the suicide: "I have no desire for death. No suicide ever had."[74] Even though employing the ideas of death as transgressing one's body, dying for love or transcending "to the light," Kane also continues to caution against romanticizing interpretations — just as she warns against interpretations which disregard the emergent nature of depression. The experiences of being alienated from others, from one's body and losing others as well as oneself are paradoxical, tragic and painful 'states of emergency', and Kane's text shows how these experiences start making sense when they are understood as an altered way of being-in-the-world.

5_Conclusion: "Listen and understand"

> Don't switch off my mind by attempting to straighten me out. Listen and understand.[75]
>
> Despair propels me to suicide
> Anguish for which doctors can find no cure
> Nor care to understand
> I hope you never understand
> Because I like you[76]

Phenomenologists have emphasized that even though it is impossible to 'feel' the experiences of others, people are able to understand each other through their shared world: "To understand other persons I do not primarily have to get into their minds; rather, I have to pay attention to the world I already share with them."[77] The ability to understand and empathize with others is based on a shared sense of the world. Even though the experiences of severe, psychotic depression are strange and often disconcerting, they also emphasize one's sense of being an embodied subject in contact with other subjects in the world. It is possible to be moved by such experiences even when one does not go through them themselves, since all humans know what it is like to be connected to others, to feel their bodies and emotions such as love, guilt and shame that connect us to the world and contest the clearness of the borders of subjectivity. Recent cognitive literary studies have also suggested that fictional narratives are able to take us even 'deeper inside' others' minds than would be possible in reality, as readers are invited to imaginatively engage with perspectives and experiences that can differ radically from their own.[78]

For this last section, I will shortly outline the specific narrative and poetic techniques through which the experientiality of the text and the emergent nature of minds is evoked. First of all, Kane uses different narrative modes that modulate the distance between the voices of the play and the speaking/narrating and experiencing selves. This oscillation between distance and proximity is also tied to the use of (medical) intertexts. In a way, the monologist relies on experiences that other texts — like diagnostic manuals or self-help books — are able to evoke, for example when s/he lists what gives meaning to life: "to be forgiven, to be loved, to be free."[79] The words carry both the intimacy of the monologist's final plea for life, and the irony of their borrowed nature.

Secondly, experiences are conveyed through the materiality of language and the emotional valence that words carry. As the monologist puts it: "Just a word on a page and there is the drama."[80] Embodied metaphors evoke corporeal experiences, like the coldness of snow or hardness of glass in the speaking I's final, fragmented sentences: "All I know / is snow / and black despair;"[81] "Here I am / and there is my body / dancing on glass."[82] Kane also uses folk psychological ideas and experiences of the duality between the mind and the body that convey the experiences of corporealization and disembodiment, as discussed earlier. The use of rhythm and repetition evokes the loops of

compulsive thought patterns of depression: "Shame. Shame. Shame. / Drown in your fucking shame."[83]

Similarly, the use of silences and gaps create changes in mood throughout the text, ranging from anger to resignation. In the final scene, the gaps grow wider and are more and more tied to the disappearance of subjectivity and approaching death:

> watch me vanish
> watch me
>
> vanish
>
> watch me
>
> watch me
>
> watch[84]

The words fall like "black snow," as mentioned at the top of the same page.[85] The imperatives of this final scene can also be thought of in the context of a performance: in a way, readers encounter a person who is vanishing.[86] On the final page, the separation between the speaking voice and the 'real' I is once more confirmed:

> It is myself I have never met, whose face is pasted on the underside of my mind
>
> please open the curtains[87]

A final literary allusion is made: the last line not only refers to the context of theater (yet in which the curtains are not closed but opened in the end) but also to Goethe's Werther, who romantically ponders suicide as the "lifting of the curtain."[88] When read literally, the opening of the curtains seems to refer to the new morning that comes after

4.48, and for example the first performance of *4.48* at the Royal Court Theatre ended in an opening of the theatre's shutters: the lights and noises of London were let in.[89] The last page offers a prime example of the way in which readers are invited to fill gaps, silences and ambiguities with embodied experiences as well as with everyday, literary and cultural knowledge. This was indeed Kane's aim in her late works, in which she started to abandon stage directions and employ an open, poetic narrative form.[90] A narrative form that comes close to poetry is very suitable for evoking the emergent nature of the mind and mental disorders, as well as their complexity. It is as if the emergency of the situation could not be conveyed with a traditional, coherent narrative — just like it cannot be reduced to medicalizing psychiatric accounts, and thus other ways of telling are needed.

