(Un)Interrupted sounds: Samuel Beckett's patients and the cacophonous clinical encounter

(Un)Interrupted Sounds: Samuel Beckett's Patients and the Cacophonous Clinical Encounter.

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Declaration

I declare that the work presented in this thesis is my own.

Signed:

Abstract

This thesis examines speaking, listening and power in the contemporary clinic through a medicalised reading of the late modernist Samuel Beckett's oeuvre. Where narrative-based medical practises have hitherto offered clinicians a framework by which to offer better care to their patients — helping doctors to help patients tell their stories, and tell them better — I argue that Beckett's writing can be used to question the restorative capabilities of narrative, by characterising language as troublesome. Beckett's works function as a translational tool to stage, narrate and record the doctor and patient interaction.

I align Beckett's formal choices with the formal aspects of the clinic and the dynamics forged between doctors and patients within these contexts. I have divided this thesis into two halves. The first is devoted to narrating illness and the second to listening to it. In the first half, Beckett's theatre and *The Unnamable* (1958) are used to explore the performativity of clinical spaces that cultivate and curate patient identity. Examining pathographical literature, chapters one and two argue that Beckett's works can be used to understand how patienthood is represented and challenge binary notions of health and illness. In the second half, I examine listening within the clinic through Beckett's radio drama for the BBC, his use of audio technologies, and later theatre works. How does the clinician listen (or not listen) to the suffering subject and how has clinical discourse inhibited patients from listening to themselves? By analysing the global contemporary patient advocacy group the Hearing Voices Network, which offers alternative models of patient experience, I argue that Beckett's works similarly provide an opportunity to stage and narrate illness differently. Utilising a critical medical humanities framework, this thesis entangles speakers and listeners within the clinic through a Beckettian aesthetic that defies traditional clinical discourse and methodologies of patient care.

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Illustrative Material

Abbreviations

AVHs: Auditory Verbal Hallucinations

HVM: Hearing Voices Movement

Acknowledgements

First and foremost, I would like to express my deepest thanks to Professor Jo Winning and Dr Peter Fifield for their guidance, unending support, enthusiasm and warmth throughout the process of writing this thesis. It would not have been completed without them and I shall greatly miss our meetings.

It is at Birkbeck that I first encountered Beckett's writing and I credit Professor Laura Salisbury with introducing me to his works with an infectious passion and interest that only continues to grow. Birkbeck has been my academic home for the past six years and I am so grateful to all the lovely people I have met along the way. Thank you to the guardian angel of the School of Arts, Anthony Shepard, for his help with any and every question I have thrown his way. Thank you to the organisers of the School of Arts and the Birkbeck Graduate Research School writing groups, and to everyone at the post-grad study room: they have kept me disciplined. Thank you to Leah Sidi for the coffee breaks, the theatre trips and her calming words of encouragement. Thank you to my great friend Leonie Shanks, her thoughtfulness and humour has meant more to me than I think she knows.

I would like to thank the staff at the Samuel Beckett Collection and James and Elizabeth Knowlson Collection at the University of Reading. I would also like to thank the BBC Written Archives, and in particular Trish Hayes, for her assistance during the initial stages of my research. Thank you, too, to the Zoë Dominic estate for permission to include one of her wonderful photographs of *Play*.

In researching this thesis, I have had the honour of meeting some incredible people through Connect - the communication disability network (now Aphasia Re-connect). Thank you first to Dr Celia Woolf for her suggestion that I contact Connect to meet people living with aphasia. She does not know how life changing her recommendation over dinner was. Through Connect I have been able to meet and work with people with aphasia and those who are at the forefront of speech and language therapy research. It was here that I was lucky enough to meet Lauren Marks, whose friendship I cherish, and whose guidance and conversation has been integral in shaping my ideas for this thesis, thank you to her.

Completing this thesis has not been easy. At times it has felt like a Beckettian struggle of the highest order. I am grateful to my dearest friends Sophie West, Holly Turner, Laura Turner and Agatha Connolly, who have helped to keep my head above water and have always been there. I will forever be indebted.

Thank you to Professor Annie Cushing who has been an inspiration. I could not be luckier to have someone so supportive, kind, bright and curious as a mother. Thank you for letting me colonise your kitchen table and for reading this thesis. Your ideas and your insight have been invaluable. Thank you too to my father, John Harries. Studying for a PhD at the same time as one another has proven to be a godsend. Thank you for all the dinners and the sharing of ideas, not to mention the books and the film recommendations. I feel so very grateful to have parents who in me have fostered their love of learning and thinking together, not to mention their obsession with hard work. Finally, my love and thanks to Rob Ballington, whose patience and kindness are infinite.

Introduction

At the beginning of 1934, shortly after the death of his father, Samuel Beckett moved from his family home in Foxrock, Dublin to London. Since his father's death, his health had been poor and tensions between him and his mother continued to increase.[1] When Beckett's childhood friend Geoffrey Thompson suggested that he move to London in pursuit of psychotherapy, Beckett was eager to do so. Psychoanalysis was forbidden in Ireland at the time, and so it was in London that Thompson introduced Beckett to Wilfred Ruprecht Bion, then a therapist in training at the Tavistock Clinic.[2] For the next two years they would meet three times a week as Beckett sought out explanations for a litany of psychosomatic symptoms: heart 'jigs […] night sweats and panic attacks',[3] and sometimes even 'total paralysis'.[4]

Therapy was not an easy undertaking, but it was clear that Beckett received the sessions well. Soon after he began working with Bion, Beckett wrote to his cousin Morris Sinclair:

> Three times a week I give myself over to probing the depths with my psychiatrist, which has already, I think, done me some good, in the sense that I can keep a little calmer, and that the panic attacks in the night are less frequent and less acute. But the treatment will necessarily be long, and I may have months more of it yet. I am not complaining, I regard myself as very fortunate to have been able to embark on it […][5]

Beckett's commitment to his treatment extended to his scholarly pursuits, as he worked through numerous psychological texts, while attending sessions with Bion. Beckett's symptoms had remained a point of shame and embarrassment, and yet in conjunction with his psychoanalysis and his relationship with Bion, they guided his reading at the time. His interest in medicine and psychology is clear in his reading and note-taking throughout the thirties and it was during these interwar years that Beckett produced a series of notes now referred to as the 'Psychology Notes'. These cover a wide range of psychological texts, from R.S. Woodworth's *Contemporary Schools of Psychology,* to Otto Rank's *The Trauma of Birth,* and Ernest Jones's *Papers on Psychoanalysis,* as well as many works by Sigmund Freud.[6] This intense interest shows that although Beckett

[1] James Knowlson, *Damned to Fame: The Life of Samuel Beckett* (London: Bloomsbury, 1996), p. 172.
[2] Ibid., p. 175.
[3] Ibid., p. 172.
[4] Ibid., p. 176.
[5] *The Letters of Samuel Beckett Volume I: 1929-1940*, ed. by Martha Dow Fehsenfeld and Lois More Overbeck (Cambridge: Cambridge University Press, 2009), p. 183.
[6] Matthew Feldman, *Beckett's Books: A Cultural History of Samuel Beckett's 'Interwar Notes'* (London: Continuum, 2006), p. 6.

had left his lecturer post at Trinity College Dublin, he nevertheless maintained his faith in the academic project, to deepen his understanding of clinical psychology and psychoanalysis.

In his reading, note-taking and therapy sessions with Bion, Beckett was trying to explain — and give a voice to — his symptoms. This thesis explores the difficulty of articulating illness. In a conversation with Georges Duthuit, Beckett famously said the artist must realise that:

> [T]here is nothing to express, nothing with which to express, nothing from which to express, no power to express, no desire to express, together with the obligation to express.[7]

Despite the supposed futility and impossibility of expression, there is still a propensity to attempt to narrate illness. This thesis asks, why? Moreover, the difficulties associated with narrating illness have a significant impact on communication within the clinical encounter. This is a study of the power dynamics at play within clinical encounters and the difficulties associated with articulating illness in a language which is either at odds with experience, or has failed entirely. In this thesis the failure of language is explored first by questioning received ideas about how illnesses can be narrated within the clinical encounter, and the problems raised when language is no longer available or controllable due to neurologically-based language disorder; second, in terms of language's inability to capture the lived experience of unusual auditory phenomena. Finding the right words and questioning whether, indeed, narrative (according to current medicalised codes) is the means by which to express and understand illness, I propose that the works of Beckett offer a way to imagine, to stage, to articulate and to reify the clinic anew.

The four chapters that follow have been divided in two different ways. Firstly, they are organized according to Beckett's formal choices, through which I read the formal aspects of the clinic. Secondly, my thesis is divided thematically, with the first two chapters devoted to narrative and the difficulties of narrating illness. In Chapters Three and Four I turn my attention to the question of how we listen to illness. I am not working within the interpretive paradigm of chronological development here, but rather, want to examine Beckett's form: both the internal structures of his works and the shape

[7] Samuel Beckett, *Proust and Three Dialogues with George Duthuit* (London: John Calder Publishers Ltd., 1999), p. 103.

given to a work by its being a novel, a play, or radio drama.[8] While Beckett's use of new forms and media, such as the turn to the radio, are tied to biographical changes, I argue that the significance of these shifts transcends the conditions of their emergence, and sustains an analysis of form that is non-biographical and non-developmental.

In Chapter One I examine the performative nature of the clinic, through my reading of Beckett's plays, *Play* (1964), *Breath* (1969), *Rough for Theatre II* (1976) and *Catastrophe* (1982).[9] In Chapter Two I use Beckett's final novel in the trilogy, *The Unnamable* (1958), to examine the challenges of narrating illness when faced with disordered language. Through its subversion of first-person narratives, I read *The Unnamable* as an aphasic anti-narrative that both adopts and undercuts the tropes of twentieth-century life writing. Chapter Three uses Beckett's first commissioned radio drama, *All That Fall* (1957) and *Krapp's Last Tape* (1958) — whose tape recorder plays a central role within the drama — to examine the difficulty of listening and the ways that the infrastructure and current approaches to clinical consultation inhibit open listening within encounters. In my final chapter I use Beckett's later works to claim that the refusal to listen remains so pervasive within the clinical encounter that it has extended beyond the clinician and now influences the way patients perceive their own conditions. By focusing on the experiences of those with Auditory Verbal Hallucinations (hereafter AVHs), I shall show how *Eh Joe* (1966), *Not I* (1972), *Footfalls* (1976) and *Ohio Impromptu* (1981) stage the experiences of voice-hearers and offer a way of thinking about voice-hearing which is counter to models used by the clinic today. Beckett's work can be used to give a voice to unheard voices. In dividing the thesis between speakers and listeners I do not exclude the concerns of each from the other chapters — these themes are entangled — but by separating them in this way, I hope to stage a conversation between Beckett and the clinic that uncovers some of the conflicts associated with power, listening and speaking.

In introducing this thesis, I want to start with Beckett's first published novel, *Murphy* (written between 1935-36).[10] By beginning with *Murphy*, I begin with the clinic. Written at the same time that Beckett was undergoing psychoanalysis in London, *Murphy* is Beckett's most explicitly clinical text. It is here that I find a germ of an idea and interest in Beckett's medical aesthetic, which was to continue (in varied, abstracted

[8] Examples of historicized readings of Beckett's work include John Pilling's *Beckett Before Godot* (1997), Knowlson and Pilling's *Frescoes of the Skull: The Later Prose and Drama of Samuel Beckett* (1979) and Matthew Feldman's *Beckett's Book's: A Cultural History of Samuel Beckett's 'Interwar Notes'* (2006).

[9] *Play* was first written in English between 1962-63, but was not published in English until 1964. While *Rough for Theatre II* was written in French in the late fifties, Grove Press, New York published the first English translation in 1976.

[10] Published in March 1938 (London: Routledge).

and estranged forms) throughout his oeuvre. While Beckett would later become famous for his depiction of other-worldly spaces and his commitment to what Rosemary Pountney called his attempt to 'vaguen', *Murphy*'s narrative is tied to specifically identifiable places.[11] The novel begins in a West Brompton mew, tracing walks that Beckett had followed during his time in London, and ends within the walls of the Magdalen Mental Mercyseat hospital, an institution that resembles Bedlam, on the outskirts of the city. Symptomatic of the literary legacy that Beckett had inherited from his modernist forbears, *Murphy* exemplifies the tropes of a modernist text that narrates urbanised wanderings, internal musings and the disjuncture between urban modernity and inner life. Scholars such as Steven Connor, Rónán McDonald, J. C. C. Mays and John Pilling have viewed *Murphy* as an example of a Beckettian style-in-progress. It is a novel that both aspires to grapple with and surpass Joyce's literary legacy, and reflects Beckett's contemporary scholarly pursuits by incorporating various philosophical, psychological and clinical texts and readings. Yet, besides the insight it offers into Beckett's early career and philosophy, the depiction of the clinic in *Murphy* has remained relatively unexamined.

To date, Beckett's works have notably been read as evidence of distinctly modernist representations of illness, and have played an important role in developing innovative medical humanities-based pedagogic methods by which to explore neurological and psychiatric conditions with doctors and patients.[12] Traditionally, there has been an inclination to read Beckett's works as schizophrenic texts, offering a vision of what Gilles Deleuze called the 'schizoid voice', and the interest in Deleuzian readings of Beckett's work endures.[13] Moreover, Beckett's work has been consistently used to expose voices that have historically remained unheard: be it the working class and politics, the voices of women, prisoners, or those suffering from mental health

[11] Matthew Feldman, *Falsifying Beckett: Essays on Archives, Philosophy and Methodology in Beckett Studies* (Stuttgart: ibidem-Verlag, 2015), p. 34.

[12] Professor Laura Salisbury has written extensively on the connections between Beckett's modernist aesthetic and language disorder within his work. Alongside Elizabeth Barry and Ulrika Maude, Salisbury led the AHRC funded project, 'Beckett and Brain Science' in 2012, which has instigated subsequent projects exploring Beckett and brain science as well as other medical humanities research projects of its kind. For example, the 'Modernism, Medicine and the Embodied Mind: Investigating Disorders of the Self' project and conference (also funded by the AHRC), as well as the Wellcome Collaborative Award in Medical Humanities funded project: 'Waiting Times', jointly led by Laura Salisbury and Lisa Baraitser. Jonathan Heron developed the 'Beckett on the Wards' workshop in which healthcare professionals discussed how Beckett's works could be useful to their own practice and teaching. The workshop consisted of practice-based role-plays using Beckett's *Not I* to frame and discuss clinical encounters. This project was based upon work done in the 'Beckett and Brain Science' project, and the Warwick workshop in particular, in which '[e]xperts in the fields of psychiatry, neurology, philosophy and theatre reflected upon the challenges to medical classifications produced by experiential approaches to the study and treatment of the mind' (Barry, n.d.).

[13] See Shane Weller's ''Some Experience of the Schizoid Voice': Samuel Beckett and the Language of Derangement' (2008) and S.E. Wilmer and Audroné Žukauskaitė's edited collection, *Deleuze and Beckett* (2015).

problems.[14] These projects have tended to draw upon Beckett's middle to late period, and have examined works in which infrastructural representations might be likened to systems that sit outside of the theatre and the novel. Yet, while many Beckett scholars, have clearly read his work through the lens of medical humanities this is by no means the current impetus within Beckett studies today.[15]

This thesis is situated within a medical humanities framework and draws upon the works of scholars including Elizabeth Barry, Matthew Broome, Jonathan Heron, Ulrika Maude, and Laura Salisbury to offer a specifically Beckettian reading of the clinic. Their vital work has formed the foundations for further analysis of the narrative-based approaches in the clinic which this thesis seeks to overturn.

Beckettian Entanglements

In *The Birth of the Clinic: An Archaeology of Medical Perception*, Michel Foucault writes:

> The formation of the clinical method was bound up with the emergence of the doctor's gaze into the field of signs and symptoms. The recognition of its constituent rights involved the effacement of their absolute distinction and postulate that henceforth the signifier (sign and symptom) would be entirely transparent for the signified, which would appear, without concealment or residue, in its most pristine reality, and that the essence of the signified — the heart of the disease — would be entirely exhausted in the intelligible syntax of the signifier.[16]

The clinical method relies upon an 'intelligible syntax', or put another way, interactions between bodies that are founded in language. This thesis explores how illness experiences are constructed by voices and by listening to those voices. I ask: can we represent and understand the experience of illness? This is neither a new question, nor a new challenge faced by the medical humanities. I argue, however, that the medical humanities needs to challenge the efficacy of prescribing narrative as its method of

[14] See Lance Duerfahrd's '*Waiting for Godot* among the prisoners' in Rabaté's *The New Samuel Beckett Studies* (2019), Linda Ben-Zvi's *Women in Beckett: Performance and Critical Perspectives*, Elizabeth Barry's 'All in My Head: Beckett, Schizophrenia and the Self' (2016), and Emilie Morin's *Beckett's Political Imagination* (2017)

[15] One of the current trends within Beckett studies today concerns archival research into Beckett's writing process. Dirk van Hulle and Mark Nixon's 'Samuel Beckett: Digital Manuscripts Project' (launched in 2011) has initiated a wave of genetic criticism within Beckett studies to chart the epigenetic developments and exogenic influences of Beckett's literary style. Moreover, there is an increasing turn towards incorporating analysis of Beckett's non-literary works into Beckett studies. Examples include, Nixon's monograph *Samuel Beckett's German Diaries 1936-1937* (2011), which traces the evolution of Beckett's creative process in his early period. Other trends include historicised and politicised readings of Beckett's works, with recent publications such as Emilie Morin's *Beckett's Political Imagination* (2017) and James McNaughton's *Samuel Beckett and the Politics of Aftermath* (2018). This thesis is situated outside of these predominant trends and instead focuses on how challenges within the contemporary clinical environment can be used to read the Beckettian and patient body as contingent, performative and affective.

[16] Michel Foucault, *The Birth of the Clinic: An Archaeology of Medical Perception*, trans. by A. M. Sheridan (London: Routledge, 2003), p. 110.

making meaning, to gain full insight into the experiential claims of patient and clinician alike.

Since its inception, the medical humanities has been seen as a potential antidote to the lack of humanist approaches within medicine, by integrating humanities based disciplines into clinical education and practice, and borrowing and occupying the methodologies of one field, so as to inform the other. Brian Dolan writes that, '[b]ringing the humanities into medical education has long been seen as helping to equalize the rigors of rote memorization *and* to provide engagement with the social milieu that impacts healthcare delivery, patients' beliefs, and physicians' emotional equanimity' [italics in original].[17] For Dolan like many others, humanities subjects are believed to enrich the medical student's study and humanise her. From a humanities' perspective, a greater knowledge of the biomedical sciences has encouraged a medical turn within literary studies that has been seen to augment literary scholarship with a richer understanding of the historical medical contexts of creative production. This thesis contests this integrative approach, and argues that integrating disciplines in this way does not achieve the epiphanies it hopes to realise.

The medical humanities is a field that is constantly redefining and performing itself. In the latest wave of medical humanities scholarship, a new critical medical humanities has emerged. Des Fitzgerald and Felicity Callard write that within critical medical humanities, the 'integrated medical humanities has indeed, in recent years, been an important and even radical move for the emergence of this field.'[18] And yet, they argue, integration does not go far enough, as the term is still founded on the belief that those things that are being integrated are inherently separate from one another. Instead, they look at the opportunities offered by the term entanglement. They write:

> What holds together much of the research employing 'entanglement' is an intuition that some set of things, commonly held as separate from one another (indeed, that define themselves precisely with reference to their separability) […] not only might have something in common, but also, in fact, may be quite *inseparable* from one another.[19]

I similarly adopt the term entanglement, as it enables me to enter into the complexity of two seemingly divergent fields and argue that the literary is already at work within

[17] Brian Dolan, 'One Hundred Years of Medical Humanities: A Thematic Overview', in *Humanitas: Readings in the Development of the Medical Humanities*, ed. by Brian Dolan (San Francisco, California: University of California Medical Humanities Press, 2015), pp. 1-31 (p. 8).
[18] Des Fitzgerald and Felicity Callard, 'Entangling the Medical Humanities', in *The Edinburgh Companion to the Critical Medical Humanities*, ed. by Anne Whitehead and Angela Woods (Edinburgh: Edinburgh University Press, 2016), pp. 35-49 (p. 38).
[19] Ibid p. 39

clinical frameworks. It is my intention, then, to establish the definitions of entanglement within the context of this thesis. I will entangle the literary and clinical to argue that literary critical tools and approaches are not only useful within the clinical encounter, but are also necessary for the clinical practitioner. Viney et al. write:

> Embracing the complex role of critical collaborator — a role based on notions of entanglement, rather than servility or antagonism, and so reflexively constituted and reworked — will, we suggest, enrich and develop the imaginative and creative heterodox qualities and practices which are the field's core strengths.[20]

Defining the medical humanities remains an open-ended project that consistently raises new questions with each attempt, but it is Viney, et al.'s theory of entanglement that informs my reading of Beckett's oeuvre as a demonstration of the challenges and conflicts between speaking and listening in the clinical encounter. The medical humanities opens discussions onto myriad ways that a text and subject can be read. To entangle is not to resolve but rather, to fold each discipline into the other, to show that their division into separate fields has a limiting effect. Viney, et al.'s entanglement argues for an interaction between medicine and humanities that produces new models of thought that sit independently from those they have drawn upon. Fitzgerald and Callard write:

> We cannot easily divide the practices (or objects) of 'science' and 'medicine' from the practices (or objects) of social and humanistic inquiry that are interested in understanding (and may be contributing to) scientific medical domains. We do not, as scholars from various disciplines, bring our objects and practices to another through a kind of free-trade agreement; rather we re-enter a long history of binding, tangling and cutting, within which current moves towards integration are much more weighted than they might at first seem.[21]

Critical medical humanities' emphasis upon entanglement is not ahistorical. Instead, the scholar enters into a conversation, which 'sets in motion a more experimental and capacious future for the medical humanities', in contrast to the 'telos' of integration.[22] The field of study is ever traced and informed by what has come before or has taken place concurrently, and so continues to redefine and perform new methodological approaches, as it continues to expand. In this thesis, I am interested in constructions of

[20] William Viney, Felicity Callard, and Angela Woods, 'Critical Medical Humanities: Embracing Entanglement, Taking Risks', *British Medical Journal*, Medical Humanities, 41.1 (2015), 2–7 (p. 2).
[21] Fitzgerald and Callard, 'Entangling the Medical Humanities', in *Edinburgh Companion to the Critical Medical Humanities*, ed. by Whitehead and Woods, pp. 35-49 (p. 39).
[22] Ibid.

mental and neurological health, as well as the spaces in which they are treated. I challenge assumed knowledge that has been historically embedded, and examine its numerous manifestations in the contemporary moment. This thesis, then, is an analysis of Beckett's work and its contemporary relevance in questions related to the clinic and the experience of illness.

In his article 'Knowing How We Know: An Epistemological Rationale for the Medical Humanities', Neville Chiavaroli proposes:

> An epistemological view of the humanities in medical education offers a significant new way of conceptualising and communicating the potential role of the humanities in medical training […] medical humanities are valuable not because they are more 'humane', but because they help constitute what it means to think like a doctor.[23]

Chiavaroli's focus lies in the way thinking is conducted within the humanities and the clinic. He claims that, '[e]pistemology teaches us that a discipline's underlying theory of knowledge has significant ramifications for how further knowledge is generated, how the discipline goes about determining what counts as knowledge.'[24] What constitutes knowledge methodologically, within literary studies, remains slippery. The critical tools available to the literary scholar and the way that the field constructs knowledge are significantly different to that of the social and medical sciences. What methodologies do we utilize as literary scholars? Close reading and a combination of trans-historicism and textual analysis that has derived from hermeneutics are central approaches in literary criticism, and here they form the basis of my analysis of Beckett's works. I employ an epistemology that is, to quote Viney et al., 'productively entangled', so as to establish a dialogic relationship between the medical and literary fields, and Beckett's texts and the clinical encounter.[25] Through this dialogue, the humanities offer a new vocabulary with which to discuss the clinic, one that hinges on a literary formal analysis of the clinic's performativity and interpersonal encounters between doctors and patients. Concentrating on the 'how' of representation — as literary studies bids us to do — renews the strangeness of scenes that seem, superficially, to be self-evident because they are familiar. In my thesis entanglement encompasses (or rather contains) these literary critical tools and clinical narrative-based approaches, in an attempt to realise

[23] Neville Chiavaroli, 'Knowing How We Know: Epistemological Rationale for the Medical Humanities', *Medical Education*, 51 (2017), 13–21 (p. 13).
[24] Ibid., p. 14.
[25] Viney et al., 'Critical Medical Humanities: Embracing Entanglement, Taking Risks', *British Medical Journal*, 2–7 (p. 2).

Chiavaroli's claim that the medical humanities can be put to practical use in clinical education and clinical practice.

