Displaced Metaphor as Madness? A Critical-Clinical Study of Schizophrenia in Joe Penhall’s Blue/Orange

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\textbf{ABSTRACT}

No other trope captures the perceived complexity of schizophrenia and the epistemological, clinical, ethical and phenomenological aporias it poses than the phrase “the sublime object of psychiatry” (Angela Woods). “Sublimity”, however, instigates further complications and problems by mystifying the nature and experience of schizophrenia rather than contributing to the development of a clearer account of it. A conspicuous case of the critique of this treatment of schizophrenia in terms of the “sublime” can be found in Joe Penhall’s two dramatic works: Some Voices (1993) and Blue/Orange (2000). This essay will argue that Penhall’s treatment of schizophrenia is distinguished by two salient features: its method (the critical-clinical) and its simultaneously symptomatic and symptomatological treatment of schizophrenia. What further distinguishes Penhall’s critical depiction of schizophrenia is his insistence that the cultural is as crucial as the clinical in the experience, representation, and perception of schizophrenia. This is attested by his acute inclusion of such crucial issues as race, class, discourse, and gender as highly determining elements in the experience, perceptions and diagnosis of schizophrenia. This essay, accordingly, will demonstrate how Blue/Orange presents a critical-clinical account of the limits of various discursively-determined treatments of schizophrenia (including both psychiatry and anti-psychiatry) thereby accentuating the necessity of developing a more holistic method in the cultural and clinical treatments of schizophrenia.

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This second edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-II) reflects the growth of the concept that people of all nations live in one world.\textsuperscript{1}

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\textsuperscript{1}Diagnostic and Statistical Manual, ix. Whilst the above epigraph promises the recognition of the ontological unity of a worldly context shared by all humans (“in-der-welt-sein”) – reflected in its invocation of “one world” – as the first step towards the recognition of ontological sharedness and unity as a challenge against racial and national difference as ontological difference, it strikingly elides how that one world is internally divided, informed by hierarchies of social power, political-economic inequality, and subjectivation at various fundamental existential-ontological levels. As Fanon would contend, the experience of poverty involves inhabiting a different world, to wit, not merely a social-economic difference, but an ontological one.
Introduction

Did you know that there is more drunkenness, suicide and madness amongst the Irish in London than any other race on earth? [...] that’s what they say because mostly you see they’re away from their family and they’re lonely probably and sometimes there’s prejudice against ‘em because of who they are and they can’t get jobs and things but also mainly it’s just loneliness.²

Thus speaks Ray, the schizophrenic protagonist of Joe Penhall’s 1994 play Some Voices, to explain to his girlfriend Laura the social-environmental factors determining his condition. This explanation is consonant with the nosological consideration of schizophrenia in psychoanalysis, in its phenomenologically-oriented strand (to be distinguished from the biological psychiatry’s rather reductionist one), where individuals’ experience of their social environment and intersubjective relations are deemed the primary causes of the disease rather than modulating factors. Another revealing instance is the rate of madness and suicide among the Irish in London which has been demonstrated to be considerably higher than that of the native English. This difference not only captures the tension between genetic/clinical and environmental/cultural accounts of schizophrenia, it also exposes the racial politics behind this particular psychopathology as a clinical-cultural phenomenon.³ This latter aspect of the disease has also been extensively researched over the last few decades. A prominent case in point is a 2007 research which shows that, among mental health patients across the UK, “21% of patients were from black and minority ethnic groups, although they represent only 7% of the population.”⁴ One of the common ways to account for this is the so-called “ethnic density effect” which refers to the assumption that minorities living in a community are prone to psychopathologies like schizophrenia more than those population groups that constitute the majority. In the UK, for example, “African-Caribbeans living in predominantly white neighbourhoods have been found to have a higher incidence of schizophrenia.”⁵ It has also been argued that ethnic minorities are more liable to experience involuntary psychiatric detention and compulsory readmission than the native majority, with the black minority being in the lead in Britain under the defective Mental Health Act.⁶ The psychological consequences of issues like unemployment, poor housing and health, social isolation and exclusion from school directly influence the rate of representation of the black minority in mental hospital statistics. Apart from such emblematic movements as “Black Lives Matter” which mark a momentous shift in cultural consciousness regarding the precarious position of black people, the increasing cultural concern with this issue is evidenced by its extensive media and academic coverage⁷ alongside scholarly debate.⁸

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²Penhall, Some Voices, 31.
³“Psychiatric characterizations of schizophrenia historically locate its source outside of culture: in nature, primitivity, and the body as a material organism. At the same time, a limited repertoire of analogies allows culture to stand in for schizophrenia and give it substance: Schizophrenia is, accordingly, apprehended as both in and outside of culture.” Lucas, 160.
⁴McKenzie and Bhui, 649.
⁵Pinto, Ashworth, and Jones, 432.
⁶Barnett et al., 8.
⁷See O’Hara; see also Fanin.
⁸See above; see also Chakraborty et al.; Morgan et al.
However, there lies a more crucial matter behind the foregoing causes of the overrepresentation of the black minority in British mental institutes: inter-personal and institutional racism. As Fernando argues,

race affects the way that mental disorder is conceptualised and so-called mentally disordered people managed. The extent of its influence is not just determined by tradition and history but also by current political and economic forces that promote the ethos of white supremacy.9

In the case of the multicultural Britain, definitions of madness have a prejudicial background that has its roots in the country’s colonial history. The racist attitudes of the white majority, police and psychiatrists are thus claimed to largely contribute to the high number of misdiagnosis of British Afro-Caribbeans with schizophrenia.10 Racism also has a second adverse effect. In the face of racial discrimination and abuse, the black minority is likely to internalise the negative self-image and racialized cultural norms, thereby developing a split mode of self-consciousness and mediated mode of self-perception which invariably renders them vulnerable to psychopathologies. As Perry aptly remarks:

Ethnic minorities also experience decreased levels of personal control because, due to racial prejudices, achievement requires greater effort and often results in fewer opportunities for people of color. The result of these circumstances [...] is a lower sense of personal control and consequently the occurrence of psychological distress.11

Recognising itself as the object of fear and hatred in the white man’s eyes, the black minority tends to evince more psychopathological symptoms than the white majority. Notably, persecutory delusions are the most common symptoms of the black minority which are overdetermined by the social alienation, vilification, discrimination, social defeat and outsider status experienced in everyday life.12

The foregoing debates also constitute some of the pervasive issues explored by politically concerned authors of the turn of the century, and most acutely perhaps, by Joe Penhall. This engagement is notably illustrated by his two plays: Some Voices and Blue/Orange (2000). What distinguishes the latter is its demonstration of the subtle entanglements between the cultural and the clinical – commonly perceived to be ostensibly two distinct realms where the latter is assumed to be highly objective and the former highly subjective. The notion of race is deployed in the play to investigate the idea of schizophrenia as both a cultural phenomenon and an issue of clinical diagnosis which entails the recognition of a whole cluster of attendant issues such as political-institutional power, epistemic authority and social control. For this reason, a more nuanced and critically informed treatment of race and schizophrenia is needed in order to grasp the indelible imbrications between race and schizophrenia and the foregoing socio-cultural elements.

Blue/Orange premiered in 2000 at the Cottesloe Theatre with the cast of Bill Nighy as Robert, Andrew Lincoln as Bruce and Chiwetel Ejiofor as Christopher and received

9Fernando, Mental Health, 105.
10See Littlewood and Lipsedge, “Some Social and Phenomenological Characteristics”; Mercer; Cox; Littlewood; Fernando, Institutional Racism, 105.
11Perry, 23.
12See Sadowsky, 246–7; Selten and Canto-Graae, 101; Littlewood and Lipsedge, Aliens and Alienists, 90.
mostly positive critical reviews. The play won Penhall three awards – Evening Standard Award, London Critics’ Circle Theatre Award and Laurence Olivier Award for Best New Play – within a year; and a BBC film adaptation followed in 2005. Three years later, the Bristol-based Plain Clothes Theatre Productions reproduced the play for a South West tour under Sam Berger’s direction. Femi Elufowoju Jr revived the play with an all-female cast at the Arcola Theatre in 2010, which was followed in 2012 by Christopher Luscombe’s Theatre Royal Brighton Productions restaging of the play. The play was revived once more at the Young Vic in 2016 by Matthew Xia and at the Birmingham Repertory Theatre in 2019 by Daniel Bailey. Blue/Orange owes its success and popularity partly to its fearless political criticism targeting The National Health Service (NHS) as the seat of institutional racism. However, despite this success and popularity, the play has garnered scant scholarly attention, by way of a full-fledged, sustained critical analysis. There have, however, been three notable reflections on the play by William Boles (2011; with which we have extensively engaged below), Ariel Watson (2008), and Chun-Yi Shih (2018).