Reading *4.48 Psychosis* in relation to phenomenological accounts of depression reveals several important consequences that the play has for the ways human minds and mental illness can be perceived. First of all, Kane's text challenges Western understandings of depression and psychosis. Rather than treating them as cognitive disorders in which the rationality of thought is lost and 'irrational' experiences take control, they are viewed as alterations in the subject's being-in-the-world: in cognitive-affective experiences, in the subject's situatedness and attunement in the world and in self-other relations. The play emphasizes the emergent nature of illness as well as the structures of the subject's being-in-the-world.

Secondly, the play portrays the human mind in a way that challenges dualistic views of subjectivity and mind. It questions — at the same time as it employs — the divisions between mind and body, subject and world, internal and external, subjective and objective, rational and irrational. This also happens on the level of fictional conventions that make the breaking of dualisms possible: literary techniques, evocation of experientiality and the themes presented are all connected to each other. The play reveals how not simply "ill minds", but all human consciousness is tied to embodiedness and situatedness in a specific environment. Subjectivity, the mind and consciousness emerge in an interplay between the self, body and world.

Thirdly, the play makes questionable pathologizing attitudes toward people who suffer from mental illness. Kane's text shows the problems of labeling and attempting to understand mental illness through reductionist diagnostics, without, however, down-

playing the emergency of the situations. Although critical of reductionist and medicalizing psychiatry, Kane's play does not romanticize mental illness or understate the severity of clinical depression. Rather, it portrays the emergency of individual pain and suffering. Instead of pathologizing and enclosing the experiences into narrow diagnostic categories, the play invites us to resonate with the protagonist and to reflect upon her/his experiences.

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[1] Sarah Kane, *4.48 Psychosis*, in *Complete Plays* (London: Methuen, 2001), 203–245, here: 213–214.

[2] Kane specifically refers to *Crave* and to *4.48 Psychosis*, cf. Kane in an interview with Dan Rebellato, qtd. in Graham Saunders, *About Kane: The Playwright and the Work* (London: Faber, 2009), 95. On the opposition between a text and a performance in Kane's work and on the context of postdramatic theatre, cf. e. g. Matthew Roberts, "Vanishing Acts: Sarah Kane's Texts for Performance and Postdramatic Theatre," in *Modern Drama* 1 (2015), 94–110.

[3] Kane wrote *4.48 Psychosis* in late 1998 and early 1999, and it was first performed at the Royal Court Jerwood Theatre Upstairs, London on June 23th 2000. The first production was directed by James Macdonald. Cf., David Greig, "Introduction," in *Complete Plays*, by Sarah Kane (London: Methuen, 2001), ix–xviii, here: xvii.

[4] Kane employs two clinical labels throughout the play: psychosis (in the title of the play) and depression (in the text). 'Psychosis' commonly refers to a condition in which contact with reality is lost. It usually involves phenomena like delusions and hallucinations, and it can be caused, for example, by schizophrenia, or severe depression, as seems to be the case in Kane's play. One could say that whereas 'depression' is the overarching diagnostic category that Kane uses, 'psychosis' is one of the symptoms and ultimate consequences of the protagonist's depression.

[5] Mel Kenyon, qtd. in Ken Urban, "An Ethics of Catastrophe: The Theatre of Sarah Kane," in *Performing Arts Journal* 3 (2001), 36–46, here: 44.

[6] By using the term 'playtext', I emphasize the textual form of the play: the text which is read. Matthew Roberts and Alicia Tycer also use the term in their readings of *4.48*, cf. Roberts, "Vanishing Acts" (cf. note 2); Alicia Tycer, "'Victim. Perpetrator. Bystander': Melancholic Witnessing of Sarah Kane's *4.48 Psychosis*," in *Theatre Journal* 1 (2008), 23–36. Another commonly used term is 'performance text', e. g. Urban, "An Ethics" (cf. note 5).

[7] I understand Kane's playtext as a narrative text despite its fragmentation and the complexity of its structure. I follow David Herman's characterization of four necessary aspects of (prototypical) narrativity: situatedness, event sequencing, world-making/world-disruption, and experientiality, cf. David Herman, *Basic Elements of Narrative* (Oxford: Wiley-Blackwell, 2009). *4.48 Psychosis* relies on all the four elements, and especially world-disruption and experientiality are prominent features in it.

[8] Kane, *4.48* (cf. note 1), 207.