The critical approaches that Beckett's work demands of the literary scholar are not only suitable, but also essential for driving forward observations in the clinical. The literary can serve to defamiliarise conceptions of the clinic and through their conversation both clinical reasoning and critical reading in the humanities become unfixed to allow for mutual influence, illumination and reflection. At the heart of this enquiry lies a study of the possibilities and pitfalls of narrative. Narrative has heretofore functioned as a bridge between medical and humanities disciplines, yet the study of how a narrative is constructed (the language used or available to create it) and how it is read, has been somewhat overlooked. Narrative has played a utilitarian role, as a means by which to communicate experiences. It has been understood as a transparent and standard medium, through which the subject simply shares whatever she wishes to say. Narratology is invariably concerned with what is meant by the term 'narrative'. In *Narrative Discourse* Gérard Genette offers this useful three-fold definition as a starting point: first as discourse (both oral and written); second as a succession of events which are the subject of this discourse, and third, the event of narration (not what is being narrated but the act itself).[26] Therefore, it is with these three definitions in mind that the narrative turn has expanded across fields, from literary and cultural studies, to the social sciences and clinical medicine. The narrative turn has grown, in part due to an increasing late twentieth-century interest in the voice that narrates and the question of narrative agency.[27] My thesis adopts this definition of narrative, but also encompasses further qualifications. Narrative is the recounting of events (the event of narration) but it is also subject to the conditions in and under which those events are recounted, it is not merely an act of objective telling, but rather what is told, how it is told, when it is told and by and for whom it is told. These conditions underpin my reading of narrative and narrativisation in Chapters One and Two and can be defined as self-reflexive narratives, which the narratologist Hanna Meretoja glosses as 'selective, perspectival interpretations that can always be contested and told otherwise.'[28]

Reading Beckett's work, across his oeuvre — his ailing and powerless figures, his abstraction and distillation of literary and dramatic form, his brittle and repetitive

[26] Gérard Genette, *Narrative Discourse: An Essay in Method*, trans. by Jane E. Lewin (Ithaca, New York: Cornell University Press, 1980), pp. 25-26.
[27] Hanna Meretoja, *The Narrative Turn in Fiction and Theory: The Crisis and Return to Storytelling from Robbe-Grillet to Tournier* (New York: Palgrave Macmillan, 2014), p. 2.
[28] Hanna Meretoja, *The Ethics of Storytelling: Narrative Hermeneutics, History and the Possible* (Oxford: Oxford University Press, 2018).

language — offers a vital intervention into expectations of narrative. Throughout this thesis I use his works in a number of ways to enact this intervention. Beckett's characters are read as analogous to patients who present with pathological symptoms. In this sense, Beckett's writing is pathographical, and by reading his characters as patient illustrations, I propose that we are able to learn more about the subjective experiences of chronic illness.

Yet beyond this — with an emphasis on the formal characteristic of Beckett's works — I want to draw comparisons between both the systemic structures of theatre and his plots, with those of the clinic. Both are performative spaces, in which identity and pathology is acted out according to the infrastructural and directorial claims of the institute. Clinical questions can be staged through Beckett's writing: staged in the sense that at times they take place on a stage, but also according to its intransitive definition as an act 'to set up a platform or scaffolding'.[29] To stage is to build the conditions onto and through which something can be performed and viewed. This comparison is not always stable: I do not assume that one thing is exactly like the other, nor that the relationships between Beckett and the clinic are constant. Moreover, they offer different ways to think about the clinic, not all of which are self-evident. Beckett's work cannot always be mapped onto a clinical situation and it would be strange if this were the case. Indeed, as I show in this introduction, *Murphy* remains the only text in this thesis that directly presents a clinical environment. However, the way we read the clinical encounter can, I argue, be expounded by employing epistemological approaches to knowing (as Chiavaroli writes) and to knowledge making that reading Beckett's writing fosters.

Discussions concerning the neglect and disempowerment of marginalised voices within the clinical encounter are vital to the expansion of contemporary critical medical humanities debates. Furthermore, those people who face such challenges within the clinical encounter often do so due to their marginalisation in other spheres.[30] Biographically speaking, Beckett is an unlikely figure with which to analyse an experience that is stratified along racial, regional, gender and class lines. But his work is

[29] Oxford University Press, *OED Online* (n.d.) <www.oed.com/view/Entry/188654> [accessed 1 December 2019].
[30] Robert McRuer's work explores this challenge by placing 'queer postcolonial and transnational theory in conversation with disability studies', arguing that dominant discourses view both heterosexuality and able-bodiedness as societal expectations (McRuer 2010, 163). Moreover, Jasbir K. Puar (who also cites McRuer) argues that current 'disability scholarship interested in moving beyond individual subject that is Euro-American, white, middle-class, and neo-liberal is impoverished'. Her work shifts the focus from Western Euro-American experiences and instead reads identity 'not as essence, but as risk coding', to form a new geopolitics of affect (2010, 161). More recently Lindsey Andrews and Jonathan M. Metzl interrogate the persistent scientific rationalisation and explication of race and behaviour. They argue that 'race is embedded not just in individuals, but in the very structure diagnostic medicine' and that medical imaging continues to be read 'within a racialised legacy of image production both within and outside of medicine in the US' (2016, 243-44).

nevertheless preoccupied with exploring underrepresented figures in society. Beckett's privilege, then, is not a limitation, but rather signifies the parameters of his own experience, and his work proves his conscious desire to shed the privilege of his upbringing and earlier academic career. Beckett is interested in more than the isolated individual; instead, he situates the self within broader sociological and institutional contexts. It is the particularity of Beckett's work, which is located and concrete in its nature, that enables the subject who is routinely 'othered' to be explored. Beckett's consistent fracturing and estranging of his characters, and his rendering of the subject that is neither fully constituted nor contained, is useful to the investigation of the 'other' be that due to their race, gender, class, or as my thesis examines, the 'othering' of underrepresented voice-hearing and aphasic communities. The potential value of the humanities, as Chiavaroli sees it, is in providing an alternative means by which to think and work through the medical. The critical reading required of the humanities and the analysis of Beckett's writing in particular, enables unheard voices to be heard. Entangling questions of narrative through the clinic and Beckett's writing, both sets the stage and acts upon it, creating an epistemological methodology that situates this thesis within a critical medical humanities framework.

Murphy's Asylum

Why has Beckett's most distinctly clinical text — set for much of its narrative within the confines of a hospital — been overlooked in medically oriented scholarship? Where Beckett's vaguening has enabled scholars to use his work as a model for medical humanities scholarship, *Murphy* has been strategically sidestepped in favour of later works. My aim is not to historicise Beckett's works, nor is it to address the modernist style of Beckett's writing to read the clinic. My interest lies in the clinic today, and how his work demonstrates and illuminates current concerns in medical humanities scholarship and clinical practice. I will read Beckett in this way so as to address questions of interpersonal communication in the clinic, through narrative and post-narrative medicine, and furthermore explore the systemic constraints placed upon communication and patient agency within the health service in the contemporary moment. Beckett's work does not offer a clear manifesto on care and illness states, but rather, I use his writing as a translational tool by which to clarify questions of how to narrate and listen to illness. Later works offer the opportunity to explore models of healthcare and clinical encounters in more oblique ways. In *Murphy*, however, the clinic

is clearly rendered through the asylum, closely based on Beckett's experiences of visiting Bedlam.

Narrative abstraction and Beckett's exploration of language's shortcomings may be evident in his later works, but in *Murphy* these themes are not addressed. Yet, despite its realist tone and third-person narration, there remains the central question of how to state and narrate the self. Half-way through the novel the narrator acknowledges the fact that *Murphy* is a text. The narrator says:

> It is most unfortunate, but the point of this story has been reached where a justification of the expression of 'Murphy's mind' has to be attempted. Happily we need not concern ourselves with this apparatus as it really was — that would be an extravagance and an impertinence — but solely with what it pictured itself to be. Murphy's mind is after all the gravamen of these informations. A short section to itself at this stage will relieve us from the necessity of apologising for it further.[31]

The point at which the narrator acknowledges the existence of the text coincides with an attempt to offer an explanation of Murphy's mind. *Murphy* traces the retreat of its protagonist away from the world and into the confines of the asylum, and it does so with a keen awareness of the contradictorily expansive and sealed inner landscape of the mind. Murphy's mind pictures 'itself as a large hollow sphere, hermetically closed to the universe without.'[32] This closed mind rejects the opportunity to interact with the world outside, instead only understanding itself in and of itself. The narrator goes on:

> He [Murphy] distinguished between the actual and the virtual of his mind, not as between form and formless yearning for form, but as between that which had both mental and physical experience and that of which he had mental experience only.[33]

The 'form and formlessness' of the mind and body binds them together and acknowledges their material and immaterial differences. Murphy's identity is thus not marked in the naming, but instead in the interactions that his body and mind have with one another, and the interactions that both have with the universe at large. These dualisms will continue to be explored throughout Beckett's works, but it is here, at the very start, that the novel enables Beckett to explore overtly a Cartesian intercourse

[31] Samuel Beckett, *Murphy* (London: Faber and Faber, 2009), p. 69.
[32] Ibid., p. 69.
[33] Ibid.

between the body, mind and world. The seeming simplicity of this extract occludes what, I argue, is an attempt to illustrate the irreconcilability of the self in narrative.[34]

It is this irreconcilability of narrating body and mind that the patient and clinician also face, as each is treated as independent from the other, and is narrated as such. Martyn Evans writes that, while the medical humanities may seek to tear apart these Cartesian divisions, there is a danger that critical medical humanities might replace one dualism with another: 'if the critique is objecting to a medical dualism, it must itself be free from any dualist taint, such as promoting the experiential self at the expense of the bodily self, for instance.'[35] This argument is central to my own, as my thesis entangles illness through embodied expression. The experiential claims of the subject are not just formed in language. Beckett's characters function as interpretive in this regard, as their language and thought is consistently rendered material and contingent upon the technologies and spaces that produce them, but they are also crucially non-narrative selves who resist narration, even in the process of being narrated. Current narrative-based approaches to clinical medicine appear to have contributed to the separation of mind and body in clinical settings. Where narrative medicine has sought to improve communications between doctors and patients, the model used for understanding patient narratives appears to embed distinctions between the mind and body further.

Within the medical humanities, narrative is now a central methodology for interpreting interactions between clinicians and patients. The clinician and literary scholar Rita Charon, who first coined the term 'Narrative Medicine', claims that, '[s]ickness calls forth stories.'[36] These stories that Charon refers to, come in various forms of narrative, as she writes:

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[34] The medical humanities has traditionally placed narrative in a privileged position. Scholars such as Arthur Kleinman, Rita Charon, Brian Hurwitz, and Trish Greenhalgh have developed a narrative-based approach to the medical humanities and clinical practice. Narrative medicine, as it is now known, stakes its claims in the value of narrativisation as a method to enable better clinical communication. Narrative medicine, as an academic and methodological pursuit, has expanded to such an extent that universities, including Columbia and King's College London, have developed Masters programmes and modules devoted to its study and practice. Within the critical medical humanities, however, there is an increasing move toward post-narrative methodologies, which challenge narrative-based approaches to healthcare. Angela Woods has published several provocations for post-narrative medical humanities that complicate the notion of the naturally narrative subject and question the ways that narrative currently functions in the clinic. Drawing on the work of Galen Strawson and Crispin Sartwell, Woods argues that placing too strong an emphasis upon narrativity in clinical medicine can do more harm than good, and that alternatives need to be found (Woods 2008, 2011, 2013). My thesis adopts this post-narrative position. It is particularly productive to challenge the precedence of narrative through a study of subjects for whom narrative and language production is inherently challenging, due to pathological conditions. I argue, however, that those with disordered language, or those who experience unusual auditory phenomena, are not only the only ones to face these challenges. Rather, these non-normative cases are a starting point from which to show that the same difficulties are at work for all subjects who attempt to narrate their experiences.

[35] Martyn Evans, 'Medical Humanities and the Place of Wonder', in *Edinburgh Companion to the Critical Medical Humanities*, ed. by Whitehead and Woods, pp. 339-55 (p. 346).

[36] Rita Charon, 'The ethicality of narrative medicine', in *Narrative Research in Health and Illness*, ed. by Brian Hurwitz, Trisha Greenhalgh, and Vieda Skultans (Oxford: BMJ Books, 2004), pp. 23-36 (p. 23).

> Whether in the patient's 'chief complaint', the intern's case presentation, the family member's saga of surgery, or the coroner's death note, patients and health professionals recognise problems, gauge progress, and lament defeat, in part through telling about illness and having others listen.[37]

Charon's claims, and the growing interest in the use of narrative studies within medical practice, identify multiple converging and divergent voices within the clinic. Each voice has its own agenda, despite the assumed commonality of the task at hand: to document, to manage, and to cure illness. Recognising these agendas is vital if we are to understand the function of narrative in the clinic. Psychiatrist and medical anthropologist Arthur Kleinman writes:

> The personal narrative does not merely reflect illness experience, but rather it contributes to the experience of symptoms and suffering. To fully appreciate a sick person's and the family's experience, the clinician must first piece together the illness narrative as it emerges from the patient's and the family's complaints and explanatory models; then he or she must interpret it in light of the different modes of illness meanings — symptoms, symbols, culturally salient illnesses, personal and social contexts.[38]

My thesis interrogates the interpretive model laid out by Kleinman. The purpose of the patient's narrative, and the question of whom such a narrative is for will be examined. In Kleinman's account, the consultation relies upon the clinician acting as an interpreter of the narrative, according to her knowledge of disease and also the social context in which this disease is experienced. This, however, relies on the clinician making assumptions, which she might not be in a position to make accurately. While it may be true that '[s]ickness calls forth stories', it is how these stories are read and the actions taken as a result of the storytelling that need to be re-evaluated.[39] Moreover, the way a narrative is constructed is influenced by the conditions under which it is composed. How do we tell the story of our illness to different people and how does the overriding power of the clinic affect the story that the patient chooses to tell?

Murphy represents the first of Beckett's texts in which the mind and body's interactions are explored, establishing a theme that persists throughout the oeuvre. I begin, therefore, by first exploring the psychological and narratological themes at play within Beckett's earlier work. Drawing on the extensive reading Beckett conducted

[37] Charon, 'The ethicality of narrative medicine', in *Narrative Research*, ed. by Hurwitz, et al., pp. 23-36 (p.23).
[38] Arthur Kleinman, *The Illness Narratives: Suffering, Healing, and the Human Condition* (New York: Basic Books, Inc., 1988), p. 49.
[39] Charon, 'The ethicality of narrative medicine', in *Narrative Research*, ed. by Hurwitz, et al., pp. 23-36 (p. 23).

during his time in London, as well as material from his 'Whoroscope Notebook', *Murphy* consolidates allusions and experiences absorbed in the months preceding its composition. Where others have shied away from reading its representation of the clinic as particularly significant within a medical humanities context, I propose that it is through Beckett's first published novel that an idea of and interest in medicine is founded. *Murphy* is the initial emblem of a thematic concern that is expounded in subsequent, more experimental texts, through to the most austere/extreme of his late formalist representations.

Beckett's understanding of the asylum was shaped by his numerous visits to Bedlam while his friend Geoffrey Thompson was working there as a Senior House Physician. The Royal Bethlam Hospital bears distinct architectural and geographical resemblance to the Magdalen Mary Mercyseat asylum in *Murphy*, most comically perhaps in that both buildings traverse two counties, as, according to Beckett's biographer James Knowlson, one part of Bedlam 'really does lie in Surrey, while one ward is situated in Kent, although Beckett exaggerates the nearness for comic effect.'[40] These journeys to Bedlam exposed Beckett to patients and conditions he would not have seen otherwise and speaking about his visits, Beckett said: 'I saw everything, from mild depression to profound dementia'.[41] Beckett's all encompassing 'everything' seems somewhat at odds with assumptions that might be made about Bedlam. The fact that Beckett claims to have seen everything suggests that he had privileged access to the hospital, and also that he was keen to place himself in a somewhat problematic position as an observer in a place that by this time was closed to the public. In addition to its patients, Beckett was also incredibly interested in the day-to-day operations of the hospital, and made extensive notes on the duties of a male nurse within Bedlam in particular. Much of the information gleaned from the nurse, 'was [written] almost verbatim in *Murphy*.'[42] His fascination with the sights and procedures of the hospital, and the impression left by having experienced them first-hand, lingered: '[t]hree decades later, Beckett could still remember 'standing five or six feet away from a schizophrenic who was "like a hunk of meat. There was no one there. He was absent."'[43]

The embodied nature of mental distress described here, can be likened to Beckett's psychosomatic symptoms that brought him to England in the first place. Writing to his

[40] Knowlson, p. 209.
[41] Ibid., p. 208.
[42] Ibid., p. 209.
[43] Ibid.

friend Thomas MacGreevy in March 1935, just over a year after he had started his psychoanalysis, Beckett wrote that it was his feelings of superiority and willed isolation that had brought on his symptoms.[44] In tracing this pattern of self-destructive isolation and anger, Beckett marks the turning point like so:

> It was not until that way of living, or rather negation of living, developed such terrifying physical symptoms that it could no longer be pursued, that I became aware of anything morbid in myself. In short, if the heart had not put the fear of death into me I would still be boozing & sneering & lounging around & feeling that I was too good for anything else.[45]

It was the body, then, that spoke up. Where the mind appeared unable to give language to this experience, the body offered a symptom, which as Beckett goes on to say, turned out to be 'the least important symptom of a diseased condition that began in a time which I could not remember'.[46] By building these connections through analysis, it seems that Beckett was witnessing the breakdown of Cartesian dualism as body and mind were now not only intertwined, but also folded in upon one another: entangled. Knowlson writes that through analysis, Bion worked to ease Beckett's symptoms by attempting to relieve the guilt he felt at having isolated himself.[47] Beckett's discovery that his self-inflicted isolation and physical symptoms might in some way be linked, brought with it a tide of negative feeling, which Bion endeavoured to contain.[48] Beckett's disdain for his body and his way of thinking now extended to both his language and creative outputs. In July 1937 Beckett wrote a letter that would become his most famous, to his friend Axel Kaun:

> And more and more my language appears to me like a veil which one has to tear apart in order to get at those things (or the nothingness) lying behind it. Grammar and style! To me they seem to have become as irrelevant as a Biedermeier bathing suit or the imperturbability of a gentleman. A mask.[49]

Beckett scholars have repeatedly used this letter as evidence of Beckett's scepticism towards language and his doubt in its creative potential.[50] In this letter, language has a

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[44] Knowlson, p. 180.
[45] *The Letters of Samuel Beckett Volume I*, ed. by Fehsenfeld and Overbeck, p. 259.
[46] Ibid.
[47] Knowlson, p. 181.
[48] Ibid.
[49] *The Letters of Samuel Beckett Volume I*, ed. by Fehsenfeld and Overbeck, p. 518.
[50] See Steven Connor's 'Beckett and Bion'1998 lecture. See also, Salisbury's 'Art of Noise: Beckett's Language in a Culture of Information' (2010) and C.J. Ackerley, 'The Uncertainty of the Self: Samuel Beckett and the Location of the Voice' (2004).

substance, which is obstructive and leaves little room for silences and spaces.[51] The 'things' and 'nothingness' of language has also been read as a material language. In this instance, I read the materiality of language in bodily terms: language as a symptom and symptom as language. By placing this in context with Beckett's experience of psychotherapy, I argue that the letter can also be read as a reaction to Beckett's understanding of his own conditions, and a reaction to his relationship with Bion.

Steven Connor posited in his lecture 'Beckett and Bion' that it is important to account for the fact that Beckett's letter to Kaun was written in the same year that Beckett concluded his therapy sessions.[52] Beckett's attack on language enacts Bion's theory of 'attacks on linking', and simultaneously illustrates Beckett's scepticism of language's ability to formulate such links in the first place.[53] Connor writes:

> I think we should see this statement [the Kaun letter] as a prolongation of an attack upon the integrating function of language as interpretation which Beckett may have begun in the discontinuation of his analysis. Analysis provided a kind of mythical scene which allowed Beckett to separate himself from the language of the interpreter, and language as such insofar as it was split off and lodged in the person of that interpreter.[54]

Beckett's scepticism is driven by his doubt in language's ability to readily bind itself with meaning. Meaning-making is a failed endeavour and the integrative function of language is to be distrusted. The mask of language that Beckett describes in his letter to Kaun is thus both barrier and shield. It fails to represent and yet, in failing to do so, it protects the patient from the repercussions and enactive recuperations of therapy. Beckett's decision to leave therapy is an important one. In an interview with Knowlson, Beckett recalls going to see Bion for only six months, when in fact he had met with Bion three times a week for almost two years.[55] While this may be a simple case of misremembering, by underestimating what was certainly a significant investment of his time and money, Beckett's evasiveness might be suggestive of the shame that he felt for needing and having therapy. Yet, it may also have been that Beckett saw the possibility

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[51] *The Letters of Samuel Beckett Volume I*, ed. by Fehsenfeld and Overbeck, pp. 518-19.
[52] Connor is incorrect here. Beckett's therapy concluded in 1935, two years prior to Beckett writing this letter. It is clear, however, that Bion's writing on language and attacks on linking continued to resonate with Beckett. Beckett's concern with the efficacy of language is proof of persistent thinking concerning his personal experiences of the clinical (and psychotherapeutic) encounter.
[53] In 'Attacks on Linking', Bion noted the propensity of his clients to seek out revelations through psychoanalysis, only to then attempt to sever the links, once they had been found. The recalcitrant patient, having made connections between her actions (or symptoms) and their source(s), was soon eager to dissociate from them, perhaps so as to absolve herself of any responsibility to act on such discoveries and alter her behaviour (1984, 101-02).
[54] Steven Connor, 'Beckett and Bion', *Steven Connor* (1998) <www.stevenconnor.com/beckbion/> [accessed 8 April 2016].
[55] Knowlson, p. 175.

of a cure as potentially damaging. Where therapy had seemed productive at first, having seen a marked improvement in his psychosomatic symptoms, Beckett was now consumed with negative and hopeless feelings towards his language and behaviour.[56] The psychotherapeutic relationship had developed into an exchange in which veils were hung, preventing the patient from interpreting the language-less behaviours of the body. Language was now 'a mask', as opposed to the means of uncovering psychically motivated physical symptoms.[57]

While Beckett maintained a fascination with the taxonomy of mental health, this interest did very little to foster a belief in the power of language to accurately represent disorder, and although in psychoanalysis Beckett found a language with which to articulate somatic and psychic experience, this language further obscured the meaning of his symptoms. The problem, it seems, is that the therapeutic encounter only helps the patient to establish the causes of suffering, rather than supplying a means for addressing them. Moreover, articulating illness and distress to the analyst makes the experience public. Discovering the causes of his symptoms in therapy, Beckett now had Bion as a witness to the suffering he had exposed. Being exposed and being witnessed were deeply troubling to Beckett and, it would seem, to the eponymous Murphy who was being written at the very same moment. *Murphy* not only helps me to understand Beckett's pursuit of a writerly voice and a philosophy of the world, it is also a text consumed with questions of care, what it means to be ill, and the influence the mind and body have upon their respective articulations.

In the opening scene of the novel, Murphy straps himself to his rocking chair:

> He sat naked in his rocking-chair […] Seven scarves held him in position. Two fastened his shins to the rockers, one his thighs to the seat, two his breast and belly to the back, one his wrist to the strut behind. Only the most local movements were possible […] He sat in his chair in this way because it gave him pleasure! First it gave his body pleasure, it appeased his body. Then it set him free in his mind. For it was not until his body was appeased that he could come alive in his mind, […] And life in his mind gave him pleasure, such pleasure that pleasure was not the word.[58]

The connection between Murphy's psychical state and his body is clear in this passage, as his body must be simultaneously bound and set in motion, so as to set his mind

[56] See letter written to Morris Sinclair in 1934 (Fehsenfeld and Overbeck 2009, 183).
[57] Yet Beckett also clung onto his symptoms. Russell Smith writes that Beckett feared psychoanalysis 'might be more debilitating than illness itself' (2016, 140). Smith also cites a letter written to MacGreevy (14 February 1935), in which Beckett professed: 'how lost I would be bereft of my incapacitation' (2009, 250). It seems that illness proved in some way beneficial to Beckett's creative project.
[58] Beckett, *Murphy*, pp. 3-4.

'free'. Psychical states are clearly influenced by the body's position and, in turn, the body's mobility can be influenced by the mind. The manner in which Murphy attempts to 'free' his mind relies upon, as Beckett puts it, Murphy appeasing his body. It is only by silencing his body that his mind can come alive and yet this all relies upon silence. Murphy's elaborate ritual, quoted above, is interrupted by Celia's telephone call and can only be resumed once Murphy is silent again. Murphy's rocking also crucially takes place in solitude and when he is discovered in Chapter Three he has attempted to conceal his actions, causing him to fall to the floor, chair and all. Moreover, his refusal to open his eyes to see who has found him further cloaks this encounter in secretive shame that is made all the more shameful when it is witnessed by somebody else.[59]

Being seen and being witnessed are crucial themes within the medical humanities, particularly for Charon, who claims that witnessing within the clinical encounter can offer a space for more effective communication between doctor and patient. She writes that 'what we learn from oral history and trauma studies is that this work of bearing witness does not do violence to the speaker, does not *interfere* in the telling, but rather is committed to active, respectful, confirming listening [italics in original].'[60] Witnessing, in this context is not judgemental.[61] The nature of the narrative that is witnessed, however, should be scrutinised. If reparation is dealt through testimonial narratives, these are narratives that are constructed on the terms laid out by the narrator. Yet we cannot assume the same of the clinic where, as this thesis argues, narratives are constructed based on the interpersonal and institutional pressures of the dominant voice in the clinical encounter: the clinic itself.

Chapter One: Performing Patienthood

In Chapter One I argue that Beckett's: *Play*, *Breath*, *Rough for Theatre II*, and *Catastrophe* can be used to explore the performative nature of both the clinic and

[59] I also read Murphy's absurd ritual with his rocking chair as a sardonic staging of the psychoanalytical encounter, in which the therapist's couch has been replaced by a rocking chair that farcically portrays the repetitiveness, the stasis and the fruitlessness of psychoanalysis.