In her essay titled “Cries of Fire: Psychotherapy in Contemporary British and Irish Drama”, Watson interprets Penhall’s Blue/Orange as one of those “psychotherapy plays” (alongside Kane’s 4.48 Psychosis and McPherson’s Shining City) that recognise the intricate relationship between the theatricality of the psychotherapeutic encounter and theatre’s self-reflexive attraction to psychotherapy as a platform where identity and power are negotiated.13 Reflecting upon the manifold notions of discourse and gaze that occupy a central place in the psychodynamics of Blue/Orange, Watson displays how the (schizophrenic) patient is erased from the diagnostic/therapeutic process by being objectified, manipulated and, ultimately, theatricalised by the therapists. Alternatively, in her essay titled “The Worst Pariah: Schizophrenia and Racism in Joe Penhall’s Blue/Orange”, Shih “sets out to explore […] the relationship between black schizophrenia and racism”14 in view of Fanon’s argument that the etiology of mental illnesses like schizophrenia is inextricable from the socio-cultural factors in the environment where patients live. For Shih, racism (on personal and institutional levels) embodied by Bruce and Robert in the play is presented not only as preventing Christopher from receiving a proper treatment for his schizophrenia, but also as causing and aggravating it. Crucially, both essays fall short of discerning and articulating two pivotal features of the play that distinguish it from all the preceding dramatic engagements with the issue of schizophrenia – to wit, the symptomatological and critical-clinical facets of the play, both of which constitute the focal points of our analytical approach to the play.

Thus, in our analytical reflection on Blue/Orange, in this essay, we will be seeking to develop a nuanced conceptual framework deriving the premises of our approach from Deleuze’s notions of the critical and the clinical, Michel Foucault’s theories of power and subjectivity, and R.D. Laing’s existentialist-phenomenological critique of clinical psychiatry in conjunction with contemporary critical responses to and refinements on his contentious insights. This will be complemented with the insights drawn from studies conducted on the sociology and cultural politics of race to keep them grounded in historical specificity.

13See Watson, 188–9.
14Shih, 79.
The argument pursued in this essay is fourfold. Firstly, we will seek to demonstrate how the incorporation of the racialized cultural norms either by a schizophrenic or a clinician can fundamentally affect both the symptomatology and experience of schizophrenia. Secondly, it will be demonstrated how the act or process of internalisation of such norms can be used to interrogate and subvert binary oppositions of normality and abnormality. Thirdly, we will ponder and probe how such a treatment of schizophrenia can reveal the cultural limits and prejudices of a certain cultural discourse and a historical period. In addition, our analysis shall demonstrate that not only a critical-clinical treatment of schizophrenia situates the authors in their cultural history but that their critical depiction of it becomes imbued with a political charge thereby making them feature as a form of cultural intervention. In other words, our analysis shall treat Penhall’s Blue/Orange as a work of art which is both symptomatic and symptomatological; to wit, both historically determined and diagnostically interventionist. And this critical-analytical materialist approach shall qualify Penhall’s work for what we would call “critical-clinical” (a term derived from Deleuze).

Seeking to articulate the interwovenness of the critical and clinical as regards the paradigmatic case of “schizophrenia”, Deleuze and Guattari argue that capitalism at once produces and excludes schizophrenia.15 Relatedly, in this essay, we will attempt to display how the psychic repression is achieved by the repressive society through social oppression in the case of a black, working-class man (Christopher) as presented in Penhall’s Blue/Orange. In other words, we will illustrate how Penhall utilises the clinical diagnosis of an individual’s psychopathology (that is Christopher’s schizophrenia) as a situation for critically reflecting on the cultural and racial politics of the ostensibly objective clinic, but also uses it as an emblematic and exemplary moment reflective of the society more broadly to make the critical diagnosis of a social/institutional pathology (that is racism coupled with class inequality) in his cultural history. Therefore, our analysis will demonstrate how Penhall’s dramatic symptomatology, in its critical-clinical nature, functions as a political intervention in a Foucauldian sense “to criticise the working of institutions […] in such a manner that the political violence which has always exercised itself obscurely through them will be unmasked, so that one can fight them.”16

This essay, in accord with the stance underpinning Penhall’s plays, adopts a twofold approach in its investigation of the issue of schizophrenia as specifically depicted in Blue/Orange: clinical-symptomatological and social-cultural. In its clinical-symptomatological focus, the play demonstrates how the institutionally standard and well-established definitions of schizophrenia – in their attempt to be as generally applicable, comprehensive, and objective as possible – far from being heuristically helpful, prove to be divorced from the lived realities of schizophrenia in the social and clinical settings. A prominent case in point is the American Psychiatric Association’s definition of schizophrenia in terms of “delusions, hallucinations, disorganized thinking (speech), grossly disorganized or abnormal motor behaviour (including catatonia), and negative symptoms.”17 Such general characterisations, as Penhall’s critical-clinical drama exposes, prove to be not only liable to, but in need of, a discursively, culturally, and subjectively mediated

15Deleuze and Guattari, 34.
16Foucault, “Human Nature,” 171.
17American Psychiatric Association, DSM 5, 87.
process of interpretation, (mis-)representation, and manipulation in practice. Penhall’s attempt at a critical symptomatology of schizophrenia is both paralleled and preceded by similarly critical attempts undertaken by various cultural theorists, prominently including R. D. Laing. Laing recasts the above abstract definition of schizophrenia in the following terms: “a possible outcome of a more than usual difficulty in being a whole person with the other, and with not sharing the common-sense (i.e. the community sense) way of experiencing oneself in the world.” More recently, Angela Woods approaches schizophrenia as a subject that is “elusive and enigmatic,” that is, scientifically less comprehensible than it is claimed to be to the extent that it cannot avoid becoming utterly eclipsed by cultural factors.

One of the reasons underlying the onset of schizophrenia, at the very core of which lies dis-embodiment, is the desire of the individual to transcend the limits of body imposed upon him through the biopolitical disciplines coupled with his socio-cultural status by the capitalist discourse and its economic logic of “desiring-production” and “social-production,” to wit, its libidinal and political economies. More strictly, it stems from the questions of race and class as social markers but also indicators of socio-symbolic value and existential desirability in Christopher’s case. This is highly consonant with Deleuze and Guattari’s contention that “the libidinal investment of the social field is primary in relation to the familial investments.” To elucidate this point, we will deploy Deleuze and Guattari’s conception of schizophrenia as a social phenomenon “determined by the conditions of capitalism, […] our very own ‘malady,’ modern man’s sickness”; and race and class as “residual and artificial, imaginary, or symbolic territorialities” instituted by capitalism “to recode, to rechannel persons who have been defined in terms of abstract quantities.” On this premise, we will probe schizophrenia, as presented in Blue/Orange, as a multifaceted phenomenon that is both clinical and critical/cultural.

Set in an NHS psychiatric hospital in London, Blue/Orange features a black schizophrenic protagonist struggling not only with his mental disorder but also institutional racism characterised by a racialized clinical space and racialized therapeutic practices. In the play, the subject of schizophrenia receives a nuanced and sustained treatment where it features not merely as a symptomatic mental state but as a discursively produced problem, thereby featuring as a symptom of contemporary British culture on racial, social, and political levels. Held in tension throughout the play is the relationship between the personal psychodrama of a black patient and the broader issues of politics and economics of psychotherapeutic diagnosis in the context of a crisis-ridden NHS, race, and masculinity. Add to this manifold thematic cluster the problematic entanglements between epistemic objectivity and subjective interpretation in the context of psychotherapy as an institute and discourse.

In keeping with this twofold focus on the nature of the experience of schizophrenia by a black subject and the cultural and racial politics informing the clinical diagnostics and space, Blue/Orange depicts how the diagnosis of Christopher’s condition pits two white
psychiatrists, Robert and Bruce, against each other. On the eve of his discharge from the hospital, Christopher is examined by the two doctors for his social competence for the outside world. While Bruce, the junior psychiatrist, is loath to discharge Christopher on the grounds that he evinces symptoms of paranoid schizophrenia, Bruce’s senior, Robert, contends for the necessity of Christopher’s immediate discharge as he believes that Christopher’s condition is culture-specific – hence a matter of ontological “difference” and thus irremediable. Robert’s argument assumes new dimensions and social-political reverberations when one accommodates his indication of a lack of resources (including beds) in the hospital. As the play progresses, the relationship between the two doctors sours into a struggle for academic and moral authority whilst Christopher’s condition remains untreated and buried under their cumulative epistemic and disciplinary conflicts. Although Bruce has compelling clinical proof that Christopher is schizophrenic and must be re-sectioned accordingly, Robert talks Christopher into filing a complaint of race discrimination against Bruce. The ideological debate between the two psychiatrists thus spirals out of control. Bruce retaliates against Robert’s cheap shot by lodging a complaint with the authority about his senior’s unethical use of his patients for research purposes. The play concludes with an open ending with no clear indication of whether Christopher has been discharged, whether Bruce has lost his job and whether any legal action has been taken against Robert or not.