[9] Cf. also Greig, "Introduction" (cf. note 3); Roberts, "Vanishing Acts" (cf. note 2), 97.

[10] Alyson Campbell, "Experiencing Kane: An Affective Analysis of Sarah Kane's 'Experiential' Theatre in Performance," in *Australasian Drama Studies* 1 (2005), 80–97, here: 80.

[11] On the evocation of experientiality in literature, cf. Marco Caracciolo, *The Experientiality of Narrative: An Enactivist Approach* (Berlin/New York: de Gruyter, 2014).

[12] Cf. Tycer, "Victim" (cf. note 6); Urban, "An Ethics" (cf. note 5); and Ariel Watson, "Cries of Fire: Psychotherapy in Contemporary British and Irish Drama," in *Modern Drama* 2 (2008), 188–210.

[13] My focus is on the playtext and its narrative and poetic techniques, but I will also mention some possible consequences for the performance of the text. Different performances of *4.48 Psychosis* and their techniques have been discussed for example by Campbell, "Experiencing Kane" (cf. note 10); Tycer, "Victim" (cf. note 6); Urban, "An Ethics" (cf. note 5), and Watson, "Cries of Fire" (cf. note 12).

[14] On this phenomenological-enactivist view of mental disorders, cf. e. g. Giovanna Colombetti, "Psychopathology and the Enactive Mind," in *The Oxford Handbook of Philosophy and Psychiatry*, eds. K. W. M. Fulford et al. (Oxford: Oxford University Press, 2013), 1083–1102; Thomas Fuchs, "Embodied Cognitive Neuropsychiatry and Its Consequences for Psychiatry," in *Poiesis & Praxis* 6 (2009), 219–233; Michelle Maiese, *Embodied Selves and Divided Minds* (Oxford: Oxford University Press, 2015).

[15] Towards the end of the play, Kane begins segments of stream-of-consciousness with a quotation dash, thus blurring the divisions between the patient-psychiatrist dialogues and the inner monologues, e. g. Kane, *4.48* (cf. note 1), 229.

[16] Cf. Antje Diedrich, "'Last in a Long Line of Literary Kleptomaniacs': Intertextuality in Sarah Kane's *4.48 Psychosis*", in *Modern Drama* 3 (2013), 374–398, here: 383. Diedrich has written in detail about the different intertexts used in the play: *4.48 Psychosis* borrows materials from and creates explicit allusions to, for example, Antonin Artaud's texts, C. S. Lewis's Narnia-series, Goethe's *Sorrows of Young Werther* and a range of different psychiatric diagnostic tools, theories and self-help books. Throughout the play, the monologue turns into seemingly abstract lists of words and numbers, as if dissolving the speaking subject altogether, but even though these lists seem chaotic, they often have intertextual meanings. For example the numbers used in the text refer to a cognitive test in which a patient is asked to count down from one hundred in sevens.

[17] Urban, "An Ethics" (cf. note 5), 44; cf. Watson, "Cries of Fire" (cf. note 12), 192.

[18] Cf. Greig, "Introduction" (cf. note 3), xvii; Tycer, "Victim" (cf. note 6), 26.

[19] Cf. Kane in an interview with Dan Rebellato, qtd. in Saunders, *About Kane* (cf. note 2), 81.

[20] For a reader this is even more urgent whereas for a theatre audience some interpretative choices have always been made by those who have visualized the text. In the first performance of the play, the voice of the play was, for example, divided into three figures, following the text's suggestion: "Victim. Perpetrator. Bystander", Kane, *4.48* (cf. note 1), 231. Cf. e. g. Greig, "Introduction" (cf. note 3); Tycer, "Victim" (cf. note 6).

[21] Kane, *4.48* (cf. note 1), 205.

[22] Kane, *4.48* (cf. note 1), 213.

[23] Kane, *4.48* (cf. note 1), 214.

[24] Kane, *4.48* (cf. note 1), 207; 212; 223.

[25] Kane, *4.48* (cf. note 1), 210.

[26] Kane, *4.48* (cf. note 1), 238.

[27] Cf. *DSM-5*: *Diagnostic and Statistical Manual of Mental Disorders*, Fifth edition (Washington D.C.: American Psychiatric Association, 2013), 160–168.

[28] Kane, *4.48* (cf. note 1), 206–207.

[29] Cf. Diedrich, "Last in" (cf. note 16), 382–383. The BDI (Beck's Depression Inventory) is a 21-question multiple-choice self-report inventory which was first developed by psychiatrist Aaron T.