[60] Rita Charon, *Narrative Medicine: Honoring the Stories of Illness* (Oxford: Oxford University Press, 2006), p. 180.

[61] Witnessing is a central term within trauma studies and twentieth-century narratology. Hanna Meretoja writes that post Second World War testimonial writing functions as a witnessing, and public sharing of trauma. The reparation that testifying brings is due, in part, to the fact that storytelling is public. The person who testifies is her own witness, or as Aleida Assmann has it, the testimonial narrator is both the narrator and listener. In order for testimony (or narrative) to fulfill a recuperative function, it is imperative that the narrator hears the story she is telling (Meretoja and Davis 2018, 205). Dori Laub writes that, 'the listener to trauma comes to be a participant and co-owner of the traumatic event: through his very listening, he comes to partially experience trauma in himself' (Shoshana Felman and Dori Laub 1992, 57), suggesting that the listener can also be an 'other', separate to that of the narrator. As she listens to the testimony, the listener is vulnerable to the same trauma that is being recounted. In psychoanalytical terms one might think of this as having similar effects to counter-transference, in that the analyst must acknowledge an unconscious overlap between 'self' and 'other'. What comes from whom, in any two-person relationship, is not always clear' (Casement 2014, 6).

patienthood. I read these theatre works as a mode of medical writing that help me to understand how patient identity is formed by the clinic, and how this differs from the construction of the healthy or 'normal' subject. If illness is seen as a violent disruption to the flow of life, this chapter asks, what can be claimed and reclaimed through medical writing and drama?

Clinical medicine is increasingly portrayed in popular culture, storytelling, drama and memoir, through the dramatization of the clinic by both patient, and doctor.[62] The proliferation of these texts is evidence of the popularity of the auto/biographical genre, and autobiography has played a crucial role in giving voice to those who have historically been denied one. Laura Marcus claims that autobiography is a genre used by women to assert their voices, in a societal structure that would otherwise leave them voiceless.[63] The difference between these texts and traditional auto/biography is that the clinical (pathological) becomes the primary focus of the text. Hunsaker Hawkins refers to these texts as pathography. The pathography is considered to be a distinctively twentieth-century form, which just like autobiography, has attempted to play an emancipatory role for its authors, by helping them to tell the story of their illness in their own language.[64] Pathography, according to Anne Hunsaker Hawkins, enables the patient to narrate her experience of illness outside the strictures of the medical world, offering an alternative story for those who, as sociologist Arthur Frank writes, are faced with the 'narrative wreckage' that illness leaves in its wake.[65]

This chapter focuses on the varying ways in which patienthood is performed. First, I use Beckett's *Rough for Theatre II* to illustrate how a patient's identity is constructed through clinical notes and documentation gathered by medical professionals. Second, through my reading of *Catastrophe* and *Play*, I consider the isolation and humiliation felt by many patients, as they are forced to interact with the clinic. It is through Beckett's movement toward abstraction that comparisons to the clinic can be so strongly drawn out. In closing this chapter, I argue that it is in Beckett's *Breath* that we see evidence of the 'narrative wreckage' which is left behind by illness.[66] The emphasis placed upon narrative throughout clinical discourse has become shorthand for meaning-

[62] There are a vast number of doctor's memoirs being published. These explore themes such as: the personal experiences of surgery, care giving and working within a national health service, featured in Henry Marsh's *Do No Harm* (2014), and end of life care and philosophies of death and dying, in Atul Gawande's *Being Mortal* (2014). A new thread of pathography includes texts written by doctors who have become patients, such as *When Breath Becomes Air* (2016) by Paul Kalanithi.
[63] Laura Marcus, *Auto/Biographical Discourses: Theory, Criticism, Practice* (Manchester: Manchester University Press, 1994), p. 2.
[64] Anne Hunsaker Hawkins, *Reconstructing Illness: Studies in Pathography*, Second (Indiana: Purdue University Press, 1999), pp. 11-12.
[65] Arthur W. Frank, *The Wounded Storyteller* (London: The University of Chicago Press, 1995), p. 55.
[66] Frank, *Wounded Storyteller*, p. 55.

making. In each of these plays, narrative is stretched, obscured and problematized to such an extent that the question of meaning-making is ironized.

The clinic can be understood as a space that both isolates and encroaches upon the patients within it. Through its architectural and interior design, the hospital has historically ordered patients according to their pathology, and yet it still prevents or inhibits patients from collectively engaging with one another to share their experiences of illness. Frank writes that medicine produces 'monadic bodies' that are gathered close enough together to compromise their privacy, and far enough away from one another to prevent meaningful interactions.[67] Naoya Mori discusses the monadic qualities of Murphy's mind, which he attempts to keep hermetically sealed. Mori writes that Beckett's early writing was strongly influenced by Leibniz's *The Monadology*. Murphy is a clear example of Leibniz's monad, but a failed one of course, as Mori says, '[w]hile he [Beckett] follows Leibniz, in that each monad is isolated, self-contained and has no interaction with others […] he reverses Leibniz in that the Beckettian monads are far from being in harmony'.[68] Like the monadic body of the patient, Murphy is both concealed and embroiled within the disharmony of the outside world. While Leibniz writes that, '[t]here is no conceivable way in which a monad could be inwardly altered or changed by some other being than itself', Frank's monad, and Murphy too, remain vulnerable to the effects of a world which encroaches upon them.[69] Murphy's monadic nature thus represents an aesthetic of isolation, which is evident in Beckett's works from the beginning, and is most significant here, as Murphy occupies a clinical space.

It seems, then, that the identity of the patient as one among many monadic bodies suffers precisely because she cannot protect herself from within the clinic, and moreover, the patient is constructed through her interactions with it. In *Rough for Theatre II*, C is made manifest through the written word, as dictated by his quasi-clinical environment. M, W1 and W2 in *Play* are bound together in this purgatorial space recounting their individual and fragmented narrative, and Protagonist in *Catastrophe* is defined by his name and location within the theatre. It is only by entering the theatre that Protagonist acquires his identity. Just like the patient — who is only defined as such within the clinic — the institution defines his role. Bodies and body parts are continually abstracted, to such an extent that in *Breath*, the body is removed from the stage and is replaced by a flattened heap of debris.

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[67] Frank, *The Wounded Storyteller*, p. 36.
[68] Naoya Mori, 'Becket's Windows and the Windowless Self', *Samuel Beckett Today / Aujourd'hui*, 14.After Beckett / D'après Beckett (2004), 357-70 (p. 366).
[69] Gottfried Wilhelm Leibniz and Herbert Wildon Carr, *The Monadology of Leibniz* (London: The Favil Press, 1930), p. 38.

Where does the patient belong? How and with whom do they act? And how are these actions to be understood in temporal and spatial terms? Narrating the patient is a challenge that extends beyond the patient's inability to voice her individual experience to a clinician, and is instead mediated and constituted through myriad infrastructural and seemingly peripheral interpersonal influences.

Chapter Two: Aphasic Storytelling and Anti-narrative in *The Unnamable*

In Chapter Two I extend the question of whether the body can be narrativised to consider whether it ought to be. I argue that by placing such a great deal of emphasis on narrative, we fall victim to the belief that there is inherent value in pursuing narrativised representations of the subject, in accordance with medicalised narrative codes. This chapter reads the final novel of Beckett's trilogy *The Unnamable* as an aphasic text, to understand the implications of narrating experiences in a language that does not belong to the subject. The narrator of *The Unnamable* succumbs to the dominant voices that surround and emanate from him, so that he is no longer in full control of the story that he tells. This chapter argues that in telling one's story, the patient remains vulnerable to the colonizing forces of the clinic. As the patient constructs her story, her language is moulded by the clinical space in which it is constructed.

Language does not happen in a vacuum: it relies upon organs of speech and neurological processes, but also depends upon interactions with other bodies in order to be constructed and communicated. Language is positioned both inside and outside of the body. It forms a connecting bridge between subjects, but the bridge itself is also made of language.[70] By focussing my reading on the neurological language disorder aphasia, I claim that the subject's relationship to language is always disordered, even for those whose language functioning is so-called 'normal'. This chapter argues that representations of disordered language can offer a template for the process of narrativisation overall. Language always fails to fully represent, and the body that produces language is always inherently incomplete, as it draws upon the outside world in order to complete its story. In this chapter, I chart aphasiology's development from locationalist approaches to John Hughlings Jackson's work on propositional speech, which argued that subjects with aphasia affect a process of linguistic substitution that shares many of the qualities associated with non-pathological language function. Laura

[70] Anthropologist Roger Bartra claims that the individual brain is incomplete in its natural state and so relies upon a cultural 'exocerebrum' that acts as a skin and interconnecting tissue, supporting the body and enabling connections between bodies (2014). The 'exocerebrum' is a network that feeds back into the subject, making her conscious. Consciousness, therefore, cannot take place in isolation.

Salisbury and Chris Code have similarly read Beckett's work in conjunction with Hughlings Jackson's to claim that aphasiology offers an insight into our speech, which counter-intuitively is 'not under ongoing, moment-to-moment control' and that Beckett's use of language is expressed through similarly embodied and uncontrollable utterances.[71] For my purposes, Hughlings Jackson's work is vital to understanding that the differences between normal and pathological speech are far more difficult to distinguish, and that non-pathological language function is far less fluid than one might have assumed. Illness does not interrupt narrative, but rather narrative and language are interrupted from the start.

Illness thus constitutes itself through language, and by doing so the clinical encounter remains focused on what can be easily articulated or what is already known about the patient's experience and condition. This forecloses the opportunity for the patient and clinician to explore the experience and nature of disease in new ways. Again, I am in discussion with the Foucauldian view of sign and symptom as understood within the clinic, only in as much as they are able to produce an 'intelligible syntax'. That disease should be discussed in such grammatical terms is embedded within the violence of the clinic, and is distilled in the combination of the spoken and the seen characteristic of clinical encounters. Foucault writes:

> In the medicine of species, the nature of disease and its description could not correspond without an intermediate stage that formed the 'picture' with its two dimensions; in clinical medicine, *to be seen* and *to be spoken* immediately communicate in the manifest truth of the disease of which it is precisely the whole *being*. There is disease only in the element of the visible and therefore statable [italics in original].[72]

Illnesses are discussed using biomedical discourse and this specific discourse has its own narrativisation. Moreover, diagnoses rely upon previously known and perceived characteristics. The clinician and the patient narrate disease differently, and I argue that the way the clinic narrates disease has come to dominate the patient's narrative.

The rise in a literary medical writing and pathography has been led by the illness story, as told by the patient. This story of storytelling must be complicated however, to account for the multiple influences affecting a narrative, as the clinician and patient's interaction is not the only element that shapes our understanding of disease. The subject is manifested in the spaces between bodies, as well as within the body. Judith Butler writes:

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[71] Salisbury and Code, 'Jackson's Parrot', in *Talking Normal*, ed. by Eagle, pp. 100-23 (p. 110).
[72] Foucault, *Birth of the Clinic*, p. 116.

> The body is constituted through perspectives it cannot inhabit; someone else sees our face in a way that we cannot and hears our voices in a way that we cannot. We are in this sense — bodily — always over there, yet here, this disposition marks the sociality to which we belong. Even as located beings, we are always elsewhere, *constituted in a sociality that exceeds us* (my emphasis).[73]

The environment in which the body is positioned constitutes the body's meaning. It must be seen and heard by both the subject and those who interact with it, but it seems as though the body is always slightly out of reach. Thus, listening to the body that cannot be accessed, and which is 'always elsewhere', proves impossible.[74] It is with this renewed interest in listening that I move to the second half of my thesis, in which the body that is heard is out of sight.

Chapter Three: Chronic Listeners and Beckett's 'heartsink' Patients

My third chapter addresses the problems and possibilities of listening. The interpretive acts required of Beckett's work for radio, and his use of audio technologies, provides particular insights into listening within the clinical encounter and material space. From his choice to write for radio to his work in television and film, Beckett's interest in media technologies informed and influenced his formal and stylistic choices. Maude writes that audio technologies offered Beckett a unique opportunity, 'to utilise sound, as opposed to purely linguistic expression.'[75] I argue that sound recording takes Beckett's work beyond the linguistic, and transforms sound into embodied acts, so much so that what is heard, and the means by which it is transmitted, takes on embodied qualities that alert us to what is and isn't listened to. By removing the visual, Martin Esslin claims that Beckett was able to 'eliminate much that was superfluous in his work, in favour of a privileged interiority.'[76] In this chapter, I argue that radio offers the listener a privileged materiality that forces its listeners to attend in significantly different ways. Foucault writes, '[t]he clinical gaze has the paradoxical ability to *hear a language* as soon as it *perceives a spectacle* [italics in original].'[77] This crucially visual spectacle, he argues, shaped the language used to describe and discuss it and as such he entangled together seeing and knowing. It is the task of the clinician to listen so that she can care for her patient, but listening is challenging because it has to overcome the dominance of

[73] Judith Butler, *Notes Toward a Performative Theory of Assembly* (London: Harvard University Press, 2015), p. 97.
[74] Ibid.
[75] Ulrika Maude, *Beckett, Technology and the Body* (Cambridge: Cambridge University Press, 2009), p. 47.
[76] Ibid., p. 48.
[77] Foucault, *Birth of the Clinic*, p. 132.

the visual. Listening is both passive and active, whereby the listener is encouraged to interpret what is heard and rearticulate it. The clinician's actions not only affect what is communicated, but also what is heard. Charon writes that the clinician must acknowledge her responsibility, not only to listen to the patient, but also to remain mindful of her own interpretation and representation of what she hears.[78] It is no surprise that the clinical encounter is filled with multiple speakers. However, as many speakers encounter many listeners, each in turn a speaker, the clinic is a performative space in which to engage with patient narratives. This chapter explores the tensions between listening and hearing by using Beckett's works in which auditory interactions are staged. Beckett's manipulation of recorded sound in his use of radio and his representation of recording devices on stage, make listening a problematic rather than a revelatory event.

In his essay *Listening*, the philosopher Jean-Luc Nancy draws distinctions between '*écouter*' (to listen) and '*entendre*' (to hear), to argue that both acts fulfil and attempt to fulfil different objectives.[79] Where in French '*entendre*' also means *'comprendre*', hearing thus has an embedded sense of understanding within it. In this sense hearing, as Jo Winning writes, 'denotes a process in which the listener has already presupposed the meaning of the sound she encounters.'[80] In the clinic, the clinician hears for the purposes of understanding (to *entendre* or to hear) a presupposed meaning rather than listening (*écouter*) which Nancy sees as an attempt to find meaning 'that is not immediately accessible.'[81] His distinction thus has implications for a clinical encounter, in which meaning-making and comprehension are central, and affect the kind of clinical care delivered to patients as the clinician only seeks out presupposed meanings. Nancy's thesis attempts to unearth a new approach to listening, one in which we listen in order to hear and not to understand. He asks:

> What secret is yielded — hence also made public — when we listen to a voice, an instrument, a sound just for itself? [...] What is at play in listening, what resonates in it, what is the tone of listening or its timbre? Is even listening itself sonorous.[82]

[78] Rita Charon and Martha Montello, 'Introduction, Memory and Anticipation: The Practice of Narrative Ethics', in *Stories Matter: The Role of Narrative in Medical Ethics*, ed. by Rita Charon and Martha Montello (London: Routledge, 2002), pp. iv-xii (p. ix).
[79] Jean-Luc Nancy, *Listening*, trans. by Charlotte Mandell (New York: Fordham University Press, 2007), pp. 5-6.
[80] Jo Winning, 'Afterword: The Body and the Senses', in *Edinburgh Companion to the Critical Medical Humanities*, ed. by Whitehead and Woods, pp. 325-35 (p. 331).
[81] Nancy, p. 6.
[82] Ibid., p. 5.

Within a verbal exchange listening has its own sounds, and thus its own characteristics. Listening also crucially occupies a space. The listener is in space and also of it, or rather, as psychoanalyst Didier Anzieu writes, 'auditory sensations prepare the Self to form a structure that incorporates the third dimension of space (orientation, distance) and the dimension of time.'[83] In *The Unnamable*, the narrator illustrates this dichotomy in aural and spatial terms when he says:

> I am the thing which divides the world in two, on the one side the outside, on the other the inside, that can be as thin as foil, I'm neither one side nor the other, I'm in the middle, I'm the partition, I've two surfaces and no thickness, perhaps that's what I feel, myself vibrating, I am the tympanum, on the one hand the mind, on the other the world, I do not belong to either.[84]

Listening takes on even richer significance here, as it is manifested in both surface and subject, and the listener and the sound. The narrator is a reverberating surface that absorbs and articulates exchanges between the inside, and outside, and itself forms the inside and outside.

I will explore how a listener is affected by hearing sounds, which are simultaneously invisible and embodied. I begin with Beckett's first radio drama, *All That Fall*, which follows the journey taken by Maddy Rooney to collect her husband Dan from Bog Hill station. Building a cacophonous soundscape of gasps, laboured breathing, dragging feet and tapping canes, *All That Fall* is, as Maude claims, a contradictory offering of characters whose physical presence remains unseen and thus offers the characters 'some respite from the constraints of embodiment,' while using experiments with sound to emphasise a 'subjectivity firmly within a material context.'[85] The radio-phonic body is no less material than the visible body, and I argue that aural representations of the body make the listener all the more aware of a subject's corporeality. In *All That Fall*, the sounds that Maddy's body makes seem to defy duplicity because they are involuntarily emitted. Unlike speech, these sounds are unconsciously or pre-consciously produced, so that they appear to both circumvent intention — including the will to deceive — as well as avoiding the signifying slippage between speech and its referents. Maddy's expressions are not mediated at the point at which she expresses them, and it is only in the hearing that these sounds take on more complicated characteristics. Crucially, the subject that produces such sounds does not

[83] Didier Anzieu, *The Skin Ego*, trans. by Naomi Segal (London: Karnac Books ltd., 2016), p. 173.
[84] Samuel Beckett, *Three Novels: Molloy, Malone Dies, The Unnamable* (New York: Grove Press, 1958), p. 376.
[85] Maude, *Beckett, Technology and the Body*, p. 48.

ask to be listened to while making them. Beckett's work for radio is abundant with incidental sounds, which are accompanied by the incidental sounds of the radio medium. The hissing of radio static, in addition to the various sound variances between voices and other recorded sounds such as music (and in the first recording of *All That Fall*, the recorded sounds of animal calls, replicated by actors), are an unmediated product of the medium. So while these sounds appear to flout duplicity, they become more apparent when mediated through the radio device:[86]

By examining the affective responses to listening to bodies, I want to consider the difficulties of listening within a clinical encounter that relies so heavily on the visual as a means by which to deliver care. Winning asks in light of clinical medicine's propensity toward the visual: 'Is medicine capable of listening'?'[87] Where Winning charts the history of the body in Western medicine as one which must be opened and made visible in order to be understood, this approach to healing equates what is seen with what is known.[88] Clinical medicine fails to listen, not because it is incapable of doing so, rather, the emphasis on understanding (even described in the English language in visual terms: 'I see') is instead to perceive, and to view.[89] The clinician's emphasis on observation renders the patient passive. While what is observable may be 'statable' in the clinical encounter, the question of who sees and who states is imperative.[90] Ultimately, the interpretive and decision-making powers lie with the clinician, and encounters between clinicians and patients take place in spaces that are similarly limiting.

All That Fall and *Krapp's Last Tape* both stage encounters that are bound by the constraints of their audio environment. But it is their specific employment of sound and its mediation through audio devices that creates embodied aural subjects. The body has a way of speaking up and sounding out its own agency in defiance of the clinical stage on which it is set.

Chapter Four: Beckett's Reluctant Voice-Hearers

Beckett's works offer portrayals of the subject and clinical institution that, through their very interpretation, produce new views of the clinical encounter and the space in which

[86] Other examples include, the whistling sibilance of Gorman's ill-fitting dentures in *The Old Tune* (1963), the sounds of inanimate objects such as the '*swish and thud of pizzle on flesh*' in *Rough for Radio II* (1976), and the clicking of the dials that She turns in *Rough for Radio I* (1961).
[87] Winning, 'Afterword', in *Edinburgh Companion to the Critical Medical Humanities*, ed. by Whitehead and Woods, pp. 325-35 (p. 331).
[88] Ibid., pp. 330-31.
[89] Jo Winning, citing Alexis Brook (Whitehead and Woods 2016, 331).
[90] Foucault, *Birth of the Clinic*, p. 116.

such encounters take place. My final chapter explores docile bodies and the staging of unusual auditory phenomena in *Eh Joe, Not I, Footfalls* and *Ohio Impromptu*. The clinician and patient's bodies are rendered docile by the environment in which encounters are staged.[91] There are shifting power imbalances between voice-hearer and her voices, between the voice-hearer (patient) and her clinician, and between the clinician and the healthcare systems in which they operate. In this chapter, I want to consider how these power shifts can be examined through performance. The theatre, like the clinic, is an institution that requires the interaction of bodies and speakers with both common and individually motivated agendas. Where patient and clinician face potentially conflicting agendas and power imbalances, similar relationships are drawn out between actors and directors, and even between actors and their characters. Yet, it should be noted that these similarities have their limits, as the theatrical space is one where there is an audience, and the clinical not and fundamentally the expectation of the audience is to be entertained, where the patient wishes to be cured. However, clinical and theatrical agendas are revealing in their dissimilarity as well as resemblance. The implications of my argument are much larger for the clinic than for theatrical performance as ultimately reforming the clinical domain affects patient care and encounters, but this dissimilarity does not inhibit reading systemic challenges within the clinic through Beckett's staging. Rather, the stage offers a model for thinking through power imbalances that are performed through a particular infrastructure. It is analysing performance and performing according to institutional codes that enables me to examine performativity within clinical spaces, which has been hitherto overlooked.

The character Mouth in *Not I* is useful, as she has come to represent not only the mental and physical pain that the character experiences in the play, but also the pain and mental torture experienced by the actor performing the role. The actor Billie Whitelaw, who first played Mouth at The Royal Court in 1973, collapsed during rehearsals and later claimed that, like all her performances of Beckett's work, *Not I* left a 'little legacy behind in [her] state of ill-health'.[92] The sheer dynamics of force at play through the practice and performance of such drama, not only stage illness but also induce it. Lisa Dwan, who has also played Mouth, attests to the terrifying force of the performance on the body. Within this fourth chapter, *Not I* helps me to explore the subjective experience of voice-hearing. Performing voice-hearing, I argue, is achieved through the presence of bodies (or body parts) that emit both sound and speech, as though these sounds were

[91] Winning, 'Afterword', in *Edinburgh Companion to the Critical Medical Humanities*, ed. by Whitehead and Woods, pp. 325-35 (p. 331).
[92] Billie Whitelaw, *Billie Whitelaw... Who He?* (London: Hodder & Stoughton, 1995), p. 131.

located elsewhere, or belonged to someone else. It is here where *Not I* offers a model for the clinical encounter, as the words that the voice produces cannot be fully attributed to the mouth that utters them. In a clinical context when a patient is asked to narrate her experience of hearing voices, she is often asked to locate the voice in spatial terms. That these voices are part of the subject, but also over there is fracturing and can be distressing for patients who seek acknowledgement that the voices they hear are theirs, and should be listened to. AVHs break through accepted boundaries within the body and the mind — they manifest in a place that is out of reach — and it is this confusion of listening and articulation that connects Beckett to the clinic.[93]

This chapter also examines the patient-led Hearing Voices Movement (hereafter HVM), which has emerged in opposition to clinical models of treatment and diagnosis of schizophrenia. The HVM rejects the notion that the voice-hearer needs to recover from her symptoms and argues instead that the patient needs to work to recover from her diagnosis. It is the diagnosis that does more harm to the schizophrenic patient than the experience of voice-hearing. The dominance of clinical discourse is such, however, that many patients find it difficult to listen in on their own voices, which may in fact prove to be a more successful method of appeasing the symptoms of voice-hearing. *Not I*'s Mouth portrays the experiences of the voice-hearer who cannot listen and speak, but who similarly rejects the voice that she hears. Beckett claims that *Not I* was specifically designed to '"work on the nerves of the audience"', but it is not only the audience's nerves that are tested.[94] The actor playing Mouth also feels the burden of this outpouring. Mouth confounds the idea of what a body should be on stage and how a body should express itself, while similarly forcing us to question our preconceived notions of what an actor should be asked to do and how an actor should be expected to perform.

May in *Footfalls* experiences a similar phenomenon as she is compelled to tell her story over and over again, and yet she tells it as though it were someone else's. May creates her characters in her image: the narrated version of herself is Amy (a clear anagram of May). Within the clinical encounter the patient's story is often distanced in order that it can be better articulated, and so through *Footfalls* we can see the staging of storyteller and listener in a single subject. While storytelling may seem to offer her some hope to break free from her stasis, May is bound by storytelling to continue to

[93] Woods describes schizophrenia as, the 'sublime object of psychiatry', in part because it cannot be clearly located. It is the 'limit point' that remains out of reach (2011, 15).
[94] *The Faber Companion to Samuel Beckett: A Reader's Guide to His Works, Life, and Thought*, ed. by C.J. Ackerley and S.E. Gontarski (London: Faber and Faber, 2006), p. 411.