Upon closer inspection, it becomes apparent that, in the play, schizophrenia does not feature as a merely psychopathological phenomenon the diagnosis and treatment of which demand a deployment of objective-scientific nosological categories. Far from its posing of merely a diagnostic problem, the racially informed case of schizophrenia at stake in Blue/orange transpires as a narrative-dramatic component which, by eliciting a complex matrix of responses to and preconception surrounding schizophrenia, comes to expose the limits of clinical-cultural knowledge and imaginings in conjunction with the latent cultural-racial politics informing British institutes in the turn-of-the-century England. In doing so, the play also interrogates the issue of anti-psychiatry in an attempt to solve the two main problematics of schizophrenia; to wit, etiology and containment. More specifically, the play ponders whether the causes of schizophrenia are traceable to the institutional and disciplinary norms of an oppressive social system and cultural discourse,23 and whether the schizophrenic’s containment is inflected by ideologies of race and class in the neo-liberal capitalist ethos.24

Situated in its cultural-historical context, the play seems sceptical as much about the institutions of psychiatry in Britain as about the British idealist valorisation of anti-psychiatry. Penhall’s symptomatological engagement with this cultural history and his response to the tradition of the asylum drama appear in the form of a power struggle between two psychiatrists for ethical and epistemic ascendancy over one another and mastery over their patient. In the play, we are confronted with highly sophisticated doctors who have learned their humanities lessons well and are well-versed in newly emerged concepts and know how to exploit them. Their professional ambition and knowledge, however, yield opposite results and lead them to manipulate their patient. The “Darwinian power struggle” among the characters in the play, the medical gaze

23See Ibid., 130.
24See Fernando, Cultural Diversity; Read.
and discourse betray their political/ideological stealth, through which Penhall diagnoses the real sickness “at the heart of a dying NHS.” Accordingly, in what follows we will probe the ways in which the post-Laingian “politics of psychotherapy” constitutes one of the vexing concerns of the play at the level of thematics, ethics, and psychodynamics. This line of inquiry will ultimately reveal how, according to the play, schizophrenia/madness must be treated as much as a cultural as a clinical phenomenon.

**Schizophrenia and the Politics of Medicine in the Post-Laingian Britain**

Despite extensive research on the subject, schizophrenia remains the ultimate mystery to medical and cultural specialists; hence the descriptions of it as “the sublime object of psychiatry” and “cancer of the mind” or “psychiatry’s quintessential other.” The sublimity of schizophrenia in clinical psychiatry results from its unresolved status as the extreme point of human psychic state and psychological disorder. Schizophrenia can thus be related to death with its approximation of death in its unknowability, (or the preclusion of the possibility of knowledge) and its denying the individual access to the social and possibility of meaning. In line with the foregoing descriptions, Robert in *Blue/Orange* describes schizophrenia as a still mysterious and stigmatising phenomenon:

> Schizophrenia is the worst pariah. One of the last great taboos. People don’t understand it. They don’t want to understand it. It scares them. It depresses them. It is not treatable with glamorous and intriguing wonderdrugs like Prozac or Viagra. It isn’t newsworthly. It isn’t curable. It isn’t heroin or Ecstasy. It is not the preserve of rock stars and super models and hip young actors. It is not a topic of dinner-party conversation. *Organised crime* gets better press. They make movies about junkies and alcoholics and gangsters and men who drink too much, fall over and beat their woman until bubbles come out of her nose, but schizophrenia, my friend, is just not in the phone book.

This is a crucial passage that illuminates both the perceived abstruseness of schizophrenia as a concept and the socio-cultural mystification of it as a psychosomatic condition. Robert’s act of situating schizophrenia outside the domain of knowledge evokes Deleuze’s analysis of Foucault’s theory of the formation of knowledge (as conceptualised by Deleuze) around two terms: “visibility” and “articulability”. For Deleuze, Foucault understands knowledge as “a practical assemblage, a mechanism of statements and visibilities.” Knowledge becomes possible when ideas are grounded on the a priori conditions of “statements and visibilities” (an improvement on Kant’s a priori forms of sensibility, to wit, time and space). By the same token, schizophrenia, as a clinical concept (that is, an assemblage of clinical statements on the “visibilities” of the experience dubbed, in clinical discourse, schizophrenia) cannot be “brought to bear on something irreducible” – which is the experience of schizophrenia by the individual. The discursive dynamics governing the clinical characterisation and cultural perception of schizophrenia evinced here can be argued to tacitly conform to what Foucault calls the

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25 Sierz, *Rewriting the Nation*, 104.
26 Woods.
27 Sass, *Madness and Modernism*, 13.
28 Ibid., 19.
29 Penhall, *Blue/Orange*, 54.
30 Deleuze, 51.
31 Ibid., 50.
analytics of power implemented through a fivefold process: institutionalisation, rationalisation, and differentiation (including exclusion and classification), along with the means and objectives of power. In such a cultural context, schizophrenia (as the extreme form of mental illness in its incurability and ineffability) has thus become a cultural taboo. Following the binary logic underpinning Foucault’s account of the process of exclusion (including sanity/insanity, reason/unreason and normal/abnormal), schizophrenia has come to serve as a means of exclusion. The schizophrenic has been excluded from society and outlawed as a non-subject or a less-than-human subject.

In the play, Robert is aware of these perils of institutionalisation and stigmatisation with schizophrenia. He believes that therapy can be counterproductive and even schizophrrenogenic: “If you detain this man any longer he will become institutionalised. He won’t get better he’ll get worse. You will make him ill.” This argument also evinces parallelism with Foucault’s claim that “the asylum no longer punished the madman’s guilt … but it did more, it organised that guilt. It organised it for the madman as a consciousness of himself.” Christopher, the schizophrenic character in the play, is a typical example of internalisation of the notion of abnormality. Without any insinuation by the doctors, he projects negative discriminatory opinions on himself, which is suggestive of the discursive and social-cultural norms to which he has been exposed and subjected in the outside world:

Christopher: Where’s the drugs, man?
Bruce: ... Oh the drugs. Of course ...
Christopher: It’s all that innit. "Where’s the drugs man? Oh man, these patients giving me massive big headache man, massive big headache, what have I got in my doctor’s bag, gimme some smack, where’s some smack? Where’s the Tamazie Party? This bad nigga patient I got. This bad nigga dude I know. My God! I Can’t Take The Pressure!”

In a similar vein, he repeatedly refers to himself as an “uppity nigger”, mirroring the discrimination and marginalisation he has suffered as a black man in London. Having been the object of fear and hatred in the public eye all his life, Christopher seems to have internalised the dominant cultural norms which have not only caused his schizophrenia but also characterised its symptomatology.

Clinically, he is depicted as suffering from hebephrenic and paranoid symptoms of schizophrenia in particular. Although he does not seem to demonstrate an obvious “flat affect” or extremes of emotion in either a positive or negative sense, Christopher’s disorder is marked by delusionary behaviour which includes confusion about his father’s identity and about the oranges presented to him being blue. His delusionary behaviour is further intensified by auditory hallucinations, one of the cardinal symptoms of schizophrenia. He says: “I hear noises. At night. Outside my window. Sometimes I hear … talking. People talking about me. […] Laughing sometimes. […] Sometimes I hear machinery. Whirring. Like a … strange droning noise. And beeping. A strange
Beeping noise. Very loud."38 Bruce adds to the list a few more symptoms that he has observed Christopher has been suffering from: “Learned Irresponsiveness, Disorganised Behaviour, Decline in Social skills”, 39 “Overburdened […] Nervous system. Can’t look me in the eye. Thinks we’re staring at him”, 40 “He’s unstable […] highly animated, shouting, staring. […] The loosening of associations.” 41 Christopher’s paranoid symptoms, on the other hand, are depicted through his concern about the negative emotional-affective attitudes harboured by “people” or their negative moral judgment towards him – a psychodynamics which involves a double process of projection-introjection. As he states: “They hate me. They think I’m bad.” 42 His paranoia is also manifested in his aversion to being watched. The gaze, for him, is always a “marker of unequal knowledge”, 43 invariably perceived as panoptic and judgmental. He says: “People stare at me. Like they know … like they know about me. Like they know something about me that I don’t know.” 44

We would argue that the nature of the gaze, as perceived and fantasised by Christopher, bears a striking affinity with the notion of object gaze as elaborated by Jacques Lacan. And this is particularly evidenced by the sadist and uncanny associations of the gaze in Christopher’s schizo-paranoid cognitive-affective dynamics. The nature of the gaze (embodied by others, according to Christopher) is presented as the gaze of the knower of the core of one’s (Christopher’s) existence and secret of one’s desire. And this further substantiates the affinities between the economy and psychodynamics of the gaze in Blue/Orange and Lacan’s idea of object gaze or the gaze of the Other. A succinct unravelling of Lacan’s concept can be illuminating.

In his account of the object gaze,

the gaze [is] the most characteristic term for apprehending the proper function of the objet a. This a is presented precisely, in the field of the mirage of the narcissistic function of desire, as the object that cannot be swallowed, as it were, which remains stuck in the gullet of signifier. It is at this point of lack that the subject has to recognize himself.45

Lacan postulates a schism between the eye and the gaze in that the latter, far from yielding the visual-epistemic mastery and clarity (promised by the former), resists specularization and features as not something that can present itself in the field of vision. As Lacan states: “What we have to circumscribe … is the pre-existence of a gaze I see only from one point, but in my existence I am looked at from all sides.” 46 This feature of the gaze stems from the fact that it constitutes the “inside-out structure” or the “underside of consciousness.” 47 By proving as an interior obstacle to self-presence, the object gaze reveals the impossibility of attaining auto-affection. As such, the object gaze registers a rupture at the core of self-presence at once featuring as the promise of the fulfilment of one’s ultimate desire and a sense of wholeness and the very formidable rupture in the texture of reality which has caused the lack and withholds its fulfilment. And, as is the case with

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38 Penhall, Blue/Orange, 59–60.
39 Ibid., 20.
40 Ibid., 22.
41 Ibid., 26.
42 Ibid., 59.
43 Watson, 201.
44 Penhall, Blue/Orange, 59.
45 Lacan, Four Fundamental Concepts, 270.
46 Ibid., 72.
47 Ibid., 82–3.
Christopher, it is indeed in the gap or space opened up between the look and the gaze that the field of “fantasm” unfurls. And as Lacan confirms, the phallus (for Christopher, that is, Idi Amin) is the fantasmatic par excellence.