Beck in the 1960's. In BDI the severity of depression is measured by calculating the patient's choices between propositions like: "(0) I do not feel sad. (1) I feel sad. (2) I am sad all the time and I can't snap out of it. (3) I am so sad or unhappy that I can't stand it. (0) I am not particularly discouraged about the future. (1) I feel discouraged about the future. (2) I feel I have nothing to look forward to. (3) I feel the future is hopeless and that things cannot improve." When compared to the inventory, Kane's monologist's score is approximately 60 — indicating extreme depression (the highest possible total is 62).

Kane's symptom listing is also very much in line with the latest DSM's description of major depressive disorder, according to which five (or more) of the following symptoms have to be present during a 2-week period: "1. Depressed mood most of the day, nearly every day, as indicated by either subjective report (e. g., feels sad, empty, hopeless) or observation made by others (e. g., appears tearful). […] 2. Markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day […]. 3. Significant weight loss when not dieting or weight gain […], or decrease or increase in appetite nearly every day. […] 4. Insomnia or hypersomnia nearly every day. 5. Psychomotor agitation or retardation nearly every day […]. 6. Fatigue or loss of energy nearly every day. 7. Feelings of worthlessness or excessive or inappropriate guilt (which may be delusional) nearly every day […]. 8. Diminished ability to think or concentrate, or indecisiveness, nearly every day […]. 9. Recurrent thoughts of death […], recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide." *DSM-5* (cf. note 27), 160–161.

[30] Kane, *4.48* (cf. note 1), 218.

[31] Cf. *DSM*-5 (cf. note 27), 160–168; Thomas Fuchs, "Depression, Intercorporeality, and Interaffectivity," in *Journal of Consciousness Studies* 7–8 (2013), 219–238, here: 233.

[32] On medicalizing and reductionist psychiatry, cf. e. g. Pat Bracken and Philip Thomas, "Challenges to the Modernist Identity of Psychiatry: User Empowerment and Recovery," in *The Oxford Handbook of Philosophy and Psychiatry*, eds. K. W. M. Fulford et al. (Oxford: Oxford University Press, 2013), 123–138; Louis C. Charland, "Why Psychiatry Should Fear Medicalization," in *The Oxford Handbook of Philosophy and Psychiatry*, eds. K. W. M. Fulford et al. (Oxford: Oxford University Press, 2013), 159–175.

[33] Kane, *4.48* (cf. note 1), 212.

[34] The psychiatrist, for example, suggests that the patient is "allowing" the illness, because s/he refuses to take medication in fear of losing the ability to work, *4.48*, 220–221.

[35] Kane, *4.48* (cf. note 1), 210–211.

[36] Kane, *4.48* (cf. note 1), 211.

[37] Kane, *4.48* (cf. note 1), 217.

[38] Kane, *4.48* (cf. note 1), 212.

[39] Elsewhere in the play, the monologic segments can be understood as the present time of the play, but here the monologue seems to encompass both the past and the present events.

[40] Kane, *4.48* (cf. note 1), 221–223.

[41] Kane, *4.48* (cf. note 1), 221–223.

[42] Kane, *4.48* (cf. note 1), 223.

[43] Kane, *4.48* (cf. note 1), 223. Setraline is an antidepressant and Zopiclone is used to treat insomnia.

[44] Kane, *4.48* (cf. note 1), 224. Lofepramine and Citalopram are commonly used antidepressants.

[45] Kane, *4.48* (cf. note 1), 224. Thorazine is an anti-psychotic drug used to treat psychotic disorders like schizophrenia.

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46 Kane, *4.48* (cf. note 1), 225.

47 Kane, *4.48* (cf. note 1), 220.

48 Another paradox is that it is exactly the drugs with which the monologist ends her/his life in the final scene. The monologist addresses the audience and lists the drugs s/he has taken: "Please don't cut me up to find out how I died / I'll tell you how I died / One hundred Lofepramine, forty five Zopiclone, twenty five Temazepam, and twenty Melleril." Kane, *4.48* (cf. note 1), 241. The monologist's demand of not performing an autopsy can also be read as a final effort to fight against the view in which the human mind is reduced to a mechanism.

49 Kane, *4.48* (cf. note 1), 205.

50 Colombetti, "Psychopathology" (cf. note 14), 1094–1095; Maiese, *Embodied Selves* (cf. note 14), ix. Cf. also David Herman, "Re-minding Modernism," in *Emergence of Mind: Representations of Consciousness in Narrative Discourse in English*, edit. David Herman (Lincoln: Nebraska University Press, 2011), 245–272.