'revolve it all', and is encased and frozen within her own narrative. The patient story evolves, but the way that patient narratives are constructed remains static, so that over time there is an increasing discrepancy between the narrative recorded, and the patient's lived experience. It remains uncertain as to who is responsible for telling the story and moreover, which systems and agents have been involved in the conditions of its making.

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This thesis endeavours to entangle rather than cure. If it is true that 'narrativity is the precondition of epitomising and reflecting on illness', then I argue that we should question the efficacy of such preconditions.[95] Through an emphasis on narrative and storytelling the medical humanities has so far attempted to enrich the practice of medicine through language, but some questions have been rarely asked: to whom does this language belong, and how do the agents and spaces in which language is produced affect its construction? For Samuel Beckett language was both the beginning and the end of expression, but it was also only one means of expression. By shifting the emphasis to listening, I argue that we are better placed to reveal and confront the challenges faced by patient and clinician alike in a cacophonous clinical encounter.

[95] Brian Hurwitz and Victoria Bates, 'The Roots and Ramifications of Narrative in Modern Medicine', in *Edinburgh Companion to the Critical Medical Humanities*, ed. by Whitehead and Woods, pp. 559-76 (p. 559).

Chapter 1

Performing Patienthood on Beckett's Clinical Stage

‘Where do they put the skull bone while they’re working inside?’ Samuel Beckett asked Lawrence Shainberg in 1980, ‘How is the skull removed?’[1] Fascinated with, as Knowlson puts it, ‘medical matters. Anything abnormal, unusual or macabre’, Samuel Beckett’s writing, from the very beginning, found its site in the body: the medical body; the atypical body, and the failing body.[2] Hailed for his exploration of the failing mind and the insistence of the subject to keep on keeping on, Beckett’s work revealed a somatic existence, bound to *and by* the performance of its Being. In a conversation with Shainberg, Beckett said, as though he had realised it only now, for the first time at the age of 76 that:

> With diminished concentration, loss of memory, obscured intelligence — what you, for example, might call ‘brain damage’ — the more chance there is for saying something closest to what one really is. Even though everything seems inexpressible, there remains the need to express.[3]

The body’s failure was — indeed had always been — an area of opportunity. The brain’s slow damage rather than stilling and inhibiting expression, seemed only to make it more necessary. That this realisation had in many ways been articulated not only in Beckett’s creative works throughout his career, but also in his letters and dialogues with other artists and writers, offers insight into the need for repetition, not only as a rediscovery, but also as the performance of that need to express. The body’s internal and external movements, indeed, its fleshliness, create a somatic language, which can neither be controlled nor contained. The body has its own language, its own tones and timbre, which play out through its failings. Viewing this somatic language from the other side, Salisbury writes that:

> Beckett was insistently to imagine language in terms of bodily functions that, though hardly expressions of an intending mind, are rarely fully automatic. The body’s oozings and excreta are, instead, more accurately understood to be highly susceptible to the formation of habits that can subserve a person’s purposes, even as they always bear within themselves the threat of an uncontrolled emission.[4]

I begin this chapter with the recognition that automaticity, purpose and the oozings of the body come together within Beckett’s creative practice and production. Medical

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[1] Lawrence Shainberg, ‘Exorcising Beckett’, *The Paris Review* (1987) <https://www.theparisreview.org/letters-essays/2632/exorcising-beckett-lawrence-shainberg> [accessed 2 November 2017] (para. 4).
[2] Knowlson, p. 668.
[3] Shainberg, ‘Exorcising Beckett’, para. 5.
[4] Laura Salisbury and Chris Code, ‘Jackson’s Parrot: Samuel Beckett, Aphasic Speech Automatisms, and Psychosomatic Language’, in *Literature, Speech Disorders, and Disability: Talking Normal*, ed. by Chris Eagle (New York: Routledge, 2014), pp. 100-23 (p. 106).

matters may have always been of interest to Beckett, but the ways in which they are understood to be medical, as opposed to personal, brings us into contact with the spaces and contexts in which the medical is most commonly implicated: the clinic. The Beckettian subject is founded within the clinic and enacted through it, both in terms of Beckett's own biographical influences on his work and his interest in the construction of the subject within therapeutic and clinical spaces. 'The client is here and nowhere else,' says Morvan in *Rough for Theatre II* as he leafs through the dossier of documents regarding C, who stands on the ledge of an open window looking onto the world outside.[5] The stories of his life are contained within the building, while his previous life resides out there through the casement.

Medical spaces such as these are liminal places into which bodies come and go and subjectivities are entangled and separated from one another. These spaces open and close, with a similarly porous quality to the leaky bodies in Beckett's works and, moreover, his leaky body of work. Characters such as Molloy, Malone, Murphy, Mercier, Camier and Watt, spill over from one text into another, appearing reformed, churned by the body of the work into new, but recognisable shapes. They weep 'liquefied brain', they dribble and spit and vomit and they produce insistent 'wordshit'.[6] As they leak, body matter moves through and across boundaries within the body, which might well have been perceived as guarded if not entirely impermeable. The body is abstracted in one instance, material in the other, consisting of an array of tubes and tissues with a 'soft and slimy' brain housed in the skull's interior.[7]

Beckett's question to Shainberg: 'Where do we put the skull bone', is so striking as it couples the complexity of neurosurgery with the unthinking body and its excess matter. The brain is information rich but mute, the creator of language while silent, and the architect of feeling and yet unfeeling. It is from Beckett's fascination with the brain and the brain in a clinical context that I want to understand how Beckett's works might give rise to a new form of medical writing.

In this first chapter, I want to begin by considering the ways in which Beckett's view of failure offers an opportunity to view the medical body — and the subjectivity of that body — as 'patient', both in clinical and creative contexts. How do we trace a line between these two fields, from the clinical encounter to the literary works of Samuel Beckett? What is the clinical encounter in this instance and what encounters could be

[5] Samuel Beckett, *The Complete Dramatic Works* (London: Faber and Faber Limited, 1990), p. 246.
[6] Beckett, *Three Novels*, p. 287 and Samuel Beckett, *Texts For Nothing and Other Shorter Prose, 1950-1976*, ed. by Mark Nixon (London: Faber and Faber, 2010), p. 37.
[7] Laura Salisbury, ''What Is the Word': Beckett's Aphasic Modernism', *Journal of Beckett Studies*, 17.1–2 (2008), 78–126 (p. 119).

deemed as clinical in his work? Moreover, how might the clinical be reimagined, reformed or articulated anew? This chapter argues that the role of the patient is contingent upon the existence of the clinic and that in adopting the role of patient, the subject is required to submit to a performance of her patienthood. The first section of this chapter, 'Encountering Clinics', begins by establishing some key definitions including the 'clinical encounter' and 'patient', in order to explore the topology of the ill subject who engages with the clinic. I argue that through a more detailed understanding of the etymology of 'patient', we gain greater insight into the expectations of the subject as a 'patient'. That is, a subject who is required to submit to and undergo the actions of the clinic. The theatre shares these characteristics, and using Beckett's later play *Catastrophe*, I show that the politics and practices of the institute — like that of the clinic — require its players to adopt roles, which occlude their subjectivity and strip them of their agency.

In section two, 'Patient Voices', I draw upon the contemporary rise in documentary, memoir and pathographical literature concerning the patient and doctor experience. The increasing popularity of the genre, I argue, is symptomatic of the rise in patient-led movements (which I shall explore further in Chapter Four) within mental health and also the broader popularization of testimonial-based entertainment and cultural production. In an attempt to reassert their authority, which has been lost through their engagement with the clinic, these patient voices subvert traditional medical narrative tropes, and provide alternative narrative forms through which to articulate the patient experience. These patients co-opt the autobiographical genre, which has historically offered the writer the opportunity to give a voice to hitherto unheard or underrepresented experience, for the purposes of telling illness stories. I will use Beckett's *Rough for Theatre II* to examine how patient identity is constructed through medical writing, and how patient care is impacted by the clinical documentation recorded and collected that concerns them. As the patient rarely contributes to a patient's notes, the documentation regarding her case seldom accounts for the personal and emotional consequences of her illness. Moreover, the language used to describe the patient belongs to the clinician. The function of narrative within medicine and the so-called narrative turn across a multitude of disciplines, not least medical humanities, leads me to question the efficacy of storytelling as a means of understanding and listening to patient experience. I will explore this further in Chapter Two through the narrator of *The Unnamable*, but here I want to examine how Beckett's work performs the narratable patient, whose experience can be rendered in narrative forms. His

preoccupation with the failing and aging body is not intended to simply show the devastating effects of decline, but rather to unsettle the received idea that any body exists as stable, autonomous and contained.

The medical narrative structures, which appear to dominate the pathographical genre, are those of the fight against illness, and the quest toward health. In Beckett's works, however, as I shall show in section three of this chapter, 'Clinical Quests', Beckett's characters invert the quest narrative, as they struggle towards nothingness. What remains, despite the shortcomings of narrative and language, however, are more storytelling and more words. There is a compulsion towards speech and narrative through Beckett's interrogation of its problems and failures. One of the problems, however, is that within narrative-based models of healthcare, a narrative can only be successful if it is heard and understood. What constitutes being heard and understood is not as simple as clinical definitions might have one believe. In the fourth section of this chapter, 'The Heard and Understood', I use the work of Charon to argue that the clinical consultation is consistently open to distraction and requires that the clinician become 'porous' to the narratives of the patient. The body and its stories are formed by the space that it occupies and in the fifth section of this chapter, 'Staging Spaces', I argue that by entering into the clinical space the patient is not only forced to adopt the role of patient, based upon the dominant clinical discourse within the clinic, but also that the design and space of the clinic governs the behaviours and encounters which take place within it.

Hospitals create what Frank has referred to as 'monadic bodies', which sit in close proximity to one another while being unable to communicate and share in their experiences of illness.[8] The clinical space is both intrusive and alienating, and the patient's encounter with the clinic renders her silent. I will explore visualisations of the clinic through Damien Hirst's 2000 adaptation of Beckett's piece *Breath*, which represents the clinical environment as a hostile wasteland filled with a detritus of medication and waste. Finally, in section six, 'Chronically Clinical', I consider the ways in which chronic illness confounds and subverts clinical medicine's expectations about illness' narrative progression. This chapter, then, defines patienthood as performed through the narrative codes, institutional hierarchies and clinical spaces in which she, the patient, finds herself. The Beckettian subject functions here as both the voice of the suffering patient and the clinical landscape, which facilitates the passivity of patienthood.

[8] Frank, *Wounded Storyteller*, p. 36.

Encountering Clinics

A clinical encounter should be understood as an encounter between a healthcare provider/practitioner and a patient. That the clinical encounter might require an interaction with a subject who is identified, or identifies as a patient, is problematic. By presuming that the subject automatically adopts the role of 'patient' we already presume too much. The expectation that a patient should identify as such within the clinical encounter is increasingly resisted, and as we shall see later in this thesis, there are growing movements toward new 'patient'-orientated taxonomies which position themselves in opposition to medicalised terminology.[9] Within this chapter and the thesis beyond, the 'patient' will be a contentious and limiting term as I explore the identity of 'service users' who may be associated with patients, or, indeed, those that may not view themselves as patients in the first place. The 'patient', then, becomes an all-encompassing term for the other (non-medical) half of an exchange with the clinical. Patients' identities are defined by the other, or that which they are not, as they form part of a complex network of speakers. 'Subjects', 'patients', 'service-users' and 'end-users' are all terms adopted by the clinic and healthcare systems, though their interchangeability should not be assumed. Instead, these roles are defined within the context in which we find them.

The foreclosed identities of both the clinician and the patient are increasingly challenged within the work of medical humanities, and the implications of assuming these roles without question means that I want to argue for further interrogation of the nomenclature used by the clinic. Similarly, the identity of many of Beckett's characters appears as foreclosed as that of clinician and patient. In his later theatre plays *Ohio Impromptu* and *Catastrophe*, characters are defined by their roles using functional names. They are Listener, Reader, Protagonist, Director and Assistant, and within their respective dramas their positions and agency are constrained by such titles. They come to define themselves by their roles within this specific context, which is governed by the institutional forces at play. The lateness of these plays may itself be telling. Written at a time when Beckett was increasingly blighted by illness and making regular visits to hospitals, his own experience of the clinic — this time biomedical as opposed to psychotherapeutic — could be said to inform his own characterisation.[10] As I shall show

[9] Despite its transactional connotations, 'end-user' might be a more appropriate term. However, I will continue to use 'patient', as it is clearly the most common word given to the ill person who engages with the clinic, across the literature cited throughout this thesis.

[10] After falling in his kitchen in the summer of 1988, Beckett underwent a number of tests, which while inconclusive, seemed to suggest that like his mother, he had developed Parkinson's disease. Beckett was then transferred from hospital to a 'hotel and medical retirement home' not far from his apartment in Paris (Knowlson 1996, 700).

later in this chapter, labelling a subject as a 'patient' has a flattening effect on the subjective identity of the person in illness. Samuel Beckett was no stranger to illness, having spent much of his late twenties and early thirties battling with an array of psychosomatic symptoms that were at times completely debilitating. His pursuit of a cure for these symptoms shows clearly his interest in relieving himself of suffering, and yet in cutting short his therapy sessions which were proving useful in appeasing his symptoms, there is something to suggest that Beckett was happy for a little of his mental — if not physical — disquiet to linger. In his youth, his own body oozed, shook and pushed outward in a way that perhaps his language could not. For the aging Beckett however, it is the diminishing of his body's mobility and the slowing down of his mind which seems to facilitate a better, or at least more honest expression, as he said to Shainberg, 'something closest to what one really is', and as a result he begins stripping down his characters to their essential function.[11] While the allegorically named characters are at their most explicit in these later pieces, throughout Beckett's work he inverts allegorical forms of storytelling. Playing with narrative expectations, Beckett resists the tropes and assumptions of quest narratives and within his theatre works he subverts and challenges the institutions that produce such drama. *Catastrophe* not only mimetically questions the state of the theatre, but also implicates the spectator in its torture of the Protagonist. The audience's acceptance of the abuse that Protagonist is subjected to, in the name of drama, causes us to question the morality of the institution as a whole.

Within the clinical encounter, the patient's role remains strikingly limited in contrast to that of the clinician, and where the clinical encounter appears to offer a multitude of identities and functions to the clinician, the patient is given relatively few. Healthcare professions are defined and differentiated from one another in ways that a patient comes to understand well. Services are separated into specialisms, and there are various hierarchical structures in place within the clinic. For the most part patients will have a vague understanding of the difference between their registrar and their consultant. They understand that their nurses and doctors have different expertise, or that the anaesthetist is responsible for a different aspect of care than their physiotherapist. Part of the initial stress of becoming a patient, however, is that one must learn these distinctions and roles, while also contending with the symptoms of one's condition. In order to be able to navigate the clinic one must learn its language and its codes. Faced with time in the clinic or hospital, such roles and statuses do become apparent and they are signified,

[11] Shainberg, 'Exorcising Beckett', para. 5.

even through the clothing worn by different specialists. The patient, however, is offered no such distinctions. It is vital that patients learn their own role quickly, so as to be able to navigate the clinic, but it is precisely this period of unknowing, coupled with the ambiguity of their position and agency within the clinic, that induces such anxiety in patients. By subdividing patients according to their symptoms and diagnoses, however, it is easier to determine the patient's role within the hospital.[12] Moreover, as hospitals struggle to accommodate increasing numbers of patients, even these distinctions according to medical conditions have become harder to accommodate. Instead, wards contain disparate and yet homogenised groups of patients, so that there is little opportunity for them to collectively experience and discuss their symptoms. The patient is now one of many in a ward, with no fellow sufferer experiencing the same condition as her to share her experience with. In addition, although patients may be admitted to the hospital with one condition, they may face further complications to other parts of the body, meaning that they now struggle to associate themselves with any one patient group.

The word 'patient' has multiple origins and myriad definitions: from the second half of the fourteenth century, 'patient' (adj) is defined as 'enduring hardship without complaint' and from a similar time period 'patient' (adj) is understood in philosophical contexts as 'undergoing an action'. The 'patient' (noun) is a person who likewise undergoes some action. The definition that proves most useful for my own understanding of the word is: 'use as adjective of present participle of patī to suffer'.[13] The patient is thus a sufferer, and often a stoical one. To be patient is to endure and undergo and to be a patient is to suffer that undergoing. What remains out of sight, however, are those actions undergone, and the ways in which they are endured.

To become the patient — to take the noun — is to have one's identity flattened out and in the clinical context, where nosological classifications might be used to differentiate one patient from another, we do not find this distinction in the definition of the patient herself. Beginning with eighteenth century approaches to diagnosis, Foucault's evaluation of the clinical method is that it is 'bound up with the emergence of the doctor's gaze into the field of signs and symptoms', which form the constituent parts of what will be understood as a whole: the disease itself.[14] The patient is neither her disease nor its symptoms in this reading, but rather, sits outside that which is to be read by the doctor. Patienthood, or the adoption of the role of patient, thus annuls the

[12] It should be noted, however, that it is the clinician who creates these categorisations, and not the patient.
[13] Oxford University Press, *OED Online* (n.d.) <www.oed.com/view/Entry/138820> [accessed 21 April 2017].
[14] Foucault, *Birth of the Clinic*, p. 111.

topography of the subject and homogenises the collective community of patients who interact with the clinic. The underlying tension between the patient and her doctor is founded in their contradictory approaches to the experience of the illness they perceive. Kay Toombs writes that, while '[t]he physician is trained to perceive illness as a collection of physical signs and symptoms which define a particular disease state,' conversely 'the patient attends to the illness for its own sake.'[15] It is these crucial differences in agenda for clinician and patient that are responsible for the schism in their perception and engagement with the condition of illness. The fact that the clinician remains the more powerful and agential of the two suggests that it is the patient who is forced to surrender to the dominant discourses of the clinic. Foucault writes that:

> Disease, which can be mapped out on the picture, becomes apparent in the body. There it meets a space with a quite different configuration: the concrete space of perception.[16]

This space is concrete precisely because it brings disease into a medicalised view, so that the subject feels the experience of illness and the 'sick organism' differently through its articulation in clinical terms.[17] It becomes visible within what Foucault terms a 'geographical system', shaped by the discourse of disease.[18]

The topography and the spatialization of both patient and clinician within the clinic become increasingly important. For the moment, however, let me return to the population of healthcare providers operating within the healthcare system. The position of the healthcare provider must also be thought of more broadly, beyond the multiple clinical roles and hierarchies I have just described. Instead, those involved in all aspects of care and support for the service-user need to be incorporated, from healthcare practitioners, to social workers, to carers and family members, and also healthcare management teams and policy makers.[19] Our understanding of end-users (as opposed to the patients) and their position in the clinical encounter can also be extended. In the published principles of the National Health Service (hereafter NHS) in the United Kingdom, the NHS accounts for a broadened base of end-users in its commitment to provide services that 'must reflect, and should be coordinated around and tailored to, the

[15] Kay S. Toombs, *The Meaning of Illness: A Phenomenological Account of the Different Perspectives of Physician and Patient* (Boston: Kluwer Academic Publishers, 1992), p. 11.
[16] Foucault, *Birth of the Clinic*, p. 9.
[17] Ibid.
[18] Ibid.
[19] Note that carers appear as both end-users and healthcare providers in varying contexts.

needs and preferences of patients, their families and their carers.'[20] The NHS Constitution states that:

> The NHS is an integrated system of organisations and services bound together by the principles and values reflected in the Constitution. The NHS is committed to working jointly with local authority services, other public sector organisations and a wide range of private and voluntary sector organisations to provide and deliver improvements in health and wellbeing.[21]

Healthcare services form part of networked systems of organisations. This is difficult for healthcare professionals to navigate, as they must account for various departments, hierarchies and agendas. But it is also difficult for the patient who attempts to make her voice heard within this multi-vocal system.

Patient Voices

The rise of the medical humanities, out of which this thesis is born, attempts to navigate clinical encounters through transdisciplinary practice. This thesis seeks out those connections between the writing of Samuel Beckett and the clinic as a means by which to entangle and inform each respectively. The field of medical humanities has had its part to play in bringing the clinical encounter into the cultural and academic zeitgeist in which patient — and increasingly doctor — testimony and pathographical writing proliferates. Testimony fashions itself into a growing number of 'infotainment' productions and yet this form is not new. From the classical doctor and patient case notes and portraits produced by the likes of Sigmund Freud, A.R Luria, V.S. Ramachandran and Oliver Sacks, to medical heroism, in Henry Marsh's memoir *Do No Harm* (saving lives against all odds), this form has been long established. Patient memoirs and testimonies such as Paul Daniel Schreber's *Memoirs of My Nervous Illness* (1903) and Frigyes Karinthy's *Journey Round My Skull* (1936) are further evidence of pathographical writing. More recently, there has been an increase in studies, which explore patienthood from both an academic and patient perspective. These scholars use their own academic disciplines as a lens through which to read and narrate their personal experiences of illness. For example, Susan Sontag's *Illness as Metaphor*, Frank's sociological exposés of illness's 'narrative wreckage', and Havi Carel's

[20] NHS, 'About the NHS: Principles and Values That Guide the NHS', *The NHS Constitution for England* (2015) <http://www.nhs.uk/NHSEngland/thenhs/about/Pages/nhscoreprinciples.aspx> [accessed 1 June 2017].
[21] Ibid.

philosophical readings of illness.[22] Furthermore, Paul Kalanithi's 2016 memoir, *When Breath Becomes Air* is a pathography written from the perspective of a clinician turned patient — Kalanithi was a highly regarded neurosurgeon at Stanford — who narrates his final years after a diagnosis of inoperable lung cancer.

The clinical encounter is also increasingly narrativised in documentaries and newspaper articles. Beyond the more traditional soap opera format broadcast by both British and American studios, there have been a number of documentary commissions in recent years, such as, *24 Hours in A&E* (2008), *Great Ormond Street* (2010-15), *Hospital* (2017), *Surgeons At the Edge of Life* (2018), and most recently *Junior Doctors – On The Front Line* (2019), all of which aired in the UK. These docudramas attempt to uncover the multiple voices and actors involved in the operation of a hospital. Casting their net wider than the interpersonal care which dominates the clinical encounter, these programmes also consider how the institute impacts, or is impacted by, care. These productions are created primarily to entertain, but many seek to expose the challenges faced in the UK by the increasing cuts to the NHS services and staff shortages. Animosity felt between clinicians and their patients only grows with a reduction in the efficiency and safety of the care that can, and will, be delivered in the future.[23]

These projects appear to subvert traditional medical narratives in which the doctor knows best and is trained to cure, revealing instead a more vulnerable clinician who, like her patients, struggles to navigate the health service. However, subversion of this kind can only take us so far and I argue that in many cases these representations embed equally reductive, if different, narrative frames into the clinic and the clinical encounter. Frames that still fundamentally rely upon narrative representation. Their popularity, however, does speak to a growing interest in new kinds of representation when it comes to the illness experience and the exploration of the clinic.

Patient-centred medical testimonials borrow tropes from the auto/biographical genre. Written in the first-person, I want to begin with these testimonies to explore the role pathography plays in offering alternative representations of illness and asserting patient identity. Writing about auto/biography, Laura Marcus writes that, since its inception, autobiographical writing has played an important role in providing a space in

[22] Frank, *Wounded Storyteller*, p. 55.

[23] See Jo Winning's article, 'Learning to think-with: Feminist Epistemology and the Practice-based Medical Humanities', for an analysis of the case of Dr Bawa-Garba, who was struck off the medical register. The tragic events of Bawa-Garba's case were due, in part, to the increasing strain put upon medical professionals who are required to work longer shifts. '[G]aps in the staffing rota' and the absence of key members of her medical team, including the Children's Assessment Unit consultant, were also cited as contributing factors (Winning 2018, 5).

which to give voice to those unrepresented and hidden subjective identities.[24] Marcus's work focuses primarily on female voices, which she argues are first found within this autobiographical tradition. She claims that the female voice is a lost voice, and that it is through autobiography that these voices can be found. If autobiography plays such an emancipatory role for unrepresented women, what other previously silenced voices might the autobiographical form enable? The adaptation of the autobiographical genre into an illness specific pathography represents one such example.

Unlike auto/biography, pathography focuses its attention on a specific moment in the subject's life and is characterised, according to Hunsaker Hawkins, as a distinctively twentieth-century form of writing, rarely found before 1900.[25] What separates the pathography from traditional auto/biographies — which can, and most certainly do, explore illness experiences — is that the illness story becomes the central subject of the text.[26] Hunsaker Hawkins explores the reasons why this form only begins to emerge in the twentieth century. What is it, she wonders, that draws this experience of illness out of the overall trajectory of the auto/biographical life and into a text of its own? She posits that it is precisely the extraction of illness from normal life experience, the fact that now 'illness is set apart from normal life by hospitalisation' and, moreover, that 'we now tend to consider health as the norm and illness as a condition to be corrected, never simply accepted', that our experience of it warrants its own literary form.[27] Yet her supposition is not without its problems. While the writers of pathography extract illness experience from the 'everyday', positing illness as an event, it is significant that much of contemporary pathographical literature seeks to unsettle the notion that such narratives are evidence of pathological and non-normative bodily function. In contrast, writers such as Carel place health and illness in flux and her work challenges this desire to extract the illness narrative from one's life story. What can be claimed, however, is that pathography 'gives the ill person a voice' and offers a new lens through which to view illness.[28] The pathographical form defies the narrative strictures of biomedical diagnosis, categorisation and discourse. There appears, then, to be a deep-rooted reliance within clinical medicine and literary studies too, on finding and articulating experience through narrative. Narrative as a methodology, as opposed to a by-product of being and pathography, is one such manifestation of patient experience. It is at this

[24] Marcus, p. 2.
[25] Hunsaker Hawkins, p. 11.
[26] Ibid.
[27] Ibid.
[28] Hunsaker Hawkins, p. 12.

point that Beckett's writing offers a crucial intervention into the dominant position that narrative has taken heretofore.