By the same token, and garnering his insights from Christopher’s descriptions of his perceptions of various elements arising from the realm of others (the socio-symbolic order) – including the gazes, voices, and names – Bruce construes them to betoken paranoid schizophrenia in Christopher:

Bruce: Nobody’s looking at you funny Chris.
Christopher: He is.
Robert: Well are you surprised?
Christopher: What?
Robert: Are you surprised? Look at yourself. Now just … sit down and … relax would you? Of course people stare at you when you act like this. You know that, you know what it’s like.

*Christopher looks from one to the other, kisses his teeth.*

Pause.
Bruce: (to Robert) Overburdened Nervous System. Can’t look me in the eye. Thinks we’re staring at him.
Robert: We are. 48

Robert, on the other hand, discerns the inherently subjectivising and judgmental nature of clinical-medical spectatorship. In a discourse acutely inflected with a literary consciousness, he finds Christopher’s paranoid symptoms to be natural emotional reactions considering his history of exposure to the judgmental and panoptic gaze. Invoking the well-worn trope of life as an inherently represented phenomenon (the world as a stage), he argues how “paranoia is […] a defamiliarisation of social interaction, a heightened awareness of life as theatre.” 49 In other words, paranoia is inherently linked to the ethnic and pathological profiling performed by society: “Bruce and I can only guess at the horror of suffering from acute paranoia and being one of a culturally oppressed minority. What a combination.” 50 Indeed, the rhetorical force of Robert’s ostensibly nuanced, culturally-conscious discourse and humanistic method renders his position so disarming that one tends to neglect the fact that he in fact intends to speculatively provide a cure for “black psychosis” through various possible ways including “cognitive therapy” and “minimal medication.” 51

One of the most salient ways through which Christopher’s emerging schizophrenia evinces itself is his expression of a belief that his thoughts are not originally his, but they are instilled in him by others, more specifically, the doctors: “When I do think, it’s not my thoughts, it’s not my voice when I talk. You tell me who I am. Who I’m not. I don’t know who I am any more!” 52 The feeling of thinking somebody else’s thoughts is termed “thought insertion” 53 in psychiatry – a case in which “patients

48 Penhall, *Blue/Orange*, 21–2.
49 Watson, 202.
50 Penhall, *Blue/Orange*, 111–2.
51 Ibid., 49.
52 Ibid., 104.
53 Alongside “thought insertion”, the schizoid lives and perceives the world as signs; “For him there are neither people nor things but meanings, endlessly and everywhere.” (Harland, *Superstructuralism*, 172) In other words, the schizoid is unable to form a whole image of the world, the self, and the other, and is so obsessed with and attentive to minute details that he becomes, in Walter Benjamin’s terms, a flâneur, the swimmer of the surface of modern signs. Moreover,
experience their self as not the agent of their own thoughts or other mental activities.”

In the play, Robert clues Christopher in the possibility that his fears and anxieties about the world outside may originally be Bruce’s projections, and Christopher takes Robert’s words quite literally and interprets them as a violation of his “free will”. He protests: “You put words in my mouth. When I said I wanted to stay and I was scared, that was you.” He feels threatened by the doctors’ inexorable manipulations and ends up admitting that he has got “an identity crisis.”

The way the two doctors approach Christopher’s symptoms aggravates this crisis. Bruce uses an objective and objectifying clinical discourse because he deems Christopher’s symptoms the natural outcome of the disease, informing the clinician of its own nature and functioning as its indexical language. He exhibits what Foucault calls “the clinical gaze” that interprets symptom’s language and then reaches the sign:

Beneath a gaze that is sensitive to difference, simultaneity or succession, and frequency, the symptom therefore becomes a sign – a spontaneously differential operation, devoted to totality and to memory, and calculating as well; and act, therefore, that joins, in a single movement, the element and the connexion of the elements among themselves.

In clinical psychiatry, this model has long been recognised as the most trustable method as it is based on the observation/analogy principle. It allows the doctor – the “gazer” – to test the medical knowledge accumulated across centuries on objectified patients who submit themselves voluntarily. As a result of his observations/analogies, Bruce believes that Christopher must be Section 3, that is, he must be diagnosed with schizophrenia.

Robert, on the other hand, adds another dimension to the foregoing politics and psychodynamics of the gaze. As Watson aptly remarks,

[the addition of Robert to the standard dyad of individual psychotherapy creates a potently dramatic triad of spectatorship and judgement. This becomes a double-layered system of spectatorship: Bruce observes and assesses Christopher, while Robert does the same to both doctor and patient.]

From his catbird seat, Robert calls for a recognition of the above symptoms as characteristic of Christopher’s culture. He seems to have come to acknowledge that these symptoms have become a part of the everyday reality, nothing unusual in the neo-liberal capitalist ethos:

And you can add, reckless, impulsive, prone to extreme behaviour, problems handling personal life, handling money, maintaining a home, family, sex, relationships, alcohol, a

the schizoid may seem to be receiving some special message or inspiration from spiritual, phantasmal or other creatures and may claim to be recipient of revelations from God. He might even assume to be in the spotlight of a world-wide spectacle under the inexorable inspection of an insidious throng or featuring in a great film about himself. These indications and many other variations can be attributed to the schizoid’s predilection to “over-reading and hyper-interpretation.” (Harland, Superstructuralism, 172) Similarly, Sass argues that schizophrenia is not a pathological disorder but a state of hyperreflexivity: “In this hyperalert state, the patient experiences mutations of the perceptual world whose effect is to give an altered look and irritating complexity to the things, sounds, voices, faces, gestures, and patterns of behavior that the patient perceives around him.” (Sass, “Negative Symptoms,” 309).

54Chung, 44.
55Watson, 201.
56Penhall, Blue/Orange, 108.
57Ibid., 20.
58Foucault, Birth of the Clinic, 94.
59Watson, 202.
fundamental inability to handle practically everything that makes us human – and hey, Some People Are Just Like That. Borderline. On the border. Occasional visits but doesn’t live here. See, technically he’s not that mentally ill. We can’t keep him here. It’s Ugly but it’s Right.\(^\text{60}\)

He goes on to explain Christopher’s auditory hallucinations: “It’s the dustbin men. […] Builders. OK? We’re in the midst of a property boom.”\(^\text{61}\) Evidently, his character is culturally and environmentally conscious and acutely aware of potentially relevant cultural factors behind his patient’s condition. He explicitly criticises Bruce’s methods in treating Christopher for having “a tendency to overlook …. cultural identity,”\(^\text{62}\) believing instead that “it should be a factor in [one’s] treatment.”\(^\text{63}\) To a certain extent, he even appears concerned with the possibility of Christopher becoming the victim of “cultural oppression” and “institutionalised racism”\(^\text{64}\) while a patient at the institution. Yet, Robert’s concern with ethnocentrism does also present an interesting paradox. While it is Robert who seems to be the more culturally aware and tolerant doctor in the play, it is also him who draws attention to the cultural difference and “colour”\(^\text{65}\) as an issue in the first place. Robert himself analyses the nature of Christopher’s symptoms as possessing a “Cultural Specificity,”\(^\text{66}\) whilst acknowledging that a certain amount of ethnocentrism comes from the doctors’ racially-inflected judgment: “you are evaluating the situation according to your own specific cultural criteria.”\(^\text{67}\) He decides that they are more idiosyncratic of Christopher’s culture than being symptomatic of an individual mental disorder, thus downplaying the nature of Christopher’s condition and exemplifying the idea of “institutionalised racism” by suggesting that his behaviours are merely symptoms of his race:

Why not? Why ever not? Think about it. There is more mental illness amongst the Afro-Caribbean population in London than any other ethnic grouping. Why? Is it the way we’re diagnosing it? Is it us? Is it them? What’s causing it? What’s the answer? What’s the cure? There’s no ‘cure’ for schizophrenia. No ‘cure’ for psychosis. Only palliative drugs. But what if it isn’t psychosis? Wouldn’t that be a relief? What if there is a cure? Cognitive therapy. Minimal medication. A ‘cure’ for ‘black psychosis’.\(^\text{68}\)

Whilst prima facie, Robert’s remarks sound to us as a highly critical and self-conscious racialized politics of the clinical categories and epistemological methods, it is, in its own turn, an ideological definition of race as an intrinsic bio-psycho-physiological feature of a culture or group of people. Such a conception of race is neocolonial since it elides the oppressive, alienating effect of the new cultural-social context (UK in this instance) and the subtle ways in which the racialized context has contributed to pushing the alleged cultural idiosyncrasy to a pathological limit.\(^\text{69}\) As such, by almost equating race, psychosomatic dynamics and culture, not only does it obliterate the fact that race