51 Cf. Maiese, *Embodied Selves* (cf. note 14), ix.

52 On the narrowing of Kane's focus in her last plays, cf. e. g. Greig, "Introduction" (cf. note 3), xvi.

53 Kane, *4.48* (cf. note 1), 206.

54 Cf. Louis A. Sass, *Madness and Modernism: Insanity in the Light of Modern Art, Literature, and Thought* (Cambridge, Massachusetts: Harvard University Press 1994), 45.

55 Cf. Matthew Ratcliffe, "Existential Feeling and Psychopathology," in *Philosophy*, *Psychiatry & Psychology* 2 (2009), 179–194, here: 181.

56 Cf. Kane qtd. in Saunders, *About Kane* (cf. note 2), 81.

57 Thomas Fuchs, "Corporealized and Disembodied Minds: A Phenomenological View of the Body in Melancholia and Schizophrenia," in *Philosophy*, *Psychiatry & Psychology* 2 (2005), 96–107, here: 99.

58 Fuchs, "Corporealized" (cf. note 57), 99.

59 Kane, *4.48* (cf. note 1), 214.

60 Fuchs, "Corporealized" (cf. note 57), 104.

61 Kane, *4.48* (cf. note 1), 213.

62 Kane, *4.48*(cf. note 1), 230.

63 For example Tycer makes this kind of an interpretation, cf. Tycer, "Victim" (cf. note 6), 27–28.

64 Kane, *4.48* (cf. note 1), 210.

65 Kane, *4.48* (cf. note 1), 237.

66 Kane, *4.48* (cf. note 1), 215.

67 Cf. Sigmund Freud, "Mourning and Melancholia," in *On Metapsychology: The Theory of Psychoanalysis*, trans. James Strachey (Harmondsworth: Penguin, 1985), 245–268.

68 Cf. e. g. Sara Ahmed, *The Cultural Politics of Emotion* (London: Routledge, 2004), 103–105.

69 Kane, *4.48* (cf. note 1), 227.

70 Kane, *4.48* (cf. note 1), 229–230.

71 Cf. Thomas Fuchs, "The Phenomenology of Affectivity," in *The Oxford Handbook of Philosophy and Psychiatry*, eds. K. W. M. Fulford et al. (Oxford: Oxford University Press, 2013), 612–631, here: 619.

72 Matthew Ratcliffe, "Depression and the Phenomenology of Free Will," in *The Oxford Handbook of Philosophy and Psychiatry*, eds. K. W. M. Fulford et al. (Oxford: Oxford University Press, 2013), 574–591, here: 579.

73 Kane, *4.48* (cf. note 1), 207; 210.

74 Kane, *4.48* (cf. note 1), 244.

75 Kane, *4.48* (cf. note 1), 220.

76 Kane, *4.48* (cf. note 1), 239.

77 Gallagher, Shaun and Dan Zahavi, *The Phenomenological Mind* (London: Routledge, 2008), 213.

78 Cf. e. g. Marco Caracciolo, "Those Insane Dream Sequences," in *Storyworlds across Media: Toward a Media-conscious Narratology*, edit. Jan-Noel Thon and Marie-Laure Ryan (Lincoln: University of Nebraska Press, 2014), 153–165, here: 158.

79 Kane, *4.48* (cf. note 1), 235. The list is taken from Henry A. Murray's book *Explorations in Personality* (1938), which in turn is qtd. in Edwin S. Shneidman's *The Suicidal Mind* (1996) — both used by Kane as materials in her play, cf. Diedrich, "Last in" (cf. note 16), 379–380.

80 Kane, *4.48* (cf. note 1), 213.

81 Kane, *4.48* (cf. note 1), 241.

82 Kane, *4.48* (cf. note 1), 230.

83 Kane, *4.48* (cf. note 1), 209.

84 Kane, *4.48* (cf. note 1), 244.

85 Ibid. (cf. note 1).

86 Another paradox is that the actors are portraying someone who is disappearing, cf. Roberts, "Vanishing Acts" (cf. note 2), 96.

87 Kane, *4.48* (cf. note 1), 245.

88 Cf. Diedrich, "Last in" (cf. note 16), 391.

89 Cf. Tycer, "Victim" (cf. note 6), 30.

90 Cf. also Kane qtd. in Saunders, *About Kane* (cf. note 2), 79–80.