The form that pathography takes, and the role the written word plays in helping to understand the subject, brings me to the first of Beckett's texts that I want to read pathographically. *Rough for Theatre II* stages a quasi-clinical, or therapeutic space, in which two practitioners (or judges) discuss the case of a silent figure (C). I ask of this text: how and where is the identity of the subject made manifest in medical writing? I claim that medical writing encompasses not only auto/biographical writing, but also all documentation concerning the patient as a subject of clinical investigation. How are these documents created, compiled and received?

Towards the close of *Rough for Theatre II*, a vexed Morvan insists, 'the client is here and nowhere else. There's the record, closed and final. That's what we're going on.'[29] The record Morvan reads from consists of a series of documents including histories, confidences and detailed anecdotes concerning C, who remains standing on the ledge of an open window downstage. C is unnamed and all that we learn of him is conveyed through these documents, each extracted and reviewed together as Morvan (B) recites their contents to Bertrand (A). The audience is not told who Bertrand and Morvan are and their location remains unspecified except that they are in a tall building: 'twenty-five [floors] in all'. We also know that their stay is brief and that they are due in Bury St Edmunds the following day, as A says: '[s]hall we go? […] We sum up and clear out […] Set to go'. [30] Both Morvan and Bertrand are reticent to help C: 'Let him jump' says Morvan glibly, as though he were beyond saving. Indeed, Bertrand and Morvan appear less concerned with C being cured than they do with being relieved of their duties (whether this is care or judgement). Moreover, their care (or incarceration) of C has been long-term and his failure to improve or perhaps reform is seen as deviant: 'This is not his home' Morvan proclaims, 'and he knows it full well.'[31]

It is evident that Bertrand and Morvan's knowledge of C relies upon the testimony that has been compiled as part of his case. C's character, his relationships and his history (a crucial word in clinical narrative discourse) is recounted to the audience through a series of case notes and testimonies of 'lifelong friend[s].' These testimonial fragments are what remain of narratives, whose aim has been to create a picture of C according to the narrators' views. Within the clinic clinical documents not only separate the story from the patient by offering various voices in place of the patient's own, they

[29] Beckett, *Complete Dramatic Works*, p. 246.
[30] Ibid., p. 238.
[31] Ibid., p. 240.

also remain static, as each document represents a specific moment in time. In *Rough for Theatre II*, this cacophony of voices and anecdotes depict a subject unlike the silent man on stage. As Morvan quotes from the notes:

> I quote: 'To hear him talk about his life, after a glass or two, you would have thought he had never set foot outside hell. He had us in stitches. I worked it up into a skit that went down well.' Testimony of Mr Moore, light comedian, c/o Widow Merryweather Moore, All Saints on the Wash, and lifelong friend.[32]

The audience only understands C's character through the documented testimony of others. This quotation is significant for its layers of mediation. We do not learn how these documents have been acquired, but we can clearly see here that the quotation is not only written by one subject and read by another, it also cites Mr Moore's recollection of C's speech, passed through a third voice (that of Widow Merryweather), which has finally been collected and read by Morvan for the benefit of Bertrand (or whomever might be responsible for the care of C in the future). While testimony in the legal sense may promise truth, the narrative here cannot be trusted implicitly. These stories remain highly subjective and vulnerable to manipulation. Moreover, the incongruity between the stories told and the state of the character balanced on the window ledge makes it clear that narrative testimony is an event and one that can quickly become inaccurate and out-dated over time. Suzanne Poirier discusses the anachronisms in patient stories for patients who are hospitalised for extended periods. She writes:

> Over the days, sometimes weeks that follow, the patient will be examined and treated by numerous physicians, most of whom will also narrate the patient's course to others. Still, the narrative voice that tells the tale at rounds will remain virtually unchanged, implying a continuity and a consensus that may not truly exist.[33]

In *Rough for Theatre II*, written testimony replaces the need for both memory and the need to examine. Documentation concerning C remains central to Bertrand and Morvan's understanding of his condition, so much so that it appears to distract them from any real analysis of C's current state. Indeed, there is only one point in the play in which C is actually examined. On examination, it becomes clear that Bertrand and Morvan have examined C before, they discuss 'the little smile on his face' which both

[32] Beckett, *Complete Dramatic Works*, p. 240.
[33] Suzanne Poirier, 'Voice in the Medical Narrative', in *Stories Matter*, ed. by Charon and Montello, pp. 41-58 (p. 51).

admit they '[c]ould never make out what he thought he was doing with that smile on his face.'[34] Looking at the patient, then, seems to yield little in the way of understanding and so instead a picture of C is formed in language. The textual rendering of C proves, to Bertrand and Morvan at least, to be the most effective way of determining the current state of their patient. Writing about biography, Laura Marcus claims:

> The idea of the model or exemplary life is thus transmuted into that of the model or exemplary text: one whose exemplariness, paradoxically, lies in its representation of the uniqueness and singularity of the individual life.[35]

Marcus's observations also hold true for the identity of the record of C's life according to the *documentation* that concerns him. Yet the question of the 'singularity of the individual life' is an important one. Where the patient's identity is flattened out upon entering the clinical space and becomes an anonymous figure that is distinguished by her symptoms, the auto/biographical text instead illustrates the individuality of the narrated subject. Pathography attempts to emulate these characteristics and yet in *Rough for Theatre II* we are presented with a form of pathographical writing which has been corrupted by the voices of the institute — it accounts for myriad voices, but still appears to silence C. Much has been said about C, but nevertheless it seems to fail in capturing the 'true' experiences and identity of C.

There is, however, always more that can be said as narrative continues to fall short in capturing the individual life. One must grapple with the fact that, as the clinical psychologist and scholar Stephen Frosh writes, 'the feeling remains that whenever we try to say something completely, the saying of it misses the point.'[36] The testimonies Morvan chooses to quote only strengthen this paradox. While the sheer volume of material would suggest that Bertrand and Morvan have gathered a comprehensive study of their subject, the voices they cite are predominantly lay voices. Moreover, the variety of testimony undercuts the uniqueness of the subject that is illustrated within them. Indeed, the exemplary nature of the text itself is assumed and undone in the same moment. This is important, specifically if we think of pathographical writing as a testimony, which sets out the *truthful* representation of the illness experience.

If 'Pathography restores the person ignored or cancelled out in the medical enterprise' then I want to question the nature of this restoration.[37] In *Rough for Theatre*

[34] Beckett, *Complete Dramatic Works*, p. 245.
[35] Marcus, p. 2.
[36] Stephen Frosh, 'Disintegrating Qualitative Research', *Theory and Psychology*, 17.5 (2007), 635–53 (p. 641).
[37] Hunsaker Hawkins, p. 12.

II, the fragmentary quoted statements read by Morvan suggest a coherent account of the patient cannot be found within a single text. Instead, the subject is created through a patchwork of perceptions and reminiscences. While we may trust the individual narratives, one should be sceptical of their validity as a collective. Jonathan Heron and Matthew Broome examine how these documents are compiled in *Rough for Theatre II*, and discuss the parallels that can be drawn between this process in the play and contemporary psychiatric practice. Heron and Broome note that while in a psychiatric context the doctor takes a history from the patient and then examines them, in *Rough for Theatre II* Bertrand and Morvan's diagnosis and treatment is primarily informed by the case notes and testimonies which have been gathered. These various documents (or texts) do not restore a sense of C's subjectivity and C's voice remains largely absent from these documents, which also raises the question of whether he is able to narrate his experiences. But, as Heron and Broome conclude:

> Beckett challenges us with the notion that not only can case notes serve as a means of idiographic, empathic and individualised understanding of another, but further, the paradoxical notion that the case notes themselves obviate the need for the existent individual to attain such understanding.[38]

I would argue also that the wealth of testimony is tantalising, as it appears to promise a greater insight into C's experience, and yet at the same time rejects the notion that an individual should need to be understood. In *Rough for Theatre II* 'we see one mode of understanding [the case notes] as being prioritized at the total exclusion of another [examination]' so that the overriding narrative concerning C is compounded by what Broome terms 'the bureaucratization of practice.'[39] Therefore, while the multi-vocal nature of the testimony might hope to capture a more honest and heterogeneous representation of C, narrative in the form that is found here, does not help to explain how C came to be in his current state, nor does it clarify what his inner state might be. These testimonies may appear to share similar characteristics to pathographies that include lay voices, but they are by no means restorative or emancipatory.

Angela Woods has cautioned against the propensity to defer to narratives, precisely because narrative forms fall short of offering the conclusive insight into patient experience that the medical humanities seeks. The interest in narrative adopted by

[38] Jonathan Heron and Matthew Broome, '"There's the Record, Closed and Final": Rough for Theatre II as Psychiatric Encounter', *Journal of Medical Humanities*, 37.2 (2016), 171–81, (p. 180).
[39] Ibid., p. 177.

clinical medicine approaches narrative as a means by which to garner the truth from the patient. Woods begins her provocation by challenging the firmly held belief and 'frequently unexamined assumption that all human beings are 'naturally narrative'.[40] The narrative turn, which has taken place both in literary and cultural studies, has hence been appropriated throughout the social and medical sciences. This has led to an increasing emphasis on the importance of storytelling and testimony. Storytelling now offers what the narratologist Meretoja refers to as a post-war reflection and acknowledgement of:

> [N]ot only the cognitive but also the complex existential relevance of narrative for our being in the world […] The subject thereby comes to be seen as constituted in a process of narrative interpretation that takes place in a dialogical relation to socio-culturally mediated models of sense making.[41]

Narratives, Meretoja argues, are both troubled and bound by their necessity and the need for storytelling. She observes that the rise in metanarrativity speaks to this problem of narratability. Woods's distinction between storytelling and narrative makes reference to various positions in which narrative and story are placed in hierarchical opposition to one another. Yet, ultimately she asserts that, 'it is frequently the case that a person's narrative or story, however defined, is assumed to be coextensive with their subjective experience, their psychological health and indeed their very humanity.'[42] It is this view of narrative, or rather medical humanities' faith in this claim that Woods's work seeks to contest. Relying on such a neat and individualistic definition of narrative in which experience is so easily represented in storytelling, means one loses sight of the multiple voices and the essential cultural and socio-economical factors that affect the creation of a narrative. It is problematic to assume that the narrative that a patient puts forward is reflective of her humanity, as is the promotion of narrative as the primary mode for understanding one's humanity. Woods writes:

> [P]romoting (particular forms of) narrative as *the* mode of human self-expression, in turn promotes a specific model of self — as an agentic, authentic, autonomous storyteller; as one with unique insight into an essentially private and emotionally rich inner world; as someone who possesses a drive for storytelling and whose stories reflect and (re)affirm a sense of enduring individual identity [italics in original].[43]

[40] Angela Woods, 'The Limits of Narrative: Provocations for the Medical Humanities', *BMJ Journals*, Medical Humanities, 37, 2011, 73–78, (p. 73).
[41] Meretoja, *The Narrative Turn*, p. 2.
[42] Woods, 'The Limits of Narrative', p. 73.
[43] Woods, 'The Limits of Narrative', p. 74.

Beckett's work — by ironizing and problematizing narratives, of and by ailing subjects — offers an altogether different means by which to access the contemporary clinical encounter. Under increasingly stringent administrations there are large unknowns and uncertainties in the futures of both the British and American healthcare systems. Challenges undoubtedly abound, and it is in this chapter that I explore the ways in which struggles in the clinical encounter today can be identified and drawn out in the staging of Beckett's works for theatre. Here, I examine how Beckett's exploration of the politics of the theatre, and the production of his prose, can be used to unearth challenges associated with power in the clinic.

Moreover, Beckett's exploration of the non-narrativised and un-narratable subject can offer new insights into the lives of patients within the healthcare system. Often set outside of any known time, Beckett's half-formed subjects, such as the narrator of *The Unnamable* (whom I will discuss in Chapter Two), offer an opportunity to consider the process of language production, the use of narrative, and lost language within the subject who clings to, but also rejects, narrativisation. Laura Salisbury proposes that in the early twentieth century, with the rise of modernism and the vast ferment of experimental literary movements, such as Dada, came a new literature which attempted to push language beyond its limits as it called into question the intentionality of utterances, and unsettled the agency of the utterer.[44] Salisbury writes that she seeks to:

> [U]se the formal resemblances between aphasic disturbances and modernist writing that cut the cords of secure intention and bend an ear to the materiality of language, to explore what explicitly 'disordered' representation might offer to an emergent discipline of critical medical humanities.[45]

Using the conception of disorder to explore modernist language not only offers a new lens through which to view modernist texts — of which Beckett's works are often considered a later example — but also enables us to re-evaluate the discourses of illness, disorder and impairment. While Salisbury's is a vital pursuit within the most recent wave of critical medical humanities, my thesis argues for a different use of Beckett's work, using it as a means to examine contemporary clinical frameworks and not for an analysis of modernist literary and artistic representation. I want to explore the connections between Beckett's depiction of and engagement with subjective,

[44] Laura Salisbury, 'Aphasic modernism: Languages for illness from a confusion of tongues', in *Edinburgh Companion to the Critical Medical Humanities*, ed. by Whitehead and Woods, pp. 444-62 (p. 445).
[45] Ibid.

interpersonal and institutional narratives of illness, and those found within current clinical spaces. Furthermore, by analysing patient discourse and pathographical writing from across multiple disciplines, I want to use Beckett's work to extend and enrich existing arguments that contest binary notions of health and disorder, and argue that by exploring disordered language one gains greater insights into the capabilities — or lack thereof — of supposedly normative bodies.

In her famous essay 'On Being Ill', Virginia Woolf writes that illness brings a 'tremendous spiritual change' and that despite its commonality it is 'astonishing […] what wastes and deserts of the soul a slight attack of influenza brings to view.'[46] Illness of any kind is an earth-shattering event. Such an event forces the sufferer (the patient) to endure and reconceive her body, which is no longer 'a sheet of plain glass through which the soul looks straight and clear.'[47] Woolf's depiction of illness, which as Winning says is now well known within the medical humanities, alerts us to the 'heightening of our senses' in illness, so that 'we become almost preternaturally sensate'.[48] And yet, while Woolf's essay importantly explores the transition of the healthy transparent body into the opaque and problematic unhealthy one, Woolf has assumed a position — still clearly held today — that the ill subject has in some sense been broken apart. Moreover, her use of the visual metaphor also conforms to traditional medicalised views, which give preference to sight over hearing, and suggests that we look through the healthy body instead of looking and hearing inside. Listening in will be my focus in the latter half of this thesis. Illness for Woolf is a fault line, threatening a 'self' that is understood as whole, and yet the split is also viewed as productive, by enabling further self-knowledge and understanding. While breaks may be good, however, I challenge the notion that a coherent and whole subject exists in the first place. After all, there has to be a whole to begin with in order for it to break. For Beckett, unlike Woolf, no such solid and self-contained subject exists and there is no whole to be broken.

Within the clinic the patient is characterised as having undergone some form of trauma which leaves her deficient, whereas for Beckett, characters are continuously constructed — from the blind and decrepit Mr Endon in *Murphy* to the spectral figures of Bam, Bem, Bim and Bom in *What Where* (1983) — as those who never truly existed. Beckett's bodies enter the scene or narrative already lacking, just like the young girl that

[46] Virginia Woolf, *On Being Ill* (Ashfield, Massachusetts: Paris Press, 2002), p. 3.
[47] Ibid., p. 4.
[48] Winning, 'Afterword', in *Edinburgh Companion to the Critical Medical Humanities*, ed. by, Whitehead and Woods, pp. 325-35 (p. 330) .

Maddy Rooney speaks of in *All That Fall*: 'the problem with her was she had never really been born.'[49] These characters do not begin as functioning subjects who will be struck down subsequently by illness. Instead, we meet them at a point in time located somewhere between their beginning and the end. Bodies increasingly fail, but this failure by no means elicits a Woolfian 'spiritual change' in the Beckettian subject. The narrator in the fourth story of the *Texts for Nothing* says: 'Where would I go, if I could go, who would I be, if I could be, what would I say, if I had a voice, who says this, saying it's me?'[50] There is no moment at which the narrators can look back to a version of themselves that was fully constituted. Furthermore, as another narrator of 'Text for Nothing III' has it, with his body 'stirring back and forth, up and down, as required', he attempts to understand what and where his body is, only to reveal that the body is in a position of persistent unknowing.[51] I will explore the challenge of narrating the self into existence in Chapter Two to show how, despite its futility, the subject is still compelled to produce stories. Here, however, I argue for further interrogation into the narrative forms adopted by clinical medicine and will use Beckett's works to show how these forms can be troubled.

Clinical Quests

Pathography situates itself, if not explicitly in opposition to, then most certainly outside of, a clinical narrative of illness. Hunsaker Hawkins writes:

> In some sense, the pathography is our modern adventure story. Life becomes filled with risk and danger as the ill person is transported out of the familiar everyday world into the realm of a body that no longer functions and an institution as bizarre as only a hospital can be; life in all its myriad dimensions is reduced to a series of battles against death and there is the inescapable sense, both for the sick person and his or her family, of being suddenly plunged into 'essential' experience — the deeper realities of life.[52]

Like the novel *Robinson Crusoe*, which Hunsaker Hawkins references at the opening of her book, the pathography is an 'adventure story' that is concerned with a narrative of survival. As pathographies often focus on the process or overcoming disease, or the restoration of health, it seems that its central mission of the narrative is not far removed from that of the medic's. So while the pathography attempts to divorce itself from the

[49] Beckett, *Complete Dramatic Works*, p. 196.
[50] Beckett, *Texts For Nothing*, p. 17.
[51] Ibid., p. 11.
[52] Hunsaker Hawkins, p. 1.

medical discourse, which sets health and illness as binary opposites, in its pursuit of a narrative of renewed equilibrium, it is another form of medical writing.

In an attempt to trace the different kinds of pathography and their reconstruction of the illness experience, Hunsaker Hawkins defines a number of pathographical sub-genres that have differing agendas and adopt various narratological traits. As autobiographical texts they contradict their assertion of an absolute truth: 'these books cannot be taken as accurate records of experience: they are too highly charged'.[53] Instead, they become allegories, adopting mythic modes of representation, and depicting quests, so that while they claim to problematise the dominant discourse of certainty within biomedicine, they in turn adopt archetypal narrative forms, which contradict (or overwrite) the chaos that ensues during times of illness. By overlaying narrative structure onto the illness experience, and moreover by falling into particular categories of pathography, the patient's story, Hunsaker Hawkins claims, is now representable.

At the forefront of the patient testimony and medical writing genres sits the cancer narrative, whose structure and style resemble that of a quest. This highly symbolic plot device, Christopher Booker suggests, is the most clearly recognisable story type in literature.[54] Quests narrate the journey of an individual, sometimes attempting to overcome adversity, accompanied by a group of companions who are either in pursuit of a great treasure, or in search of something that the individual has lost. The cancer narrative appears to replicate the generic plot structure of the quest, as events can be plotted through the patient's interaction with the clinic and the patient is often characterised as one who quests toward renewed health. Indeed, Frank likens his own experience of having cancer to that of a 'quest', and suggests that the way cancer is narrated implies or expects some form heroism from the sufferer. He writes:

> Quest stories meet suffering head on; they accept illness and seek to *use* it. Illness is the occasion of a journey that becomes a quest. What is quested for may never be wholly clear, but the quest is defined by the ill person's belief that something is to be gained through the experience.[55]

Adopting the quest as a narrative plot device has significant implications for clinical care. Allegorical in tone, Booker claims that the hero's quest initiates a trail across terrains which are 'wild, alien and unfriendly', in which '[s]ome of the perils they [the hero and his companions] encounter therefore are simply those of the hostile terrain

[53] Hunsaker Hawkins, p. 14.
[54] Christopher Booker, *The Seven Basic Plots: Why We Tell Stories* (London: Continuum, 2004), p. 69.
[55] Frank, *Wounded Storyteller*, p. 115.

itself.'[56] This experience has a topography that the hero must navigate. Quests ultimately culminate in renewed forms of existence, which for the ill person are founded in the forming and reforming of the patient's subjectivity throughout the course of her illness. Frank notes that once diagnosed with cancer, the patient is never without that diagnosis. One never fully recovers, but instead becomes a member of what he terms the 'remission society'.[57] Remission is the best that can be hoped for and so the quest does not ensure recovery, but rather, offers a way of charting the experience. The quest genre is so effective because the plot structure is so widely understood. Clinical medicine's rhetoric of both the quest and the fight against cancer, indeed the representation of this fight as a kind of mutiny, highlights, as Sontag argues, that illness lends itself so readily to metaphorical reifications.[58] In contrast, metaphorical quests and mutiny within Beckett's writing lack the sense of movement and vitality that medical discourse implies. Characters do not fight in the traditional sense, nor are the majority of them able to move. Within his trilogy as I will show, the quest remains a failed endeavour for bedbound and inert characters who are left beaten rather than saved by their journeys.

Illness is consistently cast as the disrupter to everyday experience. For Charon illness is saturated with '*emotions of shame, blame and fear'* [italics in original].[59] For Frank 'illness is a crisis of self'.[60] Illness elicits the quest and how this narrative ends is no longer certain. Treatment may form part of the journey and remission or death may lie at its end, but there is an end. Yet it is uncertain as to what can really be gained from illness or how the patient might, as Frank writes, 'seek to *use* it'.[61] Indeed, this position is dangerous if we are to presume that illness makes the sufferer a better person. I want to guard against this reading of illness's story as one of self-discovery, of recovery and a desired movement back towards a 'natural' state of health. Frank writes that the quest for the 'what' is never necessarily answered, but the quest continues and it is the seeking out of ways in which to narrativise illness that is tantamount to healing. While this process might on the one hand bee seen as a form of healing, on the other quests are subverted in Beckett's writing in such a way as to emphasise narrative's persistence, while failing to help the subject to get well. Narrative is necessary, but by no means is it restorative. Frank's exposition of the quest, and my focus on the cancer narrative in

[56] Booker, p. 73.
[57] Frank, *Wounded Storyteller*, p. 8.
[58] Susan Sontag, *Illness as Metaphor* (New York: Farrar, Straus and Giroux, 1978), pp. 3-4.
[59] Charon, *Narrative Medicine*, p. 22.
[60] Frank, *Wounded Storyteller*, p. 56.
[61] Ibid., p. 115.

particular, is illuminating in that it outlines received expectations of illness narratives within medicine, as well as the medical humanities canon. It is from here that Beckett's work can then be used to problematise the generic plot structures which have hitherto defined the illness narrative, through his inversion of the quest.

The quest narrative is inevitably a troubled one in which its protagonist must face hardships, leaving her changed by the experiences she has faced. Changed, but according the conventions of the genre, changed for the better. The goal of a quest once achieved, offers its hero the 'assurance of a renewed life stretching indefinitely into the future', a form of rebirth for the protagonist.[62] I want to strongly contest this view in cases of chronic illnesses and argue that quests in Beckett's work similarly contest these established genre expectations. And by doing so Beckett's writing represents (and narrates) chronic illness in a way that is more akin to the experience of it. While many of Beckett's works appear to depict quests in one way or another, it is in his trilogy where I find the clearest examples of inverted quests. Many critics have noted the stumbling and interrupted nature of the journeys that take place in Beckett's works. Mark Byron writes that:

> Beckett's prose narratives can be said to describe an interrupted journey, or even journeys of chronic interruption, but these interruptions take the form of different sorts of digression and systems of aspiration and futility, slowly shifting from the events of the plot to the fabric of the narrative and textual composition itself.[63]

The Beckettian quest, then, is flawed from the start, interrupted throughout, and bound to fail, but it also dissipates so that the culmination of the quest leads the narrator full circle. Where the traditional quest narrative initiates a journey away from 'home' toward something else (a goal), we see Beckett's protagonists at the point at which they have already left.[64] Banished from their homes or lost, or not sure how they came to be where they are, they try to remember their origins, to return to them and even eradicate what has been. They attempt to get on, as Molloy says, and 'speak of the things that are left, my goodbyes, finish dying.'[65] Molloy's quest is not so much a quest towards the end of his life, as it is a desire to undo his being, and trapped within his immobile body,

[62] Booker, p. 83.
[63] Mark Byron, 'To End, Yet Again: Samuel Beckett's Interrupted Journeys', *Forum for Modern Language Studies*, 49.4 (2013), 406–22 (p.407).
[64] For example, in Beckett's *First Love and Other Novellas*, the stories begin with the expulsion of the protagonist from his home. In 'The Calmative' the story begins with the protagonist having already died: 'I don't know when I died. It seemed to me I died old', so that the story that ensues takes place after the journey has already finished, and yet it charts a new journey in death (Beckett 2000, 47).
[65] Beckett, *Three Novels*, p. 3.

the opportunity for a return of any kind seems impossible. It is the rhetoric associated with the clinical narrative of recovery, of returning to 'normal', which Beckett's work helps me to contest. Degeneration in some senses is epiphanic, but this epiphany promises nothing more than the realisation of degeneration itself. Molloy says:

> Physically speaking it seems to me I was now becoming rapidly unrecognizable. And when I passed my hands over my face, in a characteristic and now more than ever pardonable gesture, the face my hands felt was not my face any more, and the hands my face felt were my hands no longer. And yet the gist of the sensation was the same as in the far-off days when I was well-shaven and perfumed and proud of my intellectual's soft white hands […] And to tell the truth I not only knew who I was, but I had a sharper and clearer sense of my identity than ever before, in spite of its deep lesions and the wounds with which it was covered. And from this point of view I was less fortunate than my other acquaintances. I am sorry if this last phrase is not so happy as it might be. It deserved, who knows, to be without ambiguity.[66]

Somewhere amidst the disorientation of illness Molloy is now able to more clearly understand not only his body, but also his subjectivity. Surely, then, this quest is not a case of narrative dissipation, but rather is in keeping with the tropes of the genre. Yet what is achieved through Molloy's realisation is neither empowering nor self-actualising. What persists is his inertia and the revelation that language has the ability to lead one astray, that is, to tell something untrue as though it were truth: 'Then I went back into the house and wrote, It is midnight. The rain is beating on the windows. It was not midnight. It was not raining.'[67]

For each of the narrators in the trilogy language offers a means by which to transcend their physical constraints, or, if not to transcend at least to imagine, helping them to explore and unpick the constraints which hold them in place. Like many of Beckett's other characters, such as bed ridden Moran, being physically trapped opens out their mental life, beyond physical illness. It is within this space that narrative enables some attempt at escape, and yet, the capabilities of narratives are consistently undercut.