\(^\text{60}\)Penhall, Blue/orange, 26.
\(^\text{61}\)Ibid., 60.
\(^\text{62}\)Ibid., 77.
\(^\text{63}\)Ibid., 78.
\(^\text{64}\)Ibid., 78.
\(^\text{65}\)Ibid., 78.
\(^\text{66}\)Ibid., 76.
\(^\text{67}\)Ibid., 49.
\(^\text{68}\)Ibid., 48–9.
\(^\text{69}\)In mental health practices “a focus on culture can in itself be racist and it therefore has to be examined in this context.” (Keating, 8) Such a tendency has been found to be quite common among British psychiatrists due to two major biases:
as ontology is a colonial category\textsuperscript{70} (part of the racialized cultural politics of the colonial discourse and its notion of racial difference) but also the ways in which the new social-cultural context has aggravated this symptomatic condition.\textsuperscript{71}

On the other hand, here, Robert encourages the idea that race should be a separating factor within treatment of schizophrenia. This cultural consciousness (displayed by Robert) of the determining role of ethnicity and race in the psychopathology of mental illnesses, in conjunction with the social-economic implications – rather than resulting in a more ethical treatment – leads to further ostracisation and deprivation. All in all, the fact that the two psychiatrists interpret the same issue differently is indicative of the necessity of viewing schizophrenia as a twofold phenomenon: clinical and cultural.

This clinical-cultural controversy between Bruce and Robert echoes the embattled relationship between mainstream clinical psychiatry and critical psychiatry (or anti-psychiatry). Indeed, the other conspicuous subtext underpinning the play (also evident in Robert’s discourse) is the “Anti-Psychiatry” movement. Penhall evokes the decisive reconceptualization of schizophrenia during the 60s and 70s as a part of the antipsychiatry movement which is characterised by an approach to schizophrenia as a culturally-shaped condition rather than a clinical disease. Contrary to clinical psychiatry’s insistence on analysing the patients’ biology, genetics, history of trauma or intoxication, the movement foregrounded social aspects of the condition with a focus on personal relationships, socialisation, the living environment, the capitalist society or simply the outside of the clinic.\textsuperscript{72} One of the precursors of this movement is the Scottish psychiatrist R. D. Laing who treats the subject of schizophrenia as an experience from an existential-phenomenological point of view in his two seminal books \emph{The Politics of Experience} (1967) and \emph{The Divided Self} (1969). He considers schizophrenia not as a clinical psychopathology, but as a socially-induced, ontological anxiety leading the individual to such severe depression, alienation, and isolation that the self develops defence mechanisms to preserve its integrity. Accentuating the necessity of adopting a holistic approach, he proposes that “the social system, not single individuals extrapolated from it, must be the object of study\textsuperscript{73} and that “the contradictions and confusions ‘internalized’ by the individual must be looked at in their larger social contexts”\textsuperscript{74} in the diagnosis and treatment of schizophrenia.

No other component of \textit{Blue/Orange} throws into relief its critical-clinical method and focus than the conflict between clinical psychiatry and anti-psychiatry. The two trends are pitted against each other primarily through gauging the consequences of their respective endorsement of a culturally-blind symptomatology and dismissal thereof. And this critical-clinical juxtaposition of the two is conducted through a sustained
dramatic focus on the power struggle (on linguistic-discursive, social-economic and psychological levels) between Bruce and Robert, with implicit associations with each trend respectively. In light of Christopher’s unrelenting insistence that ordinary oranges shown to him are blue and that his father is Idi Amin (a soldier turned despot known notoriously as the Butcher of Uganda), Bruce wants to subtly negotiate the possibility of diagnosing Christopher with “paranoid schizophreni[a],”75 whilst the Laingian Robert dismisses Bruce’s diagnosis on the grounds that Christopher will be stigmatised and institutionalised. He tells Bruce:

“apart from anything else do you really want to make a schizophrenia diagnosis now? He’s twenty-four hours away from normality. Do you want this man stigmatised? For the rest of his life. Don’t you think he has enough problems as it is?”76

Robert’s seeming concern with Christopher’s freedom and psychological well-being extends to a questioning of the long-established cultural and clinical definitions of normality. He argues:

“We spend our lives asking whether or not this or that person is to be judged normal, a ‘normal’ person, a ‘human’, and we blithely assume that we know what ‘normal’ is. What ‘human’ is. Maybe he’s more ‘human’ than us. Maybe we’re the sick ones. […] just maybe he’s a right to be angry and paranoid and depressed and unstable. Maybe it’s the only suitable response to the human condition. […] The human species is the only species which is innately insane. ‘Sanity is a conditioned response to environmental […] stimulae.’77

His argument echoes Horwitz’s critique of diagnostic psychiatry as a discipline that has severed symptoms from their social and environmental causes and, thus, made perfectly “normal” people adjust to a “mad” world. Robert shares Horwitz’s social-constructionist conceptualisation of mental illness which views definitions of psychiatric disorders as contingent on changing social systems of meaning – particularly, on changing cultural rules that define what is normal and abnormal.78 Robert’s concern with the dichotomies of normal/abnormal and sane/insane is also reminiscent of Laing’s words in The Politics of Experience:

“A feature of the interplay between psychiatrist and patient is that if the patient’s part is taken out of context, as is done in the clinical description, it might seem very odd. The psychiatrist’s part, however, is taken as the very touchstone for our common-sense view of normality. The psychiatrist, as ipso facto sane, shows that the patient is out of contact with him. The fact that he is out of contact with the patient shows that there is something wrong with the patient, but not with the psychiatrist.”79

In the neoliberal capitalist ethos, ontological insecurity and the resulting social alienation are the new realities of human existence. Individuals’ efforts to cling to their isolation for preserving their sense of self can easily be mistaken for abnormality when their behaviours are interpreted outside of their experiential contexts. Laing targets this mistaken association of isolation/alienation and abnormality in the foregoing passage, a concern

75Penhall, Blue/Orange, 32.
76Ibid., 53.
77Ibid., 32–3.
78See Horwitz, 5.
79Laing, The Politics of Experience, 89–90.
shared in *Blue/Orange* by Robert who draws Bruce’s attention to the constructed hierarchies of normalcy that turn patients into the “pariahs of reason.” Robert seems aware that Christopher’s defiance of common sense does not mean defiance of sense altogether. From his perspective, Christopher’s schizophrenia can be interpreted as a “normal” reaction to the “abnormal” circumstances (of racialized subjectivation, racist exclusion, and poverty) under which he struggles to survive as a black, working-class man in London. This strikingly resonates with Deleuze and Guattari’s remark that “capitalism, through its process of production, produces an awesome schizophrenic accumulation of energy or charge, against which it brings all its vast powers of repression to bear, but which nonetheless continues to act as capitalism’s limit.”

Soon, however, Robert’s seeming insightfulness gives way to status quoism and bureaucratic concerns: “The Government guidelines clearly state that The Community is the preferred and proper place and it’s our duty to subscribe to that. Otherwise it’s no end of trouble.” The government guidelines that Robert underscores here point to the Thatcherite “Care in the Community” programme that Penhall investigated as a journalist in London for the *Hammersmith Guardian*. What Penhall must have observed during his time in the field is the transformation of the programme from an “effort to rehabilitate patients to decent living conditions and a useful role in the community […] into a rush to dump patients on the street and in nursing homes in order to save money.” Penhall’s critical exposure of the deficiencies of the measures taken by the Thatcher government in conjunction with his implicit projection of the disastrous fate awaiting the schizophrenic protagonist in case of his premature discharge readily evokes the notorious Clunis affair. In an interview, he remarks: “There is no doubt that Christopher in *Blue/Orange* will get out of the mental hospital, but it won’t be the best solution for him.” Another cogent case in point is Penhall’s *Some Voices* where another schizophrenic, Ray, who is prematurely discharged from the mental institute to the care of his brother. The Thatcher government’s “Care in the Community” policy is questioned here by Penhall with Ray ending up first almost killing a man with a hammer on the head and then almost burning his brother’s restaurant.

In *Blue/Orange*, Christopher is much more disadvantaged than Ray. Christopher does not have a family or a job, and he is a black man in a dominantly white and obviously racist society. Bruce tells him: “You see, my point is, when they let you out this afternoon, the theory is that you’ll go back to your family. To your community. But you don’t have any family, do you? Not any more. Not so far as we know.” Although Bruce tells these to convince Christopher to withdraw his charges of abuse and neglect (originally fabricated by Robert) his words speak one noteworthy truth. In Christopher’s case, Thatcher’s solution is bound to fail as neither Christopher nor the society are ready for his discharge.

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80 See Kane, 228; Watson, 198; Shih.
81 Deleuze and Guattari, 34.
82 Penhall, *Blue/Orange*, 34.
83 See Boles, 4.
84 Warner, 110.
85 See Evans, 66–7; Gorsky, 445–6; Cummins, 73–94.
86 The Clunis affair refers to “the manslaughter in 1992 of a tube passenger, Jonathan Zito, by a diagnosed schizophrenic, Christopher Clunis […] in an open public place, in broad daylight, without any apparent motive.” (Crossley, 177–8) qtd. in Klein, 78.
87 Penhall, *Blue/Orange*, 107.
This is one instance where Penhall’s symptomatological analysis of Christopher’s clinical condition extends to a critical engagement with the contemporary subject’s predicament in the face of pathologizing socio-political forces. Here, Christopher’s case is consonant with Foucault’s establishment of a link between sickness and bad government. Foucault attributes a political dimension to the practice of doctors as at the root of diseases—physical or psychological—lies poverty generated by “bad government” which determines what people eat, where they live and how much freedom they have:

If medicine could be politically more effective, it would no longer be indispensable medically. And in a society that was free at last, in which inequalities were reduced, and in which concord reigned, the doctor would have no more than a temporary role.89

However, as politics continues to fail in governing people equally and rightly, medicine begins to occupy a bio-politically and anatomo-politically much more important place in determining men’s wellbeing, happiness and security under the pretext of advising for a healthy life. Therefore, as Littlewood and Lipsedge contend, “the human individual and his illnesses are a pervasive metaphor for society and its ‘ills’.”90 By the same token, in Blue/Orange, Penhall forms a parallelism as well as a causal link between Christopher’s psychopathology and the ills afflicting Britain on a socio-political level.

Through Christopher, Penhall identifies poverty, precarity and racism not only as symptoms of ill government but also as schizophrenogenic factors. Such an interpretation would be in line with Deleuze and Guattari’s argument that “extreme situations of war trauma, of colonisation, of dire poverty, and so on, are unfavourable to the construction of the Oedipal apparatus—and that it is precisely because of this that these situations favour a psychotic development or explosion.”91 As a black, working-class schizophrenic, Christopher’s condition can be interpreted as a process whose roots must not be sought in biology, but in negative life experiences caused by racist discrimination and socio-economic disadvantage. Regardless of modern psychiatrists’ biologically reductionist explanations, “deprivation and discrimination […] are causative factors for psychosis.”92 Particularly in Europe and North America, the poor constitute the majority of patients hospitalised for psychosis. The number of working-class people diagnosed with schizophrenia has been found to be eight times more than the number of upper-class individuals.93 In the play, poverty is depicted as not only a cause of Christopher’s schizophrenia, but also a force that informs the symptomatology of the disease. It manifests itself by means of a delusion of grandeur through which, by imagining himself as the son of people of higher social status and better public image (Idi Amin and Muhammad Ali), he aims to compensate for his social disadvantage. As Trotter in his expatiation of the symmetrical economy of the symptomatology of paranoia—comprising an alternation between the “delusion of grandeur” and the “delusion of persecution”—observes, paranoia becomes more rampant in societies characterised by a “withholding of recognition.”94

89Foucault, Birth of the Clinic, 33–4.
90Littlewood and Lipsedge, Aliens and Alienists, 160.
91Deleuze and Guattari, 96.
92Read, Johnstone, and Taitimu, 191–205.
93Hollingshead and Redlic; Kohn, 177.
94See Trotter, 19–23.
Alongside poverty, ethnicity also plays an important role in patients’ diagnosis with schizophrenia: “‘ethnic minorities’ – whether immigrants or colonised indigenous peoples – are significantly more likely to be diagnosed with ‘schizophrenia’ than members of the dominant culture.”95 More specifically in Britain, Afro-Caribbeans are more likely to be diagnosed “schizophrenic” than the white majority.96 In such multicultural societies, adverse life experiences of the minority in the form of racist discrimination and abuse are among the major causes of schizophrenia: “those who had actually experienced racist verbal abuse […] were 2.9 times more likely than others to be experiencing psychotic symptoms, while those who had suffered a racist physical attack were 4.8 times more likely to have such symptoms.”97 The high number of schizophrenia cases among the black population in white-dominant societies can thus be explained as a reaction to racism, social discrimination and disadvantage. The symptoms these minority members display can also be interpreted as “merely a strong reiteration of the experience of discrimination.”98 Racist discrimination and the concomitant sense of insecurity experienced by Christopher in the outside world result in delusions of persecution during his time in the clinic.99 He tells Robert: “I am being harassed. I’m in fear of my life. I live in fear. They Know Who I Am.”100 Persecutory delusion is a common type of paranoia in which the patient feels consistently that he will be harmed by external forces or he is the target of an organised conspiracy.101 The strongest emotional manifestation of persecutory delusion is mistrust towards the others that determines the patient’s general mood and attitude. What renders Christopher’s case more noteworthy and curious is the subject of his persecutory delusions. He explains to Robert:

Christopher: When I’m at work. Even at work – d’you know what I mean! Big bloke with a little pointy head. Long thin arms trailing along the ground. A real knuckle-dragger. Very white skin. Hideous-looking bastard. He’s the ring-leader. I see him at night. He bangs on my door. Says he’s coming to get me. He says he’ll do me and nobody would even notice and I believe him. There’s a whole family of them. A tribe. I don’t like them at all. They’re a race apart. Zombies! The undead. Monsters! […] Zombies. […] They look half dead. It’s that ghostly white skin, looks like tapioca, d’you know what I mean?102

As is evident here, Christopher’s delusions are determined by the racist discrimination and abuse he has suffered in his immediate environment outside the clinic. This is in line with Kinderman and Bentall’s argument that “paranoid beliefs often arise in a context of actual victimization.”103 What is more striking is the collective nature of Christopher’s phantasy where the skinheads are depicted as a tribe of zombies, in other words, as a group of blood-sucking, death-bringing and less-than-human creatures. Equally conspicuous is his emphasis on the ugly physical appearances of the skinheads that

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95 Read, Johnstone, and Taitimu, 197.
96 See Bresnahan et al.; Fernando Cultural Diversity; Read; Sashidharan.
97 Read, Johnstone and Taitimu, 200.
98 Littlewood and Lipsedge, Aliens and Alienists, 246.
99 See Vitols, Waters, and Keeler, 472–6.
100 Penhall, Blue/Orange, 65.
101 See Chung, 30; Radden, 257.
102 Penhall, Blue/Orange, 65–6.
103 Kinderman and Bentall, 286.
persecute him. Considered from this point of view, this persecutory delusion speaks not only for Christopher’s victimisation and powerlessness in the face of racist abuse, but also for his strong emotional investment in what he experiences in society. Constructing this elaborate phantasy in his delusion, he displays “a logical reasoning” and proves that, once situated in their cultural contexts, psychopathologies become etiologically and symptomatically unequivocal.

Here, Penhall reveals the double-edged nature of both Laingian critical psychiatry and Thatcherite “Community Care”. The “community” that is supposed to provide care for patients like Christopher consists of sociodemographic factors that are more causative than preventive or curative of psychosis. Christopher describes the world outside the clinic as a dangerous place for a black man where he is constantly harassed by the police: “I get stopped a lot in White City. That’s why I was arrested in Shepherd’s Bush. […] they was after me, man. […] Cos they’re fascists. It’s obvious.” He is also subjected to racist assaults by skinheads: “Another man. He throws bananas at me […] They call me ‘Jungle Boy’. […] It’s their appearance that spooks me the most. Those tiny, bony, shrunken heads. All shaved. Ugly.” This renders the policy of deinstitutionalisation advocated by anti-psychiatry and implemented by the Thatcher government at best facile and at worst paradoxical. Whilst the Laingian enthusiast Robert draws attention to the fact that Christopher’s paranoid delusions are rooted in his immediate cultural environment and personal experiences in Shepherd’s Bush, it is also him who stands up for Christopher’s immediate release to the very community that has caused his psychological distress in the first place.

In addition, the authenticity of the anti-psychiatric concern for patients’ health and freedom is compromised when the political and economic anxieties surface. On the one hand, Robert seems concerned with Christopher’s freedom not being restricted when he protests against Bruce’s attempts to further incarcerate Christopher: “You’re not ‘throwing him out’ … you’re doing what we are here to do. What they are here for us to do – and what everybody expects us to do. […] You are giving this man his freedom.” On the other, his very words reveal the bureaucratic cant and professional ambition underlying his false compassion:

Those beds are Prioritised for Emergency Admissions and Level Ones. Otherwise we’ll wind up with a hospital full of long-term chronic mental patients hurtling about on trolleys – it’ll