Frosh guards against the belief that language is able to capture all that it attempts to communicate through narrative. Yet, despite the difficulty in depicting what 'cannot be said', the compulsion to attempt to do so always remains. Frosh writes:

> [W]e might indeed be positioned by language — and yet the feeling

[66] Beckett, *Three Novels*, p. 164.
[67] Beckett, *Three Novels*, p. 170.

> remains that whenever we try to say something completely, the saying of it misses the point. That we keep on trying is a testament both to the importance of putting things into words and to the defensive elements of this narrative: without it, we spiral into nothingness.[68]

Narrative may be a defence against nothingness, but for many of Beckett's characters, producing a narrative is a means by which to try and give language to nothingness. Marcus notes that where the first-person narrative voice is used within autobiography to create the person, for the narrator of Beckett's *The Unnamable*, the narrative becomes one of 'non-person', and thus subverts the recuperative qualities of first-person narration.[69] Narrating one's story may be an attempt to give shape to experience, but this is ultimately a flawed pursuit.

It is unsurprising that the doctor-patient interaction shapes the illness story. It is the transition from healthy transparent subject to visible ill patient, however, that is fundamental to the trajectory of the cancer narrative in particular. Of course, generalising these experiences is reductive, and the point at which health is interrupted by the illness (cancer in this instance) varies. Moreover, one should question exactly when it is that that the illness narrative begins. For example, the patient's narrative of herself may be disrupted by the symptoms that she starts to experience, or it may be from the moment that she first encounters the clinic. Carel writes that illness 'splits apart the biological and lived body. Instead of the flawless correspondence between our objective body and our lived experience of it, in illness the biological body behaves oddly'.[70] Carel's *Illness: the Cry of the Flesh* is in many ways an example of the cancer narratives discussed here, and yet Carel resists a binary view of health and illness. She argues for a 'move from seeing them as mutually exclusive opposites, towards a continuum or a blend of the two, allowing for health within illness in people who seem objectively ill.'[71] Cancer, and I argue illness and disorder more broadly, is often represented as a state in which one cannot experience health. Patienthood is always a burden to be borne, as it drags the subject from the invisible to the visible world of a body and its functions. As Carel writes in her most recent book *The Phenomenology of Illness*: 'The fundamental bodily experience of health is one of harmony, control and predictability […] we do not experience it [the body] explicitly […] nor does it play centre stage in our actions, even if those actions are explicitly physical.'[72] Carel exposes

[68] Frosh, p. 641.
[69] Marcus, p. 195.
[70] Havi Carel, *Illness: The Cry of the Flesh* (Stocksfield: Acumen Publishing Limited, 2008), p. 72.
[71] Ibid., p. 77.
[72] Havi Carel, *Phenomenology of Illness* (Oxford: Oxford University Press, 2016), p. 56.

the problematic assumption that bodies should be consistently able and functioning. The body that is no longer ready at hand, she says, proves transgressive because it fails.[73] Carel's work provides a vital intervention into the current expectations placed upon the well and ill body. The subject is required to perform these roles and to treat them as mutually exclusive, but it would seem that this is a false dichotomy, and that to treat the body in this way denies the multiplicity of experiences that the body can encounter and endure at any one moment. Moreover, by troubling the notion that there is an easily definable point at which an illness narrative begins (i.e. at the onset of illness), Carel provides an alternative, and I would argue a more beneficially holistic means by which to understand and describe the body than that offered by the quest.

While the patient is defined as one who endures an action and suffers, it is important to question the source of her suffering. For many patients, suffering is not only caused by their symptoms, but also by their interaction with the clinic that labels them a patient. In Sontag's *Illness as Metaphor*, she writes that illness is often represented as a form of moral transgression that conjures up images of economic catastrophe, inhibited growth and stunted passion.[74] The 'concept of disease is never innocent. But it could be argued that the cancer metaphors are themselves implicitly genocidal.'[75] Cancer appears to end all time for Sontag, whereas for Frank it instigates the journey through/of illness. The most common and attractive narrative arc for an illness such as cancer to take is one in which the illness is faced head-on, then battled and finally overcome. While symptoms might precede the subject's interaction with the doctor, these symptoms have yet to be defined, or in some cases even to be felt as symptoms. It is the patient's diagnosis in the clinical encounter that begins the story of her transition from identity-as-subject to identity-as-patient. By assuming the identity of patient, the power and agency of the subject is compromised. Her body changes, not only by becoming visible to the subject, but also through her commitment to inhabiting a body that has been appropriated by the clinical context it is forced to occupy. Illness therefore exists outside of the clinical environment, however, it is only within this space that the subject becomes a patient and adopts the role she has been given as a sufferer. The space must

[73] Disability Studies is a burgeoning field that seeks to make narratives of disability visible in wider academic and cultural conversations, so as to undo the stigma of disability and 'explore the richness of experience and creativity offered by the opportunity of disability' (Davis 2006, xviii). In the first Disability Studies reader, Lennard J. Davis argues that disability has historically been placed on the periphery: 'seen as eccentric, therapeutically oriented, out-of-the-mainstream, and certainly not representative of the human condition' (2006, xv).

[74] Sontag's use of the word 'passion' is of particular importance, as suffering shares its etymological root with passion, and thus passion means (in some senses) to suffer. Sontag explores passion through a history of tuberculosis, which was thought to affect the bodies of impassioned people. Passion, according to Sontag's use of the word, is an excessive expression and spilling over, in contrast to her image of the cancer patient as a morally stunted, unproductive and compromised individual (1978, 62-63).

[75] Sontag, p. 84.

be endured, and the actions undergone within the clinic are those that are suffered by the patient. It is not only our interaction with clinical spaces, however, which proves so distressing. Darian Leader and David Corfield posit that simply labelling illness can have significant repercussions for the person who is ill. They write:

> Labelling illness generates a host of problems. Psychiatrists and anthropologists have studied so-called 'illness behaviour', where the patient's relation to their role as a 'sick person' is explored. Some people seem to resist the role, others to embrace it. But what if the sickness itself is not so clear-cut? Illnesses are far less homogenous than we expect them to be, and disease recognition, naming and classification depend more than we might like to think on social factors.[76]

The quest can be seen as one example of what Leader and Corfield call 'illness behaviour'. Becoming the 'sick person' (or patient) means submitting to a homogenous identity built around sickness. Resisting 'illness behaviour' means embracing the heterogeneity of disease and disorder, but this is not an easy feat. Illness behaviour, then, in Leader and Corfield's account is illness that submits itself to narrativisation.

The pull of the narrative is undoubtedly felt, as we have seen, by both the patient and the clinician. Like Woods, Frosh observes the allure of narrative, but acknowledges that there are multiple dangers associated with it. To represent in language is to build narratives that attempt to make meaning, and yet, 'something is always left out precisely because something more can be said, and each new way of saying will add a new dimension, often contradicting what has gone before.'[77] Beckett's writing appears to offer the 'something more' that Frosh describes. Or, if it does not offer it, his work at least attempts to reach towards what cannot be said, and enfold the contradictory dimensions of subsequent narratives within them. As I shall go on to argue in Chapter Two, there is always a compulsion to speak and narrate, despite the inevitable shortcomings of speaking and narrating. How then, are these narratives to be received within clinical contexts?

The Heard and Understood

Often considered the quintessential example of the clinical encounter, the clinical consultation stages both the organisational and interpersonal challenges associated with medicine. Charon writes that clinicians must 'become porous to that which patients emit

[76] Darian Leader and David Corfield, *Why Do People Get Ill* (London: Penguin Books Ltd., 2007), p. 114.
[77] Frosh, p. 641.

about themselves in many, many channels.'[78] Like the Beckettian body, the body of the clinician must bear the sign of holes and openings. Yet, unlike the leaks and dribbles of the patient, these holes allow for something to enter into the clinician, rather than leak out. A clinician must use her body so as to take on embodied information that the patient has emitted. Embodied listening is challenging however, not least because the clinic remains full of distractions, both inside and outside of the consulting room. According to Charon, in order to attend to their patients and overcome the inevitable distractions of the clinic, clinicians must take on information through embodied interpretations. These interpretations require, at their heart a form (or multiple forms) of affective listening. This listening must also be reflective, and account for what Freud termed 'counter-transference' within psychoanalytical encounters.[79] Reflection on the form and interpretation of doctor-patient communication hinges on the awareness of listening, and an attention to the ways that the clinical encounter works and performs.

As I alluded to in the first section of this chapter, 'Encountering Clinics', *Catastrophe,* one of Beckett's most mimetic plays, provides a direct analysis of the world of the theatre. Written in 1982, and one of his final pieces for the theatre, *Catastrophe* stages the rehearsal of a play, in which the characters are putting the 'final touches to the last scene'.[80] The audience will never see this play, and its plot is impossible to predict, but what the audience is shown is a world in which bodies on stage are modelled by, and fall victim to, the decisions made by those that have the power to control them. Through the presence of the body, and a vulnerable body at that, the audience witnesses the power of the institution and the threat of spectatorship on stage. Protagonist ('*age and physique unimportant*') stands on a black block mid-stage with his head bowed throughout the play while the male Director instructs Assistant in her noting and manhandling of him.[81] Protagonist's 'skull', 'hands', 'cranium' and 'skin colouring' are all under scrutiny throughout the play. Protagonist lacks any agency and remains silent, as his body is exposed to the audience bit by bit. It is evident that he is vulnerable to the voices and movements of those around him. In contrast to the actors in *Not I*, *Play*, and *Footfalls*, *Catastrophe*'s protagonist remains relatively unscathed, despite his humiliation. No personal injury or torture is bestowed upon him, nor does

[78] Charon, *Narrative Medicine*, p. 187.
[79] Sigmund Freud, *The Standard Edition of the Complete Psychological Works of Sigmund Freud*, trans. by James Strachey (London Hogarth Press and the Institute of Psycho-Analysis, 1910), XI, pp. 144-45.
[80] Beckett, *Complete Dramatic Works*, p. 457.
[81] Beckett, *Complete Dramatic Works*, p. 457.

the actor suffer as others have done in performances.[82] While the audience is implicated in this act of public humiliation, Protagonist's pain is not as explicit as that of Beckett's other works. Protagonist's humiliation is also not witnessed by the imagined audience who feature as an anticipated collective character within the play.

Yet, while the pain of performance may be minimal in comparison to those plays mentioned, it is important to consider the significance of Beckett's choice to place the action of *Catastrophe* in a theatre. The audience watch the rehearsal of a performance that is not intended for them, and none of the play that is supposedly being rehearsed is acted out. While the audience only see and hear the action on stage once, the fact that this is a rehearsal signals to the repetition and reproduction of the performance as a play. As this rehearsal is to complete the final touches to the last scene, the audience is also made aware of the fact that multiple rehearsals have already taken place. The notion that a play is repeated draws attention to the existence of the work across multiple times and spaces. The topography of the space in which the rehearsal (and soon to be play) is being performed is repeatedly commented on, in such a way as to make the audience aware of their own location within the theatre. 'I'm sitting in the front row of the stalls and I can't see the toes', exclaims Director from off stage. But the theatre in which *Catastrophe* is produced affects what the present audience can see, and is subject to change according to the design of the theatre. While repetitions abound throughout his works, Beckett's examination of the theatre here reveals a repeated model of performance in space one that can be used to draw distinct parallels between theatrical and clinical encounters. Within theatrical performance bodies are brought together in a space that has been designed for them to be viewed, and the audiences that perceive them shape the way that these bodies are seen. The questions of who presents and who listens are similarly played out theatrically, both on and off stage. The Beckettian performer is constantly aware of the voices, the bodies and the spaces that characterise performance as a singular event, but she is also conscious of the event's repeatability.

Merleau-Ponty writes that 'to be a body is to be tied to a certain world […] our body is not primarily *in* space: it is of it', so that it is not as simple as the subject inhabiting different spaces, but instead it is these spaces that form the subject.[83] As the following section of this chapter will show, material space plays a vital role in

[82] Billie Whitelaw writes of her 'rehearsal agonies' with Beckett, admitting that 'every play I did with Beckett left a little legacy behind in the state of my ill-health' (1995, 125, 131). Actor Lisa Dwan (who has also played Mouth in *Not I*), says in the recent BBC Radio 4 documentary, *Beckett's Last Tapes*, that when she returns backstage after performing her ears are bleeding from the straps holding her head in place during the performance (2019). Performing Beckett's work can be a painful and gruelling process in which torture is both thematised and performed.
[83] Maurice Merleau-Ponty, *Phenomenology of Perception*, trans. by Colin Smith (London: Routledge & Kegan Paul, 2003), p.171.

understanding the challenges at play within the clinical encounter. Protagonist can be understood as a protagonist precisely because he inhabits the theatre. It is in the theatrical space that he becomes a protagonist, just like the patient who is defined as such by her interaction with the clinic. Furthermore, Butler writes that:

> [B]y being called a name, one is also paradoxically, given a certain possibility for social existence, initiated into a temporal life of language that exceeds the prior purposes that animate that call.[84]

'Patient' might be one such name, 'disabled' another, and 'protagonist' another still. With such names, we come to face the differing and often conflicting communities who are engaged within the clinical encounter. It seems clear that these groups inherently exceed the prior purposes of the 'call', especially for those identifying as voice-hearers whose identity is set in stark opposition to that of patient and more specifically 'schizophrenic'.[85]

The clinic, like the stage, is populated with speakers and listeners and it is through these speakers that we can expose the varied agendas and power struggles of both. The pervasive power of the clinic means that the distinction between medical and social spaces becomes increasingly hard to distinguish. Following the ferment of medicalised discourse in the eighteenth century and what Foucault calls the 'dogmatic medicalization of society', 'medical space can coincide with social space, or, rather, traverse it and wholly penetrate it'.[86] Therefore, while it seems that social models of care have been formed to contest clinical codes, they are still defined by their relation to and convergence upon the clinic.

What do I mean when I speak of a clinical stage? Is the clinic that which stages, does it set up the conditions for staging, or might it be seen as an environment which is itself performed? This thesis argues for an account of each of these readings for 'stage' as verb and noun, in which and on which, the clinical encounter is performed.[87]

Staging Spaces

The challenge for the clinic is to manage the inevitable isolation patients experience as they occupy clinical spaces. Frank writes that:

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[84] Judith Butler, *Excitable Speech: A Politics of the Performative* (London: Routledge, 1997), p.2.
[85] See Angela Woods', *The Sublime Object of Psychiatry: Schizophrenia in Clinical and Cultural Theor*y (2011). See also, Chapter Four for further discussion on debates concerning voice-hearing, schizophrenia and diagnosis.
[86] Foucault, *Birth of the Clinic*, pp. 35-36.
[87] The idiom 'stage' is also used throughout Freud's writing on the psychosexual development of the subject. At these various stages, psychosexual development is performed. Freud highlights the potential for fixation at any point throughout the development of the subject's sexual instinct (1949, 112).

> Medicine encourages monadic bodies in many ways. Hospitals treat patients in close enough proximity to each other to obviate any meaningful privacy, but at just enough distance to eliminate any meaningful contact [...] Patients relate individually to medical staff, not collectively among themselves, and this pattern of relating seems to result from how medical spaces are designed and how movement within them is orchestrated.[88]

This damning picture of the clinic illustrates the difficulty patients face in connecting with others, while simultaneously denying them any real privacy in clinical environments. The patient lacks the opportunity to voice her experiences with other patients, so despite having medical professionals who attend to her, there is little opportunity to form a patient community that might be more able to empathise with, and share in, the experience of illness. Frank's stark image of 'monadic bodies' in the hospital is redolent of Beckett's *Play*, in which three characters are placed in urns side by side on stage.[89] They are connected to one another and yet isolated, so that like patients in their beds, W1, W2 and M are contained within their urns, in close proximity to one another, but also alone.

[88] Frank, *Wounded Storyteller*, p. 36.
[89] Frank, *Wounded Storyteller*, p. 36.

Figure 1 - ©Zoë Dominic, 'Photographs of Play, The National Theatre Company, Old Vic Theatre, London', in *Short Plays Series BC MS 5538 H* (Samuel Beckett Collection, University of Reading, 1964 [BC MS 3575]).

Each character tells a repeated story of the love triangle between the three of them, but while they speak they seem unable to see or hear one another. Monadic and monolithic, W1, W2 and M only speak when directed by a spotlight. Their collective experience builds a coherent narrative, yet as they speak each individual story appears incomplete. Beckett's constriction of his characters into situations analogous to the hospital can also be found in other works, such as *Happy Days* (1961). Winnie's gradual submersion into the mound of earth that surrounds her holds her to her position,

imprisoning her with little in the way of stimulation, and no hope of sleep. In the second act of *Happy Days*, no sooner has Winnie closed her eyes to try to rest, than a 'bell rings loudly' to wake her.[90] The lack of rest and subsequent exhaustion caused by being beholden to the space itself seems, again, only too familiar to the patient in a busy ward.

The design of clinical space has a significant effect on how patients experience their time in it, as well as impacting the way that care is provided. While the design of these spaces is informed by the kind of care that the clinic might want to deliver, the motives for certain design choices are historically and socially located. In *Medicine by Design*, Annmarie Adams charts the history of Montreal's The Royal Victoria Hospital, whose design by British architect Henry Saxon Snell at the end of the nineteenth century was based on a traditional 'pavilion-plan building'.[91] Adams offers a meticulous reading of a hospital located in a city where the cultural influences at play were almost unique. Yet despite its specificity, Adams's survey of the 'Royal Vic' and its evolution throughout the early twentieth century makes important observations about how the design of the hospital reflected the caring practices and medical education provided, and its impact on the clinical care delivered. Furthermore, the vision of the hospital and its role as a social institution affected its design. Adams begins with the pavilion-plan design, 'inspired by the ideas of Florence Nightingale and other mid-century reformers, the concept of separate (or minimally connected) pavilions and the open plan of the wards maximized ventilation'. The design was a 'medical instrument by which patients could be carefully positioned in space, according to the gravity of their conditions.'[92] The space was not only constructed to maximize light and comfort for the patient, but also to reduce the chances of infection and cross contamination between patients.

Patients were placed together but separated and 'fundamental to [the ward's] operation was the relationship between the patients' beds and the nurses' station or desk,' which ensured a clear view of the patients in the ward.[93] Reducing the privacy of the patients was seen as an act of care to ensure patient safety. Yet in spite of these honourable claims, the arrangement of the ward shares characteristics with Jeremy Bentham's panopticon — an architectural structure conceived as a method for surveillance — much explored by Foucault as an emblem of control that was designed to enact this control upon whoever might be deemed abnormal: 'shut up in each cell a

[90] Beckett, *Complete Dramatic Works*, p. 162.
[91] Annmarie Adams, *Medicine by Design: The Architect and the Modern Hospital 1893-1943* (Minneapolis: University of Minnesota Press, 2008), p. xvii.
[92] Adams, p. 10.
[93] Ibid.

madman, a patient, a condemned man, a worker or a schoolboy.'[94] The effect of the panopticon was to bring incarcerated peoples into close proximity with one another, while denying them the ability to communicate with one another. For the spectator, all was visible, whereas the prisoners remained ignorant of the company they kept. Foucault writes:

> They are like so many cages, so many small theatres, in which each actor is alone, perfectly individualised and constantly visible. The panoptic mechanism arranges spatial unities that make it possible to see constantly and to recognise immediately […] Visibility is a trap […] He [the incarcerated] is seen, but he does not see he is the subject of information, never a subject of communication.[95]

Foucault's performative description of the incarcerated person placed on one's own stage, like the hospital patient, or the three figures in *Play*, shows that the power lies with the person who can see, not the one who is seen. Manipulating the visibility of subjects is a way of enacting control over them. The use of light, in both the dramaturgy of *Play* and the panopticon, is a crucial way of determining authority. For the characters in *Play*, the beam of light that shines on each of them in turn, initiates their storytelling (or retelling). Moreover, as the light lands upon them, they do not communicate with one another, but rather urgently recount their own stories, which cannot be shared across the bodies on stage. The panopticon, like the hospital ward produces 'monadic bodies' whose visibility is subject to, and a symptom of, the oppressive forces of the institute.[96]

The hospital, like all municipal buildings, was a civic monument, but, as Adams writes, in the nineteenth century specifically it was primarily 'an institution for the poor'.[97] Foucault writes that while the hospital was associated with financial destitution, it was also seen as an 'indispensable measure of protection'.[98] It ensured the '[p]rotection of the healthy against disease; protection of the sick against nostrums of the ignorant […] protection of the sick from one another.'[99] At the end of the nineteenth century those who were able to afford medical care at home would have no need for hospitals, which equated with poverty and lower socio-economic standing. In addition, Adams writes that the Royal Victoria became the centre of clinical innovation and education, with buildings dedicated to surgery and pathology, as well as nurses' training

[94] Michel Foucault, *Discipline and Punish: The Birth of the Prison*, trans. by Alan Sheridan (London: Penguin Books Ltd., 1977), p. 200.
[95] Ibid.
[96] Frank, *Wounded Storyteller*, p. 36.
[97] Adams, p. 7.
[98] Foucault, *Birth of the Clinic*, p. 49.
[99] Ibid.

and accommodation. The topography of the hospital continued to expand throughout the first half of the twentieth century to accommodate more patients, including specific maternity and children's wings. New buildings were constructed at the Royal Victoria for the middle class and wealthy paying patients and, as Adams puts it, '[e]very aspect of the architecture of private patients' pavilions stressed separation and differentiation'.[100] Built on a hill above the main hospital complex, this separate pavilion had been designed to evoke a sense of domestic space. The architecture of the hospital thus reflected contemporary class and gender distinctions and embedded these hierarchical structures within medical practice and its performance. Interactions across this clinical complex were influenced by the architecture and the landscape in which they were taking place, and siphoned off one group from another. By assembling people for a common cause, each of whom may have different expectations of that assembling based upon their own gender, socio-economical and pathological status, the hospital becomes subject to the concerns of collectivisation. Moreover, the patient's individuality is not accounted for in this configuration. Patients are assembled and yet they are isolated. The individuality of the patient is occluded through this process of categorisation. Bringing bodies together into a single location thus has both political and performative implications.

In *Notes Toward a Performative Theory of Assembly* Butler begins her argument by questioning the seemingly innocuous phrase 'the people'. She writes:

> 'The people' are not given a population, but are rather constituted by the lines of demarcation that we implicitly or explicitly establish. As result, as much as we need to test whether any given way of positing 'the people' is inclusive, we can only indicate excluded populations through a further demarcation […] Even when we say 'everyone' in an effort to posit an all-inclusive group, we are still making implicit assumptions about who is included […][101]

Patients should be thought of in much the same way, as a people — that is, an iteration of the people — for whom patienthood, much like gender, race or nationality, comes to determine their presence within a communal space. The clinic is made all the more complicated by its bridging of public and private spheres, or rather, it is both public and private, and neither all at once. Within the fabric of hospital design, the integration and segregation of people is distributed spatially. It is just as Butler says when she writes:

[100] Adams, p. 35.
[101] Judith Butler, *Notes Toward a Performative Theory of Assembly*, pp. 3-4.

> We cannot talk about a body without knowing what supports that body, and what its relation to that support — or lack of support — might be. In this way, the body is less an entity than a living set of relations; the body cannot be fully dissociated from the infrastructural and environmental conditions of its living. Its acting is always conditioned acting, which is one sense of the historical character of the body.[102]

Beckett's consistent fragmentation of the body into individual pieces illustrates this notion of a body as a set of relations in space. These relations are constituted in narrative-based, performative and institutional contexts. As with Protagonist in *Catastrophe*, Mouth in *Not I*, May's pacing in *Footfalls*, and Maddy Rooney's puffing and panting in *All That Fall*, ultimately the body is embedded within the space in which it is encountered and brought about. While this embodiment is, in the Butlerian sense, a form of appearance — these bodies appear in a space — I want to consider the ways in which the body is excluded by the very space it inhabits.