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104See Radden, 257.
105Penhall, Blue/Orange, 36.
106Penhall, Blue/Orange, 65–6.
107Freedom is a complicated matter within the context of schizophrenia. Although Blue/Orange does not present schizophrenia as such, Deleuze and Guattari claim it to be a panacea or remedy for the ills of capitalism, a line of flight as well as a liberating, productive delirium that can perhaps deliver someone from the reifying grips of capitalism and the so-called Oedipal triangle: ‘Wouldn’t it be better to schizophrenize – to schizophrenia the domain of the unconscious as well as the sociohistorical domain, so as to shatter the iron collar of Oedipus and rediscover everywhere the force of desiring-production; to renew, on the level of the real, the tie between analytic machine, desire and production?’ (Deleuze and Guattari, 33) To them, capitalism and schizophrenia closely resemble each other, “yet it would be a serious error to consider the capitalist flows and the schizophrenic flows as identical, under the general theme of a decoding of the flows of desire.” (Ibid., 245) In Anti-Oedipus, they define schizophrenia as “desiring-production as the limit of social-production” (Ibid., 35), and as “the boundary between the molar organization and the molecular multiplicity of desire.” (Ibid., 102) It is envisaged not as a breakdown, but as a breakthrough. Capitalism, on the other hand, appropriates schizophrenic flows of desire, turning them into forms of its own perverted death drive. In this respect, capitalism is parasitical; it forms “a gigantic machine for social repression – psychic repression, aimed at what nevertheless constitutes its own reality – the decoded flows.” (Ibid., 245).
108Penhall, Blue/Orange, 25.
be like the *Wacky Races*. […] There’d be a scandal. They’d have my arse out of here faster than his and you’d be next. That’s right. I’ll never make professor. You’ll never make your Specialist Registrar Training.¹⁰⁹

Robert’s words here are reminiscent of what Foucault refers to as the "spontaneous and deeply rooted convergence between the requirements of political ideology and those of medical technology."¹¹⁰ An advocate of the Thatcherite deinstitutionalisation in the play, Robert sees the hospital space as one where examining and curing diseases are secondary both to the primacy of bureaucratic concerns (with government guidelines, hospital resources and the number of beds) and to deciphering, understanding and extracting instruction material from the patients. He openly declares: “This is a ‘Teaching Hospital’ and I am here to teach.”¹¹¹ In the play, the function of the hospital space does not appear to be the treatment of Christopher’s sickness anymore; yet, as Foucault observes in *Discipline and Punish*, it seems “a place of training and of the correlation of knowledge”¹¹² where patient health is only of secondary importance. In this respect, the modern clinic is an adulterated space where the clinician’s sensibility functions in a methodical and mediated way. Despite Bruce’s competent clinical evidence for Christopher’s paranoid schizophrenia, Robert argues that releasing Christopher will be “textbook medically beneficial.”¹¹³ Robert’s foregoing statements function not only as the declaration of modern psychiatry’s helplessness in the face of schizophrenia, but also as a sign of “the fecundity of the clinic” being obscured by “a scientific, political, and economic liberalism”, to wit, “the ideological theme that prevented the organization of clinical medicine.”¹¹⁴ The prevailing ideological theme makes the two psychiatrists in the play so personally and libidinally invested in their work that personal desire (under the guise of culture) inflects doctors’ supposedly impersonal clinical decisions. The severity of schizophrenia is therefore eclipsed by Robert and Bruce’s epistemic blind spots coupled with their ambitions for ideological/moral authority, career progression and personal success.

**Metaphor as Madness**

In *Blue Orange*, Penhall seems to have created Bruce and Robert to represent the two dominant psychiatric schools’ approaches to the paradigmatic case of schizophrenia. He depicts the former clinically and the latter culturally reductionist in their treatment of Christopher’s case. Penahll, in his phenomenologically-oriented account, however, moves beyond the two aforementioned stances by enacting a critical-clinical method in his dramatic treatment of the etiology and dynamics of schizophrenia as a lived experience. Penhall calls for the recognition of schizophrenia as a phenomenon more complex (both etiologically and symptomatologically) than a mere pathology induced by a genetic disposition or the person’s cultural environment. This bifocal method is not only evidenced by Penhall’s maintaining a simultaneously clinical-psychiatric and a racialized-cultural context and discourse throughout, both of which are shown to induce

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¹⁰⁹Ibid., 24.
¹¹⁰Foucault, *Birth of the Clinic*, 38.
¹¹¹Penhall, *Blue/Orange*, 55.
¹¹²Foucault, *Discipline and Punish*, 186.
¹¹³Penhall, *Blue/Orange*, 23.
¹¹⁴Foucault, *Birth of the Clinic*, 52.
cognitive–affective fragmentation, identity crisis and paranoia in the Other (African, Asian, etc.). Equally crucially, this bifocality is reflected in Penhall’s demonstration of schizophrenia to stem from a double source or double economy. In addition to the social-cultural and schizophrenogenic facets/causes explored above, Christopher’s schizophrenia is shown to arise from an Oedipal capitalist political economy and discourse.

In the play, for instance, Christopher’s psychopathological condition stems as much from the lack of the father as from racist discrimination. He has never known his father nor is he in contact with his mother anymore. The questions of origin, legacy and parenthood feature so prominently and prove so crucial regarding the cause of Christopher’s symptomatic/pathological state of mind that the father keeps recurring in his phantasies and delusions. He tells Bruce and Robert: “My father … my dad … was a very important man. Pause. Believe it or not … my dad … is former Ugandan President His Excellency Idi Amin.”115 Obviously, Christopher experiences a crisis of identity and masculinity related to the lack of a father and consequently strives to concoct (via phantasy) and identify with a powerful and authoritative father figure in the image of the Ugandan President Idi Amin. In his exploration of the role of the father in the emergence and prognosis of schizophrenia, Da Silva argues: “The absence of the father, whether it is a physical absence (death, divorce, long separation) or an emotional absence (lack of involvement as a leader of the family unit) appears to contribute significantly to the illness of the son.”116 Avramaki and Tsekeris confirm this claim: “the father’s absence involves the danger of the appearance of pathological disturbances in boys.”117 These arguments are originally predicated on Lacan’s correlation of psychosis with the “failing father” in his seminar *The Sinthome*. Lacan explains the relation between the two by means of the Freudian concept of “castration”:

> Castration means that the phallus is transmitted from father to son, and this even entails something that cancels out the father’s phallus before the son has any right to bear it. Freud refers to the idea of castration essentially in this manner, where castration is a transmission that is plainly symbolic.118

The absence of the father, in this sense, signifies the failure of the transmission of the father’s phallus to the son, which obstructs the child’s psychosexual development. This is exactly the case with Christopher who never had any girlfriends or even friends for that matter. He complains: “I need a girlfriend, man. D’you know what I mean? That’s all I ever wanted. I just wanted somebody nice to be with. A lady.”119 He is revealed to even have tried having sex with a grapefruit once.120 Lacan refers to the perversion caused by the absence of the father (le père) as “père-version.”121 Elsewhere, Lacan (1994) argues that, in the case of the absence of the real father, the paternal function is performed by an imago for the child’s symbolic castration to take place: “Depending on the cultural representations, the imaginary father appears as tyrannical or extremely

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115Penhall, *Blue/Orange*, 41–2.
116Da Silva, 201–2.
117Avramaki and Tsekeris, 190.
118Lacan, *The Sinthome*, 69.
119Penhall, *Blue/Orange*, 114.
120Ibid., 60.
121Lacan, *The Sinthome*, 69.
kind, repulsive or adorable, terrifying or exciting. Unavoidably, the child dresses his father with one or another disguise and transforms him as good or evil imaginary father.”

Due to the absence of the father in his Oedipal triangle, Christopher creates an imago in the form of Idi Amin, a symbolic figure of power, authority and masculinity who is equally respected and feared in the Ugandan community. Later, he switches Idi Amin with Muhammad Ali who is basically the embodiment of phallic/symbolic power, physical strength and black pride in the public eye.

Christopher’s split between body and mind is evinced through his different stories about the identity of his father. The identities he creates are integral to his “false-self”, and he seems to use them to elevate the status of his own identity. This mind–body split resonates with the idea of alienated self-image or double consciousness elaborated by Fanon. In The Wretched of the Earth, he blames Western “civilisation” for “the pathological dismembering” of the black man’s functions and “the erosion of his unity” by means of racial hatred. Elsewhere he writes: “The black man has two dimensions. [...] That this self-division is a result of colonial subjugation is beyond question.”

In the play, Christopher experiences a similar self-division and attempts to disguise his othere’d and abused true self by constructing a false self which, although distanced from him, is of an undeniably higher social status. Robert observes: “One of the most feared men in history and one of the most loved. Both immensely powerful. Both role models. Both of African origins.” However, instead of constructing an identity that conforms to society’s norms, Christopher creates one that subverts them. He draws attention to himself by claiming to be the son of notable figures; yet his inner self is concealed. As Laing acknowledges, if it “is not known it is safe.”

Perhaps the orange itself can be read as a symbol for this concealment of a true inner self.

The titular notion of “blue orange” is the key to the fundamental problematics of Penhall’s play. When Christopher is shown ordinary oranges and asked what colour they are, he simply answers: “They’re blue oranges. [...] Bright blue. [...] It’s bad. It’s a bad orange. Don’t eat it.” What does the orange being perceived as blue stand for in Christopher’s case? Is it a perceptual anomaly on his part that can count as a hebephrenic delusional symptom of schizophrenia or a symptom of his paranoia: the recognition of an ostensibly “good object” (healthy, orange oranges) as an actually “bad object”: blue, bad oranges (a la Klein)?