Beckett's shortest play *Breath* offers a new way of staging and performing the body. There is some dispute as to whether this play was produced by request, or written much earlier than the performance and the first production of *Breath* somewhat incongruously featured as part of Kenneth Tynan's 'sextravaganza' *Oh! Calcutta!*[103] *Breath* offers its audience the sound of a single off-stage inhalation and exhalation, whose crescendo and diminuendo is mirrored by the swelling and fading of the stage lights. The breath is bookended by the sound of two identical 'faint brief' cries, the first of which might be likened to Mouth's cry in *Not I*: 'just a birth cry to get her going … breathing …then no more till this…'[104] This one breath signifies all of life in its single cycle and is visually represented by the 'miscellaneous rubbish' that litters the stage.[105] This detritus can be read as a visual representation of air expended by the invisible body that breathes off-stage. Beckett importantly states that the wasteland of rubbish on stage should have '[n]o verticals, all scattered and lying'.[106] Whereas the other spaces I have explored in this chapter have been designed and staged to account for the myriad hierarchies that operate within them, this rubbish lies flattened out. The topography lacks any clear

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[102] Judith Butler, *Notes Toward a Performative Theory of Assembly*, p. 65.
[103] Ackerley and Gontarski write that *Breath* was surprisingly Beckett's most viewed play. Having moved to Broadway it was performed between 1971-1989, and seen by 85 million people, at more than a thousand performances (2006, 73).
[104] Beckett, *Complete Dramatic Works*, p. 380.
[105] The first production of *Breath* proved distressing to Beckett as unbeknownst to him, his text had been amended with the stage direction: 'including naked people' alongside the miscellaneous rubbish. Knowlson writes that Beckett's name was the only one attributed to the piece. Furious at the betrayal, Beckett's anger is evidence of his continued desire for control over his material. Moreover, Knowlson writes that the breath itself was intended 'to be an ironic comment on what was to follow'. The explicit use of naked bodies would seem to rather overplay the potential sexual connotations of the piece (1996, 566).
[106] Beckett, *Complete Dramatic Works*, p. 371.

distinctions, and so like the patient whose identity has been flattened and homogenised through their interaction with the clinic, the staging of *Breath* shares characteristics with shapelessness and anonymity of the hospital patient in particular. In a more recent adaptation for the 'Beckett on Film' project the conceptual artist Damien Hirst was asked to direct *Breath*. True to his own aesthetic inclinations, Hirst stages *Breath* as an expanse of medical and hospital waste, passing the camera over a disorientating landscape.

Figure 2: 2001 production of *Breath*, directed by Damien Hirst for Channel 4's 'Beckett on Film'.

In Hirst's production the breath does not produce unspecified rubbish, but rather an array of medical waste. Panning from above, the final view of the rubbish shows an ashtray and a bottle of pills in the foreground. Hirst's preoccupation with the clinical is clear from his various installations and pieces, including: 'Pharmacy' (1992), 'Medicine Cabinets' (1989) and 'Schizophrenogenesis' (2014). Hirst is also concerned with behaviours that lead to medical encounters, such as in his piece 'Crematorium' (1996), which features an oversized ashtray that is half filled with cigarette butts and other detritus including sweet papers and drug paraphernalia. Hirst's interest in medicine and health has undoubtedly influenced his staging of *Breath*, but the ease with which this particular rendering is achieved is striking. The topography of the waste isn't clear at first, but as the camera continues to pan across the rubbish it is as though the viewer were orbiting a flattened plane of rubbish, whose edges only come into view in the final seconds when the shot opens out onto a black expanse. Hirst's medicalised wasteland

illuminates the all-consuming nature of illness within the clinical encounter. As the single inhalation and exhalation in *Breath* signifies the beginning and ending of life, Hirst's celestial orbit of the medical world connects the experience of living — from beginning to end — with a medical space and the stuff of medical care. Life, not only illness then, is a product of a medical world, which must be undergone and suffered.

Chronically Clinical

I want to determine the parameters of the clinic and the clinical. The clinical encounter is more than the sum of its individual parts, as it connects with wider systems of health and social care, beyond the confines of the clinic and the consultation room. In this thesis, I examine chronic conditions in particular, as they offer an opportunity to explore clinical encounters which are not only affected by doctor-patient interactions (though these remain central), but also the combination of interpersonal and institutional factors which influence the clinical encounter. Aphasia and AVHs are an entry point into the clinical encounter and both conditions challenge normative expectations of what the body can do, and how a body should behave.

While aphasia proves a particularly pertinent condition for the exploration of language and listening at the hand of patients and clinicians alike, I also wish to explore the experiences of people who hear voices. AVHs, as they are more commonly known, are one of the symptoms listed among the diagnostic criteria for schizophrenia. While unusual auditory phenomena might seem to be a very different disorder to aphasia, both conditions are chronic and concern the supposedly non-normative relationship between the subject and language. Moreover, the social stigma associated with both disordered speech and mental health means that many patients feel isolated and overlooked by both the clinic and society more broadly. The voice-hearer's experience is complicated further in her encounters with the clinic, as the symptom remains inaccessible to the clinician. While clinicians are able to listen to their patients describe the condition, the condition itself, namely the voice the patient hears, cannot be heard. Therefore, there is always an element of the clinical encounter, which the clinician can only imagine. Silent voices must be understood, even if they cannot be heard. For the person with aphasia, the condition similarly remains out of reach of the clinician. While the neurological foundations of aphasia might be well understood, the manifestation of the condition is equally interpretative. Why one word is supplanted for another in paraphasic speech is subject as much to the personal history and psychological state of the patient as it is a result of her acquired language disorder. The aphasic and voice-hearer, furthermore,

occupy deeply politicised positions, not only within the framework of Disability Studies but also in healthcare today. Chronic conditions such as these are seen to place increasing pressures on diminishing funds, both in mental healthcare and allied healthcare services, such as speech and language therapy and occupational health (both of which play a vital role to the rehabilitation process for post-stroke survivors).

Aphasia and voice-hearing are chronic conditions and their responsiveness to therapies, medication and other treatment is often uncertain.[107] While patients who experience AVHs are commonly prescribed medication, people with aphasia predominantly receive speech and language therapy in the weeks and months following their injury.[108] Chronic conditions face specific challenges, as they require interconnected approaches to care, delivered by a variety of healthcare providers. Between 2010 and 2017 there has been a 40 per cent cut to social care funding in the UK, which has, amongst its many repercussions, led to stretched budgets and greater pressure on hospitals to support the rising number of patients attending A&E departments.[109] In addition to the economic implications associated with chronic conditions, which according to the World Health Organization (WHO) account for 60 per cent of all deaths in the world, chronic illness also challenges the expectation of both patients and doctors by defying or remaining resistant to cure.[110]

Many people with chronic conditions such as aphasia require support from a multitude of healthcare and social care professionals. For example, the 'core multidisciplinary team' assigned to a patient who has suffered a stroke may consist of consultant physicians, nurses, physiotherapists, occupational and speech and language therapists, clinical psychologists, rehabilitation assistants and social workers.[111] With the NHS facing increasing budgetary constraints there is a concern that the needs of those with chronic conditions may not be met, given the level of resource that is required in order to support them. Furthermore, for those experiencing mental health problems such as schizophrenia (and therefore voice-hearing), there are continued

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[107] According the NHS, a chronic condition, also known as a long term physical health condition, 'is a health problem that requires ongoing management over a period of years or decades.' These conditions, 'cannot currently be cured but can be controlled with the use of medication and/or other therapies (NHS, n.d).

[108] Though a number of trials are being conducted into the effect of Deep Brain Stimulation using MRI and Transcranial Magnetic Stimulation. This forms part of the research strategy at UCL Queen Square Institute of Neurology.

[109] Polly Toynbee, 'NHS Crisis: The One Act of Self-Sacrifice That Could Rescue Our Health Service', *The Guardian* (2017) <https://www.theguardian.com/commentisfree/2017/jan/17/nhs-crisis-act-self-sacrifice-rescue-health-service> [accessed 17 January 2017].

[110] World Health Organization, 'Chronic Disease and Health Promotion: Integrated Chronic Disease Prevention and Control', *WHO* (2001) <https://www.who.int/chp/about/integrated_cd/en/index1.html> [accessed 17 June 2019].

[111] National Institute for Healthcare Excellence (NICE), 'Stroke Rehabilitation in Adults', *National Institute for Healthcare Excellence* (2013) <https://www.nice.org.uk/guidance/cg162/chapter/1-Recommendations> [accessed 17 June 2017].

tensions between healthcare providers, mental health support services and patients. Woods writes that: '[i]n mainstream psychiatry, schizophrenia is strongly associated with a *lack* of insight, a failure to recognise that one is ill and in need of medical care that is regarded as itself symptomatic of the condition [italics in original].'[112] Woods sees 'insight' as a troubling term, which according to the psychiatric community has become synonymous with 'psychiatric knowledge'.[113] Within patient-led communities, however, alternative forms of insight can be found. The HVM global network consists of voice-hearers and psychologists who are committed to offering peer-support and community-led experience sharing sessions, as well as therapy groups for its members. These groups endeavour to reinterpret voices, not as a pathologised malfunction, but rather as an experience which can offer insight into the psychological state of the voice-hearer and which should be acknowledged as real and worthy of interpretation. Similar social models of care have also been created worldwide for people with aphasia and other communication disorders. This approach takes the view that it is the environment that is disabling, as opposed to the condition itself.[114]

Clinical institutes, such as hospitals, are not necessarily designed with the impaired subject's needs in mind. One only has to think of the labyrinthine corridors of a hospital and its use of medical terminology and signage, to consider how difficult it might be for a patient with a language disorder to try to navigate it. As such, the clinic can become a disorientating space to those vulnerable persons who must interact with it.

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Upon entering the clinic the patient is required to perform her patienthood. What makes her a good patient is determined by how effectively she performs this role. There is a gulf between the way illness is narrated by the patient and by the clinician. In the wake of the 'narrative wreckage' brought about by illness, medicalised narratives attempt to overlay patient stories with seemingly coherent and self-contained stories of diagnosis, disease and recovery.[115] At its heart, the clinical encounter suffers from the lack of understanding that the clinician is able to have in the face of the ill patient. Charon writes that:

[112] Angela Woods, 'Rethinking 'Patient Testimony' in the Medical Humanities: The Case of Schizophrenia Bulletin's First Person Accounts', *Journal of Literature and Science*, 6.1 (2013), 38–54 (p. 43).
[113] Ibid.
[114] Chapter Two will examine the disabling effect of societal expectations related to communication and fluency on those with disordered language.
[115] Frank, *Wounded Storyteller*, p. 55.

> Health professionals do not understand what patients go through unless they themselves are ill, so patients feel unbridgeable chasms between themselves and those who are supposed to take care of them. The isolation of each is arresting — the patient isolated by fear of disease, the professional isolated by knowledge of it. There are dangerous divides also, for example, between nurses and doctors, between surgeons and physical therapists, between social workers and psychiatrists, and between homecare nurses and hospital nurses. These divides prevent them all from doing their best.[116]

Charon's claim that it is understanding that is lacking within the clinical encounter, and that this extends beyond the doctor-patient interaction, is important since it shows how the institute and multiple levels of care giving are embroiled in an overarching narrative of care, which is also constituted through a multitude of interpersonal and individual narratives. It is important to recognise that clinicians also suffer. However, I argue that they not only suffer from isolation based on their knowledge of disease, but also from the fact that their knowledge of a disease cannot match the understanding that patients have of their own condition. By asking the patient to perform her illness the clinic is searching for a definition of disease and illness, which can be understood and narrated in biomedical terms. When the patient is unable to perform her illness according to the clinic's narrative codes, she is thus unable to represent her experiences. This is to say that the fear that the patient experiences, and the knowledge of it that the clinician possesses, are both incomplete pictures and they cannot fully capture what it is to be ill, or what it is to live with that illness. Patient and clinical narratives are interdependent and neither can be fully understood in isolation. Butler writes:

> To speak about what is living in human life is already to admit that human ways of living are bound up with nonhuman modes of life. Indeed, the connection with nonhuman life is indispensable to what we call human life.[117]

In this chapter I have argued that the nonhuman modes of life are equally entangled within the human life of the ill subject. Institutes of care giving, such as the clinic and the hospital, are not only designed to enable encounters between doctors and patients, but have also been designed as a means of organising people according to need, class, gender, age and infirmity. Organising should be understood here as a means of categorising, dividing, isolating and narrativising subjects. The precarity of the patient status within the clinic is founded in the strange borderland that the hospital and clinic

[116] Charon, *Narrative Medicine*, p. 19.
[117] Butler, *Notes Toward a Performative Theory of Assembly*, p. 42.

represents as both a private and public space, which, as Frank notes, leaves patients feeling both isolated and encroached upon.[118] Beckett's drama offers a distinct representation of this dichotomy in the plays I have explored in this chapter — *Rough for Theatre II, Play and Catastrophe* — by exposing and humiliating isolated characters within a theatrical context that is explicitly referenced. One is rough for theatre, one is a play and in *Catastrophe* a rehearsal is being finalised. Each work is conscious of its place and status within the theatre.[119] While the rehearsal in *Catastrophe* is a somewhat private encounter, the threat of public performance is palpable and in *Play* the spotlight, the audience and the stage forces the characters to share their private experiences in public as a form of purgatorial punishment. Another example of the public and private might also be found in *Not I*, in which an isolated Mouth tells the story of her exposure in public places such as the court and the 'busy shopping centre'.[120] Through my analysis, I have sought to show how public and private spaces are difficult to navigate within institutional constraints, be they the constraints of the clinic or the theatre.

I began this chapter by questioning how Beckett's view of failure proves a productive means of viewing the medical body, and the subjectivity of that body as a patient, within clinical and creative contexts. Tracing the line between subject and patient, I argue that one of the vital challenges that Beckett's work offers towards pathological and biomedical approaches is the rejection of binary definitions and narrative codes used to describe a subject in any state. In Chapter Two I will expand upon this argument to show that the body's existence is contingent upon all the temporalities which it has, does and will occupy. Here, however, I have laid the foundations for an understanding of how the ill body is constructed on stage and how patienthood is performed both through drama and the adaptation of life writing, so that it is the experience of illness that begins to take centre stage in pathographical writing of the twentieth century. My examination of the quest narrative has shown the discrepancy between the medical expectations of narrative and the lived experience of chronic illness, and how Beckett's works illustrate the inversion of the quest to reflect the defeated, rather than the triumphant patient. Chronic illnesses problematize the predominant tropes of the recovery narrative structure by refusing to do just that, they do not recover, but instead they go on.

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[118] Frank, *Wounded Storyteller*, p. 36.

[119] Heron and Broome write that *Rough for Theatre II*'s 'status as a 'rough for theatre' and its textual history of abandonment locates the play in the margins […] showing a performing body that refuses to do what you expect on stage (to be expressive, to face us, to speak, to communicate how it feels, to reveal its inner life)' (2016). C's isolation is also exposing, as while his inner life remains unknown his public life, or rather a version of it, is laid bare for the audience.

[120] Beckett, *Complete Dramatic Works*, p. 379.

By determining the etymological roots of the term 'patient', this chapter argues that patients are rendered passive by the spaces in which they are made to interact with clinical medicine. Just like the archetypal characters of Beckett's later theatre work, being 'named' a patient denotes her function in clinical space. The role of patient flattens the topography of subjectivity, forming a homogenised group that is left unable to determine themselves as individuals, while also denying them the opportunity for collective advocacy and empowerment. Writing on the nature of political assembly and advocacy, Butler writes:

> The discursive move to establish 'the people' in one way or another is a bid to have a certain border recognized, whether we understand that as a border of a nation or as the frontier of that class of people to be considered 'recognizable' as a people.[121]

What Butler highlights is the need for a group to define itself through the carving out of its limits. Defining a group — however large or small that group may be — is done by establishing the boundaries within which that group is contained. What makes a group recognizable is their ability to be contained within a certain category, but defining that category is not without its problems.

Defining the patient appears to be similarly fraught, as by doing so we also demarcate those who are not considered to be patients, and thus embed binary stereotypes of the well and the ill subject further. My argument, however, is that by seeking to understand the roots of patienthood, we are better placed to understand how the role is expected to be performed in current medical models, and also how it might be possible to perform it in more nuanced and heterogenic ways. Patient testimony, patient-led advocacy movements such as the HVM and, moreover, patient initiated collaborative projects with healthcare professionals and artists, have already begun to challenge the assembly of patients into homogenous groups.[122] Beckett's preoccupation with medical matters has thus offered an entry point into questions concerning narrative agency and performance for both patients and actors. If Morvan is right to say, 'the client is here and nowhere else', this chapter has attempted to interrogate what 'here' is comprised of: from clinical documentation, to patient testimony, and most importantly, the institutional spaces that give rise to narrative.[123]

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[121] Butler, *Notes Toward a Performative Theory of Assembly*, p. 5.
[122] See Deborah Padfield's 'Face2face' and 'Pain: Speaking the Threshold' projects in collaboration with the University College London Hospitals, NHS Foundation Trust. See also, 'As If… Visualizing Pain', which was the result of a collaborative project with Brian Hurwitz and INPUT Pain Management Unit, St Thomas' Hospital in 2001 (*International Journal of Epidemiology* 32.5, 2003).
[123] Beckett, *Complete Dramatic Works*, p. 246.

Chapter 2

‘Where now? Who now? When now?’: Aphasic Storytelling and Anti-narrative in *The Unnamable*

‘Where now? Who now? When now?’ begins the narrator of *The Unnamable,* ‘I shall have to speak of things of which I cannot speak’.[1] From the opening lines of Samuel Beckett’s third novel in his trilogy, the unnamed narrator begins his monologue in an attempt to determine: where he is, who he is and when he is. The shape and boundary of his body is unclear, he is denied coherent subjectivity and agency and he revolves in his narrative, claiming ‘[a]t no point do I know what I’m talking about, nor of whom, nor of where, nor why’.[2] Storytelling for the narrator is hard, but also necessary. He is compelled, despite its seeming impossibility to use narrative as a means of understanding his experience. This chapter is about the difficulty of finding the right words. It is about language’s function as a tool for building narratives and the role that narrative plays in constructing a subject. I propose that through Beckett’s *The Unnamable*, such difficulties help to articulate the challenges associated with narrativisation within clinical contexts. In Chapter One I used a selection of Beckett’s theatre — covering almost twenty years — to argue that patient and clinical narratives are culturally, temporally, and institutionally implicated. I examined the role of clinical documentation and pathographical literature to argue that patient identity is performed through the spaces in which clinical encounters take place, and through the writing and documentation produced by these encounters. I want to continue this line of questioning, the difference being, however, that I want to understand how those with disordered language construct narratives, in order to shed light on the difficulties of narrativisation for all subjects more broadly.

In this chapter, patient identity is unsettled by narrativisation. By adopting the first-person narrative in *The Unnamable*, Beckett was able to explore the relationship between the subject and the language that she produces to reveal that language and storytelling — indeed expression of any kind — is troubling. While language may appear readily available to us, I examine language in terms of its inaccessibility. I argue that Beckett’s *The Unnamable* illustrates aphasic symptoms and produces an aphasic aesthetic that calls into question narrative’s restorative capabilities. Furthermore, I claim that by adopting a literary style that incorporates characteristics which might be termed dysfluent, Beckett offers up the opportunity to consider utterance — pathological or otherwise — as functioning in a non-normative way. Just as I argued for a reading of health and illness that places them both on a continuum as opposed binary opposites, I similarly want to claim that fluency and dysfluency cannot be so easily demarcated.

[1] Beckett, *Three Novels*, p. 285.
[2] Ibid., p. 332.

These terms still prove useful however, in so far as they help to signpost current thinking regarding disordered language. In Beckett's trilogy, language is cast as a troublesome tool: one that is difficult to locate and perpetually resists making meaning. This brings me to this chapter's central question: how do we narrate the self in illness and how is our ability to narrate ourselves compromised by the definitions of narrative put forward by clinical medicine? While my thesis is concerned with the way that stories are told and listened to in literary and clinical settings, this chapter specifically explores how stories are constructed when language is no longer at hand. Depictions of inaccessible language reveal that language is never easy, and our assumptions about the ways that stories are told leads to misconceptions about narrative's constancy and transparency. Disordered language, I argue, can offer a template for understanding and thinking through all narrativisation.

In her appeal toward a post-narrative medical humanities, Woods writes that the 'seldom-acknowledged assumption underpinning the medical humanities' enchantment with narrative is the view of illness narrative as the distinctive, authentic, autonomous expression of a unique individual.'[3] She continues: '[t]he scholarship on illness narrative privileges individuality, interiority, and authenticity, downplaying the interpersonal, the performative, and culturally contingent dimensions of narrative.'[4] The narrating subject, according to Woods's depiction of current thinking in the medical humanities and the clinic, should be attuned to and adept at constructing self-contained and coherent narratives. Woods's article is a call for the reappraisal of the role narrative plays within medical humanities and medical practice. While Woods writes that narrative-based approaches have previously been 'seen as salvation from biomedical reductionism […] a humanizing force,' she argues that the formalisation of this approach into narrative medicine can in fact do more harm than good.[5] She writes that 'as narrative is increasingly becoming a culturally and clinically sanctioned imperative, narrating one's *illness* experience is on the verge of becoming a compulsory activity in certain contexts [italics in original].'[6] The patient is expected to produce a narrative, and if we read narrative here as a coherent and self contained story, I argue that this view denies the opportunity for a diverse, affective and embodied understanding of a patient's experience.

[3] Angela Woods, 'Post-Narrative: An Appeal', *Narrative Inquiry*, 21.2 (2011), 399–406 (p. 402).
[4] Ibid.
[5] Ibid., p. 400.
[6] Ibid.

In her book on the ethics of storytelling, Meretoja's 'narrative hermeneutics' offers a different approach to narrative, which may prove more useful than the definition of narrative that has been formalised by narrative medicine. She writes:

> Most approaches to narrative […] rely on a hierarchical dichotomy between living and telling, based on the assumption that there is pure or raw experience on which narrative retrospectively imposes order. Narrative then easily appears as a projection of false order, or a distortion of the original experiences or events. Narrative hermeneutics, in contrast, questions the dichotomy between living and telling by stressing that experience is continuously mediated. Its key insight is that *cultural webs of narratives affect the way in which we experience things in the first place* [italics in original].[7]

While I agree that 'experience is continuously mediated', and that experience does not happen only to be followed up by narrative, I wish to extend this argument to claim that narratives and language production are both mediated through experience, and are also temporally determined. Narratives cannot remain static, just as experience cannot. Instead, the language that is used to narrate an experience is specific to that particular instance of narration, that is to say it is tethered to a particular time and place. Narrative, therefore, does not only concern the story but also the conditions under which it is told. These narratives rely upon language in order to be communicated and it is with this in mind that I explore language production in philosophical, psychological, anthropological and neurological terms. The various manifestations of language as an organ or speech, a neuronal process, a series of interconnecting systems, and an externalised network, are explored to show that language is connected and indeed connects each of these elements to one another. By focussing on the intersection between aphasic symptoms — Beckett's aphasic (or dysfluent) writing — and the so-called 'normative' function of language, I argue that we are better equipped to determine an alternative to the conception of narrative that is so firmly held by the medical practitioners, whom Woods cites. Beckett's language is material, but it is also non-pathological. While it shares characteristics with aphasia and dysfluency, I am using Beckett's *The Unnamable* in this chapter to posit that the process of narrativisation is always difficult.

In section one of this chapter, 'Narrative-Based Bodies', I question Charon and Hurwitz's work on the possibilities of narrative-based medicine and Charon's problematic depiction of co-produced clinical encounters. Hurwitz and Charon seek to

[7] Hanna Meretoja, *The Ethics of Storytelling*, pp. 8-9.

cultivate a sense of inclusion and collaboration during their consultations, by arguing for medical care that allows space for the patient's voice within the encounter. I argue, however, that the co-constructed nature of these patient narratives is still dominated by biomedical discourse, which presupposes that the narratives recorded remain fixed. Beckett's narrator in *The Unnamable* approaches narrative construction as though it were absolutely necessary, despite its inevitable failure. As he tries to understand who and what he is through narrative, it is his inability to locate himself temporally and spatially, which challenges and reifies the biomedical view of language: this narrative is necessary, subject to change, vulnerable to the more powerful discourses which lead it on and astray, and is always troubled. The breakdown of narrative through the act of narrating shows storytelling to be an event that retells experience, but it also comes to represent the new experience of telling.

Section two, 'The Contingently Ill Body' argues that, while the patient is expected to narrate herself as a self-contained individual, the body defies such autonomy and produces messier, material language that is both intentional and automatic. Aphasia is a productive focus for the study of telling illness stories, as it both crosses and occupies the boundary between automaticity and intentionality. These patient narratives are contingent upon the body's materiality and also its position among a wider network of environments, narratives and speakers. I will use the anthropologist Roger Bartra's study of the brain, which hypothesises the existence of a cultural exocerebrum that functions as a prosthetic substitute for the shortcomings of neural processes, to argue that non-pathological cognitive functioning is contingent upon the outside world. Language is one such cultural prosthesis, which functions as a connecting tool between the subject and the world around them. Narratives, I argue, do not sit independently from the person who creates them, or from the person who listens to them. They are affectively embodied, taking place between bodies, while linking them to one another. This dynamic is troubled, however, in the face of pathological disordered language. Telling stories of any kind of illness is challenging, but when language is no longer accessible to the subject who wishes to articulate it, greater problems are encountered.