Or is it akin to one of those unique instances of hyperreflexivity peculiar to (modernist) artists with their exceptional skill of defamiliarisation? While on the one hand it clearly portrays the hebephrenic delusional symptoms of schizophrenia, the

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122 Avramaki and Tsekeris, 196.
123 Laing, The Divided Self, 69.
124 Fanon, Wretched, 238.
125 Fanon, Black Skin, 17.
126 Penhall, Blue/Orange, 101.
127 Laing, The Divided Self, 163.
128 Penhall, Blue/Orange, 39.
129 As indicated earlier, delusional perception is one of the cardinal symptoms of schizophrenia according to Schneider. (Schneider, 133–4).
130 In his Madness and Modernism, Sass finds strong formal and epistemological affinities between schizophrenia and modernist art in terms of their “desire to escape the blinders of conventional perception.” (Sass, Madness and Modernism, 135) To him, they both manifest themselves “as expressions of an extreme self-consciousness or as rather desperate (and often unavailing) attempts to escape from alienation and hyperawareness.” (Sass, Madness and Modernism, 38) For both a schizophrenic patient and a modernist artist, “objects lose their normal functional meanings; they begin to seem absurdly substantial; they fragment into parts; they take on curious meanings.” (Sass, Madness and Modernism, 67).
blue orange is also an object which subverts the idea of normality; in Christopher’s eyes at least it does not conform to the norms of what an orange should look like. Penhall thus hints at the notion of subjectivity – the idea that objects are susceptible to different views and are not always as one might expect. Furthermore, discernible here is a latent identification between Chris and blue orange – where he, vocalizing the introjected view of racist ideology, reckons himself as the bad object.

As expected, in the play, the idealist Bruce interprets Christopher’s visual misperception as delusional behaviour and argues for Christopher’s re-sectioning with the diagnosis of schizophrenia: “classic hallucinatory behaviour.” The champion of anti-psychiatry, Robert, on the other hand, tries to find logical cultural explanations to the same complication:

‘Le Monde est Bleu comme une Orange’. […] It’s a poem by Paul Eluard. He was a French surrealist. […] Maybe he knows the poem. […] There’s a lot of French speakers in Central Africa. His mother could have read it to him as a child. It planted an image in his mind. […] There’s a Tintin book. Tintin and the Blue Oranges. It’s about a ‘mad professor’ who invents an orange which will grow in the Sahara. Only trouble is it’s bright blue and tastes salty. Tintin was banned in the Belgian Congo. They thought he was a communist. But in colonial Uganda the notoriety no doubt made Tintin a ‘must read’ for the bourgeoisie. He was a cultural icon and a symbol of middle-class insurrection.

Robert’s reductionist approach here is reminiscent of Claude Levi-Strauss’s theory of “the savage mind” in his book of the same name. In The Savage Mind (1962), Levi-Strauss refers to the primitive man as a “bricoleur” whose uncultivated thoughts give rise to a practical creativity and artistic logic. Here, primitivity does not signify negativity or backwardness for Levi-Strauss. On the contrary, to him, the primitive man is capable of attributing authentic and distinctive meanings to ordinary phenomena thanks to “the freshness and vivacity of [his] perception […] and a vision undistorted by theoretical speculation.” Robert adopts a similar logic in his attempt to explain Christopher’s delusion of blue oranges; yet, his conception of primitivism is obviously not as objectively-meant as Levi-Strauss’s. By associating delusional perception with Christopher’s ethnic background, Robert equates schizophrenia with black African culture.

Here lies the crux of the issue and the flaw in Robert’s pseudo-culturalist stance. His nativist approach is discursively misguided and manipulative in that he fails and refuses to see the patient in his singularity and rather posits him as representative of one whole culture and race. By taking the individual as the emblematic representation of his native culture and ignoring the specificity of the content of his symptom, Robert elides the singular and personally lived experience of the individual and his culturally hybrid life. As Shih acutely observes,

Robert ignores the fact that Christopher is a black man from Shepherd’s Bush, an African and also a Londoner – he places stress primarily on the influence of African culture on

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131Penhall, Blue/Orange, 45.
132Ibid., 45.
133In Anti-Oedipus, Deleuze and Guattari use the term “bricolage” to refer to the characteristic mode of production of the schizophrenic who is “the universal producer.” (Deleuze and Guattari, 7).
134Levi-Strauss, 113.
Christopher without a consideration of the impacts of English social and cultural milieus on Christopher.\textsuperscript{135}

Although he is aware that Christopher spent most of his life in London, Robert is loath to admit that his patient is at least half-British:

\begin{quote}
Robert: (icily) I’m saying where he comes from it is almost certainly not an unrealistic notion. Where we come from, it evidently is. Get it?
Bruce: But he comes from Shepherd’s Bush. […]
Robert: All right, he’s ‘African’.
Bruce: From Shepherd’s Bush. […]
Robert: I’m not going to squabble. His ‘origins’ are in Africa.\textsuperscript{136}
\end{quote}

Here, Robert’s culturalist argument is reductive and myopic, ignoring the life of this subject in the metropolis and the psychological and existential effects of the British culture on him. He keeps the other so ontologically and epistemologically Other that not only the possibility of any shared, dialogical ground is denied and elided, but the very possibility of judgment, dialogue and therapy is also dismissed.

To Robert, the personal and socio-cultural background of both the diagnoser and the diagnosed are inextricable from the clinical diagnosis. He acts in this way because of his fixation on the subject of his PhD: “Cultural Antecedent and Cultural Specificity in Connection with a Delusional Belief System.”\textsuperscript{137} His research is essential in that it explores the cultural origins and content of psychotic delusions. In the play, Bruce summarises his senior’s findings:

\begin{quote}
African tribesmen develop delusions about sorcerers; Westerners develop delusions about the Spice Girls and extraterrestrials. The specifics of Christopher’s cultural background are that his mother once lived in Uganda: he’s got a delusion about a Ugandan dictator she no doubt talked about. You’re saying he’s not sick, it’s a cultural thing.\textsuperscript{138}
\end{quote}

The argument underpinning Robert’s PhD thesis is resonant with the findings and premises of the conceptual metaphor theory (CMT) first presented by Lakoff and Johnson (1980). According to this theory, metaphor is not a mere word or expression but “the ontological mapping across conceptual domains.”\textsuperscript{139} According to Grady (2007), mapping is the most fundamental subject in CMT; it refers to the systematic correspondence between closely correlated concepts and ideas in one or two domain(s) of experience. This metaphorical correspondence can be between the two concepts as in their totality or between some of their elements. Furthermore, in CMT, metaphor is the very means through which the historical and cognitive-affective content and dynamics of a culture manifest themselves and work. To CMT, metaphor is inherently related to the issue of culture, ideology, and cultural models in such a way that the most fundamental values in a culture will be coherent with the metaphorical structure of the most fundamental concepts in that culture.\textsuperscript{140} As Vengadasamy (2011) argues, CMT can be used to explain the collective cultural and ideological unconscious of a community by a close

\textsuperscript{135}Shih, 88–9.
\textsuperscript{136}Penhall, Blue/Orange, 51–2.
\textsuperscript{137}Ibid., 48.
\textsuperscript{138}Ibid., 48.
\textsuperscript{139}Lakoff, 208.
\textsuperscript{140}Lakoff and Johnson, 22.
analysis of the structures of metaphors. In Blue/Orange, Robert tries to explain to Bruce about Christopher’s inability “to distinguish between realistic and utterly unrealistic notions” with reference to Christopher’s ethnic background. Coupled with his tacit assumption that the white race is the normal, rational race in comparison to others, Robert, in an ostensibly benign interpretation, tends to associate African culture with the metaphorical and the poetic (hence irrational and imaginative), and White culture with reason, science and rationality.

Thus, Robert dismisses Bruce’s diagnosis and, instead, announces: “There is a Cultural Specificity to the apparently delusionary nature of some of your beliefs”141 and explicitly references the subject of “Black Psychosis.”142 Through Robert’s ethnocentric approach to Christopher’s condition, Blue/Orange focuses explicitly on the institutionalisation of the schizophrenic man and the relationship of this condition to his race. By describing Christopher’s symptoms as characteristic of his race, Robert not only projects preconceived cultural ideas and stereotypes onto his patient but also sheds light on the elusive, slippery and subjective nature of ostensibly nosological categories of psychiatry which decontextualise patients’ behaviours, affects and cognition.143

Consequently, the notion of race is used in Blue/Orange to investigate the idea of schizophrenia as a cultural phenomenon (in addition to a clinical diagnosis) which entails a whole cluster of attendant issues like power, knowledge, authority, agency and social control. Penhall seems to argue that clinical elicitations concerning schizophrenia like Bruce’s are obviously reductionist and show a tendency to overlook the relationship between culture and schizophrenia. However, predicating psychopathologies solely on cultural specificities as instantiated by Robert is not an adequate alternative to it either. In this respect, Blue/Orange can be considered as Penhall’s twofold move where, by adopting a critical-clinical aesthetic method, not only does he present a critical-clinical account of the limits of various discursively-determined treatments of schizophrenia. He also demonstrates, at a thematic-diegetic level, the methodological necessity of conjoining the clinical and the critical (socio-cultural, to wit) aspects of schizophrenia in treatments of this condition.

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141 Penhall, Blue/Orange, 76.
142 Ibid., 87.
143 See Brockington, 207; James, 148.
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