The study and practice of aphasiology has focused on the variances in language production. Evolved from studies of phrenology, nineteenth-century aphasiologists attempted to define and depict aphasia by creating a litany of maps and diagrams. These visual representations of the brain and language function sought to illustrate language and speech centres within the brain, and in doing so locationalist aphasiologists, such as Josef Gall, Paul Broca and Henry Charlton hoped to better understand the causes for

this heterogeneous condition. While this approach remained dominant, there was significant backlash to locationalist theories, as I shall explore in the third section of this chapter, 'Locating and Narrating Aphasia'. British neurologist and aphasiologist John Hughlings Jackson was highly sceptical of the value that diagrammatic renderings of the condition brought to the study of aphasia. 'To locate the damage which destroys speech and to locate speech are two different things', writes Hughlings Jackson.[8] The source of speech, he believed, could not be as easily located as the brain damage that affected it. As a physician, Hughlings Jackson was primarily concerned with examining individual patient cases and manifestations of aphasia, as opposed to establishing a global definition and illustration of it. Moreover, Hughlings Jackson's emphasis on the patient's symptoms, and his particular interest in the effects of aphasia on speech, helps to expand upon dualistic theories of intentional (or 'intellectual' as Hughlings Jackson saw it) and automatic speech.[9] Chris Code and Laura Salisbury write that:

> Reading Beckett's work alongside Hughlings Jackson's thus allows us to explore the ways in which Beckett persistently returns to a sense of language as a product of a fragile, material brain, which, though partially able to subserve subjective intention and relationality, is nevertheless always both in continuity with a material body and in cahoots with those automatic and involuntary aspects of human functioning that force any understanding of the self beyond the impervious boundaries of the Cartesian *cogito* [italics in original].[10]

I agree with Code and Salisbury's claim, and yet, while their use of his work is productive to an understanding of Beckett, I argue that Hughlings Jackson is of further use when understood in the context of clinical practice as opposed to as a theoretical aphasiologist. Hughlings Jackson's depictions of aphasia and its associated symptoms were formed through his engagement with patients, and it was through individual cases that a broader understanding of the condition was founded. I argue, therefore, that his work on the emergence of new linguistic circumventions presented a more nuanced view of aphasia, as a condition that shares many characteristics with non-pathological functioning. The distinction between so-called 'normal' and pathological functioning becomes increasingly contested and problematic in Hughlings Jackson's conception of

[8] John Hughlings Jackson, *Selected Writings of John Hughlings Jackson Volume Two: Evolution and Dissolution of the Nervous System Speech, Various Papers, Addresses and Lectures*, ed. by James Taylor (London: Staples Press, 1958), p. 130.
[9] L.S. Jacyna, *Lost Words: Narratives of Language and the Brain 1825-1926* (Oxford: Princeton University Press, 2000), p. 138.
[10] Salisbury and Code, 'Jackson's Parrot', in *Talking Normal*, ed. by Eagle, pp. 100-23 (p. 102).

the articulating subject. Non-pathological language is not, as has previously been believed, seamlessly and fluidly produced.

I will also use the work of contemporary clinical psychologists Ben Alderson-Day and Charles Fernyhough, to examine inner speech, which is vital to myriad cognitive processes, including: word finding, self-regulation and meaning-making (all of which are impacted by aphasia). The case of Jill Bolte Taylor, who suffered a left hemisphere stroke, gives insight into the aphasic patient experience, and I use her story to draw connections between word finding, the aphasic subject's self-awareness and the narrator in *The Unnamable*. Read through the lens of patient and clinical testimony on the effects of aphasia, *The Unnamable* can be understood as an aphasic text that also challenges notions of normative language function. By reading *The Unnamable* in this way I argue that the inherent difficulty of narrating one's experience can be illuminated, as it is not only challenging to find the right words with which to tell one's story, the story itself is also subject to change based upon when and how often it is told. The final section of this chapter, 'Dysfluent Storytelling', considers the implications of temporality upon the production of narratives and the retelling of patient stories. Deleuze writes that 'a body's structure is the composition of its relation',[11] it 'is defined by duration' and so constituted temporally (or across multiple temporalities).[12] Deleuze's theory of duration helps to better understand how the body of the patient and the narrator of *The Unnamable* are constructed and narrated temporally. The present body is composed in its relation to all those temporalities that it has, does, and will occupy. In this sense the body cannot exist within a binary medicalised framework of now and then, or well and ill. Instead, it traverses all states, each of which informs and is founded upon the other, at the same time. The body exists in a temporal flux, which I argue should be entangled into notions of narrative within the clinical encounter. Deleuze's reading of Beckett's language also plays a vital role in this chapter. Salisbury writes that Deleuze's work on Beckett: 'recognises the suggestive continuity between the ways both art and disease reformulate the givens of sensation, perception, cognition and even subjectivity itself.'[13] Both art and disease, it seems, have the ability to challenge normative models of language and narrativisation.

Contemporary dysfluency scholars, such as Chris Eagle, call for new representations of language disorder, and contest prevailing ablelist narratives that see

[11] Gilles Deleuze, *Expressionism in Philosophy: Spinoza*, trans. by Martin Joughin (Cambridge, Massachusetts: The MIT Press, 1990), p. 218
[12] Ibid., p. 220.
[13] Laura Salisbury, 'What Is the Word', p. 118.

disordered language as a disability. Taking the discourse of Disability Studies as its guide, Eagle argues that a new Dysfluency Studies, would 'destabilize rigid or facile notions of fluency. It would understand mastery over language as always already tenuous, fragile, and partial.'[14] The problematic position of dysfluency within the schema of disability is caused, in part, by its invisibility. Dysfluency does not appear to affect the way that the subject occupies space and moves about the world. It does, however, have a significant effect on the subject's ability to narrativise her experience. Without language, narratives are hard to construct, but the crucial argument laid out in Eagle's collection is that producing language is never easy and that to assert one's identity effectively it is expected that one must do so fluently. Based upon a growing interest and consideration of the 'status of the self in relation to language loss and language breakdown', Eagle claims that these conditions have hitherto occupied a 'liminal position' in wider scholarly fields, including philosophy, literary criticism, medical humanities, sociolinguistic, etc.[15] He writes that 'the more fundamental issue of fluency, or access to normal speech is hardly ever raised in discussions of political marginalization. Much theoretical work in identity politics, in short, depends upon a normalization of fluency', which must be challenged and interrogated.[16] The marginalization of these conditions is due in part to the subject's inability to voice them, but a new dysfluent canon, he argues, should encompass 'works that portray or perform clinically disordered speech as well as aesthetically defamiliarised works that force us reassess the boundaries of normal speech.'[17] While Eagle might be criticised for his omission of a clear definition of the 'normal', this seems to be precisely the point. The 'normal' or 'fluent' does not have such easily defined boundaries and the abnormal or dysfluent is not simply antithetical to normative fluency. The spectrum between the 'normal' and pathological is far more nuanced than the two binaries would suggest. If, like Georges Canguilhem, I use the pathological as a means of understanding the 'normal,' it is not to reveal how the 'normal' functions *normally*, but rather, to uncover the non-normative relationship we have with normal experience and functioning, and challenge the notion that the subject in nature is in 'harmony and equilibrium.'[18] What Canguilhem, and Foucault after him, both stress is the violence that this does to patient, when they are forced to adhere to these distinctions. Within clinical contexts, this

[14] Chris Eagle, 'Introduction: Talking Normal', in *Talking Normal*, ed. by Eagle, pp. 1-8 (p. 6).
[15] Ibid., p. 2.
[16] Ibid., p. 4
[17] Ibid.
[18] Georges Canguilhem, *The Normal and the Pathological*, trans. by Carolyn R. Fawcett and Robert S. Cohen (New York: Urzone Inc., 1989), p. 40.

establishes a narrative form, which will always leave patients vulnerable to the categories that are laid upon them. The storyteller in illness can be reconfigured through Dysfluency Studies, and Beckett's adoption of pathologised traits in *The Unnamable* can be read to contest notions of a stable and self-contained 'normal' subject.

Meretoja writes:

> Narratives are not only a means of understanding the self and other; they also function as practices of social interaction that perpetuate, create, and transform intersubjective spaces and identities. Storytelling is a mode of interaction that makes it possible to connect with other people, share experiences, and establish new communities and modes of relationality. It curates, shapes, and perpetuates both ethically productive and problematic narrative in-betweens.[19]

This chapter is located in these 'narrative in-betweens'. Beckett's *The Unnamable* places its protagonist and the reader within this borderland and demonstrates the difficulties of articulation through insistent, urgent and entropic narration. While we attempt to use narrative as a 'means of understanding self and other', the self remains consistently under question.[20] For the pathological and non-pathological subject alike, expression is always a challenge, but as Beckett wrote in 1949, the artist must recognise 'the expression that there is nothing to express, nothing with which to express, no desire to express together with the obligation to express.'[21] This famous claim can be used to read both the difficulty of artistic production and the challenge of articulating experiences of illness within the clinic. Regardless of whether or not the subject is pathological, speaking and narrating the self is always troubled, despite its necessity.

Narrative-Based Bodies

Steven Connor writes that *The Unnamable* is 'the ultimate point of paradoxical intensification, where narrative means have shrunk to nothing, but narration must go on'.[22] It is with this in mind that I begin my exploration of the narrator of *The Unnamable*, who uses language as a tool by which to tell his story and connect him to his surroundings, at the same time as revealing language's shortcomings. The narrators in Beckett's trilogy, *Molloy*, *Malone Dies*, and *The Unnamable*, are diversely impaired, but the narrator's impairment in *The Unnamable* — both his difficulties with language and his bodily ailments — is more pronounced and inhibitive than those of the

[19] Meretoja, *The Ethics of Storytelling*, p. 117.
[20] Ibid.
[21] Beckett, *Proust*, p. 103.
[22] Samuel Beckett, *The Unnamable*, ed. by Steven Connor (London: Faber and Faber, 2010), p. xviii.

preceding novels. The narrator's language brings him into existence, but his identity is constantly undercut, both as he doubts the intelligibility of his words and by his repeated replacement of himself with a series of characters he names his 'vice-existers'.[23] The narrator's narrative is a profusion of language that asks questions of his place in the world, how he came to be where he is and who it is that is dictating his narrative, and although he attempts to answer these questions they are never resolved.

Connor's claim that narrative has 'shrunk to nothing' suggests that the narratives of the preceding novels are more concrete.[24] The eponymous Molloy begins his narrative: 'I am in my mother's room. It is I who live there now.'[25] And Malone in *Malone Dies* says: 'I shall soon be quite dead at last in spite of it all. Perhaps next month. Then it will be the month of April or of May.'[26] Molloy seems to know where he is, and Malone has a sense of when his story is taking place. By contrast, the narrator of *The Unnamable* opens, 'Where now? Who now? When now?'[27] This denies the reader any specific time, place and characterisation within the narrative. It is also the beginning of the novel, which is to say that despite all these uncertainties, and despite the fact that the novel may not be able to answer each of these questions, narration still continues. What keeps the reader reading then is the form that the novel takes. It is not a question of what the narrative tells, but how it is told.

Beckett's choice of form always provided new opportunities for different ways of writing and offered him the chance to engage with various kinds of technology, performance, prose and voice. The trilogy represents a significant moment in Beckett's career, in which the first-person narrative and a (supposedly) single voice, is responsible for storytelling. I want to question how this narrative is constructed. The notion that the first-person narrative belongs to the subject who narrates it, and, moreover, that he has control over what he narrates, is misleading, and fails to account for the myriad factors that influence the narrative. Narratives, I argue, are co-constructed. They are contingent upon the space in which they happen, the voice that produces them, and the subjects that are present to hear and interpret them. By claiming that Beckett's 'narrative means have shrunk to nothing', Connor overlooks the narrator's entangled, multi-vocal narrative which, as a product of co-constructed discourse, demonstrates the depleted but defiant voice of the narrating subject.[28] This narrative is not a simple one. It does not make

[23] Beckett, *Three Novels*, p. 309.
[24] Beckett, *The Unnamable*, p. xviii.
[25] Ibid., p. 3.
[26] Ibid., p. 173.
[27] Ibid., p. 285.
[28] Beckett, *The Unnamable*, p. xviii.

confident assertions about the self who narrates, but its insistence, and its continued attempts to try and narrate experience, illustrates the difficulty and importance of narration.

Narrative's difficulty and necessity has been much discussed within the medical humanities and clinical practice. The construction of a narrative-based methodology for medicine has been put forth by clinicians/scholars such as Hurwitz and Charon, who claim '[n]arrative medical practices and sensitivities help clinicians appreciate relational styles of thought and interaction in medicine that go beyond disease-framed, chronological history-taking.'[29] Writing in *The Lancet*, Hurwitz and Charon argue for a 'narrative future for healthcare', which 'acknowledge[s] the role of expressive storytelling and story-listening in medicine as forms of exploration, assimilation, and communication that promise better understanding and improvement of healthcare.'[30] Narrative needs to explore, assimilate and communicate through storytelling, but while this positivist view of narrative's capacity to augment healthcare might be tempting for the clinician who cares for, and empathises with her patient, the problem remains as to who explores, who is required to assimilate and what it is that is being (or ought to be) communicated. Hurwitz and Charon are quick to remark that narrative-based healthcare should go 'beyond disease-framed, chronological history-taking', but their focus remains on understanding 'narrative codes and techniques which shape clinical conversations' and it is these codes and techniques that perpetuate a utilitarian approach to narrative.[31] Narrative, according to their reading, has a clinical function and their focus on the quality of the narrative, in so far as it is possible for it to be interpreted, emphasises that a narrative is read (or heard) primarily for its content. For this branch of narrative-based medicine what is said appears to be more important than how it is said.

The form that the narrative takes is, in some senses, invisible in this instance. Hurwitz writes that clinical encounters are 'complex processes of story construction and exchange where fragments of experience in different stages of narrativity are elaborated and pieced together.'[32] I want to contest this view of narrative, which deems so-called 'fragments' of a story as intrinsically insufficient. According to Hurwitz, these fragments must be brought together into a cohesive whole in order to be made sensible to the clinician. Moreover, it is significant that it is the clinician that pieces these

[29] Brian Hurwitz and Rita Charon, 'A Narrative Future for Healthcare', *The Lancet*, 381.9881 (2013), 1886–87 (p. 1887).
[30] Ibid.
[31] Ibid.
[32] Brian Hurwitz, 'Narrative and the Practice of Medicine', *The Lancet*, Literature and Medicine, 356.9247 (2000), 2086–89 (p. 2087).

fragments together. I argue instead, that the fragments should be examined more closely and that each fragment operates, and is reconstructed, across multiple temporalities. First, that each fragment is contingent upon the time and place in which it has occurred. Second, that by narrating that fragment of experience we create another temporally located narrative, and thus a reification of the experience through narration. Third, through the consolidation of these fragments into what Hurwitz calls the 'story', a new narrative is constructed. Once the clinician has consolidated these fragments, the narrative is now fixed and cannot take into account subsequent changes to the patient's attitude, experience, or condition. While Charon and Hurwitz pay lip service to the non-linear and non-chronological nature of narratives, their objective remains fundamentally to re-order and assimilate the experience of the patient into a single story, which occludes the temporal specificity of the narrative within the wider field of experience. Narratives, I argue, are fixed to the instance in which they are told, so that we can rarely (if ever) tell a story the same way twice. And so, by forcing fragments — which are necessarily fragments — into a narrative whole, the freedom to express some sense of the experience, however disordered that experience might appear, is lost for the patient and clinician alike.

In his 1929 essay 'Dante… Bruno. Vico. . Joyce', Beckett boldly opens with: '[t]he danger is in the neatness of identifications.'[33] This examination of Joyce's *Finnegans Wake* — then titled 'Work In Progress' — warned against the scholar's need to 'wring the neck of a certain system in order to stuff it into a contemporary pigeon-hole, or modify the dimensions of that pigeon-hole for the satisfaction of analogymongers', for the sake of neat, and well-ordered literary criticism.[34] Hurwitz's compulsion to weave the threads of a patient's story into a cohesive whole is redolent of the approach taken by literary critics, which Beckett reprimands here. Beckett's scathing view of those critics that saw literary criticism as a kind of 'book-keeping' illustrates the damage that can be done by imposing retroactive and fixed meanings onto the storyteller and her story.[35] It suggests, as I have said already, that the importance of the story lies in its content and that the form a story adopts should lend itself to easy (and diagnostic) interpretation. I argue that an attention to form can help improve the way that patient narratives are read and understood and that this literary critical approach could serve as a means by which to better attend to the patient's story. While Hurwitz and Charon

[33] Samuel Beckett, *Disjecta: Miscellaneous Writings and a Dramatic Fragment*, ed. by Ruby Cohn (London: Calder, 1983), p. 19.
[34] Ibid.
[35] Ibid.

consistently examine the content of their patients' stories, the process of narrative production as an event in and of itself is somewhat overlooked.

I want to understand how the patient constructs her narrative in the clinic, when the form itself is flawed from the outset. Medicine's conception of narrative has played a central role in determining the clinical care delivered to the patient. Charon writes of one consultation:

> I listen not only for the content of [the patient's] narrative but its form — its temporal course, its images, its associated subplots, its silences, where he chooses to begin in telling himself, how he sequences symptoms with other life events.[36]

While Charon mentions form, the form that she is most concerned with is the form given to the content of the patient's narrative. I see Beckett's depiction of form as markedly different. It is the act of telling, rather than the way in which something is told, which is significant. It is with this in mind that *The Unnamable* offers narrative which tells the story of a body in illness, through a language which is disordered. The language rejects interpretation and is its own event, and while it is told through first-person narration, the voice is clearly a product of multiple voices and the environmental context that leads and informs its production.

Much of Charon's work on narrative medicine sets up the clinical consultation as a co-productive space in which the patient and clinician play an equal part in telling the patient's story. She writes:

> I have come slowly to appreciate that patients should be the curators of what we write about them. At the conclusion of visits, I give patients a copy of my chart note, making sure that they can read my handwriting and encouraging them to add to what has been said […][37]

In Chapter One I showed how patienthood is performed and enacted through clinical notes and documentation and, as such, often becomes a purely clinical representation of the chronically ill patient. Charon acknowledges this precedence and so proposes an alternative method by which the patient's perspective is incorporated into her medical notes. By encouraging the patient 'to add to what has been said', it seems that Charon cultivates a co-produced narrative of — and for — the patient, in an attempt to work against received understandings of what patient notes should look like, and thus align

[36] Rita Charon, 'Where Does Narrative Medicine Come From? Diseases, Drives, Attention and the Body', in *Psychoanalysis and Narrative Medicine*, ed. by Peter L. Rudnytsky and Rita Charon (New York: State University of New York Press, 2008), pp. 23-36 (p. 23).
[37] Charon, *Narrative Medicine*, p. 190.

the notes with the patient's experience of her condition.[38] Yet, like her supposed rejection of non-linear and non-chronological narratives, by letting patients contribute to their notes and validate them as it were, Charon does not solve some of the fundamental problems of doctor-patient documentation. What matters here is that the patient feels that her notes have been co-produced and that she has had some role in telling her story, but the collaboration between the doctor and patient is somewhat gestural, as the medical voice remains the more dominant one within clinical documentation.

The examples I have described here illustrate narratives that have been told for the first time. Stories change, however, when they are told more than once. Often patients are required to tell their stories many times over and to multiple clinicians, and when they do, their storytelling evolves. I have argued that the dominant clinical narrative fixes the patient's story, while denying its specific temporality, and therefore it would seem that this initial narrative shapes further iterations of supposedly the same story. In his landmark book, *The Illness Narratives: Suffering, Healing and the Human Condition*, Kleinman explores how illness narratives are constructed, and what should be done with them once they have been produced. His line of enquiry is similar to that of Charon and Hurwitz (both of whom are influenced by Kleinman's work), as he defines the illness narrative as 'a story the patient tells, and significant others retell, to give coherence to the distinctive events and long-term course of suffering.'[39] Kleinman's examination of storytelling's chronicity, however, raises an important issue concerning the entanglement of experience and narrative in cases of chronic illness. Storytelling has chronicity precisely because it takes place over time at the same time as incorporating multiple temporalities within the instance of storytelling. He writes:

> The plot lines, core metaphors, and rhetorical devices that structure the illness narrative are drawn from cultural and personal models for arranging experiences in meaningful ways and for effectively communicating those meanings. Over the long course of chronic disorder, *these model texts shape and even create experience*. The personal narrative does not merely reflect illness experience, but rather it contributes to the experience of symptoms and suffering (my emphasis).[40]

Storytelling not only attempts to reflect experience, it also creates it, as it becomes another manifestation of the patient's symptoms, and a symptom in its own right. When a patient tells her story, this story becomes fixed. The clinician records it in the first

[38] Charon, *Narrative Medicine*, p. 190.
[39] Kleinman, p. 49.
[40] Ibid.

instance, but it is also often necessary for the patient to have to repeat her story to other members of a clinical team. The story may have been told at first so that the clinician can come to a diagnosis, but as the story is repeated over time it no longer serves this purpose and is no longer reflective of the patient's immediate experience. Moreover, with the emphasis placed on telling a story from which meaning can be drawn, the patient is led to reorder her story according to what the clinician deems to be valuable. The patient tells her story for others, so that narrative becomes another manifestation of clinical control, as opposed to an opportunity for the patient to articulate her present experience and concerns.

The narrator of *The Unnamable* is also subjected to the dominating force of others, as he attempts to construct his narrative. In this dizzying extract, the narrator desperately tries to assert control over his story, only to find himself beholden to the narrative expectations of an 'other', exogenous force:

> I know no more questions and they keep on pouring out of my mouth. I think I know what it is, it's to prevent the discourse from coming to an end, this futile discourse which is not credited to me and brings me not a syllable nearer silence. But now I am on my guard, I shall not answer them any more, I shall not pretend any more to answer them. Perhaps I shall be obliged, in order not to peter out, to invent another fairy-tale, yet another, with heads, trunks, arms, legs and all that follows, let loose in the changeless round of imperfect shadow and dubious light.[41]

The narrator must continue to tell (or reinvent) what he calls 'another fairy-tale' so as 'not to peter out'. He must submit himself to the narrative that is expected of him, as opposed to one that he has autonomously constructed. While these narrative forces are pressed upon him from the outside, the pressure to speak, and the questions the narrator must answer, are importantly positioned as both coming to him and from within him, as the questions pour from the narrator's own mouth. The compulsion to narrate persists from within the subject, at the same time as coming from externalised encounters. Like Kleinman's claim that storytelling is born from the experience that subsequently comes to shape it, the obligation for the narrator to tell his story, and answer questions, comes to and from him. When producing further versions of her story, the patient must make them appropriate for the attention of the doctor. She must amend her story to make it valuable to the clinician, so as to feel that something has been said, and that something will be heard. Patient narratives may be co-produced, but the clinician whom the patient consults governs this production. As this chapter is concerned primarily with aphasic

[41] Beckett, *Three Novels*, p. 301.

storytelling, I want to argue that the aphasic experience troubles the matter of narrative production further, as the patient tries to give voice to a story with disordered language.

The opportunity arises, then, for me to extend this co-productive storytelling to conceive of new ways in which to tell, show and think stories with and without language. Medical historian L.S. Jacyna writes that:

> [N]arrative does not present a single way of knowing the patient or the disease. There is on the contrary a multiplicity of narrative forms in which very different patients and diseases can be constructed as legitimate objects of knowledge. The 'clinical reality' to which rhetorical appeal is so regularly made is therefore an historically contingent entity.[42]

While disease and disorder are understood as 'objects of knowledge', it is still unclear as to what one comes to know. The multiplicity of formal representation means that there is no one way to tell a story and that no one story can be told the same way twice. The illness story or pathography is distinct from other genres of storytelling and in Chapter One I argued that the pathographical form often adopts the tropes of a quest, using the first-person narrative to explore the experience of illness as a rupture in the life of the sufferer. The hero/pioneer of the pathography seeks to return to a healthy state and is made stronger and more defiant by the trauma that they have experienced. As I have already argued, however, these perspectives on illness, recovery and the regenerative potential of narrative are deeply troubling. Jacyna's claim that narrative enables heterogeneous patients and diseases to become 'legitimate objects of knowledge' similarly suggests that, prior to narration, these subjects and their symptoms were hitherto in some way illegitimate. While I disagree with the view that narrative is a legitimizing force, it is true that the so-called 'reality' that is captured within a narrative is historically contingent. This is a question of the ethical implications of narrative within the clinic. How can narrative function effectively and who is it that decides whether a narrative has been effective or not?

Meretoja's work is helpful in addressing these questions. She argues that storytelling has the power to both unite and 'impoverish' the spaces in which individuals interact with one another.[43] In the wake of the Holocaust, Meretjoa, like Adorno before her, considers the implications of attempting to narrate trauma and configures a new 'narrative hermeneutics', which considers how narratives arise, and how they are interpreted. In the second half of the twentieth century, the driving force

[42] Jacyna, p. 24.
[43] Meretoja, *The Ethics of Storytelling*, p. 2.

behind much of these narrative forms was an attempt to communicate the horror of the events of the Second World War, and to potentially repair oneself of trauma. Yet, as Meretoja writes:

> Poststructuralistically oriented trauma theorists not only suggest that trauma is de facto inassimilable to narrative understanding, but also that narrative form itself is ethically problematic in its attempts to make sense of traumatic experience. This is because the act of storytelling is taken to reduce an irrevocably singular event into an account that appropriates it by giving it a general meaning or explanation.[44]

It is dangerous and damaging to assume that such horrifying events might be narratable. The event, as she says, is so 'irrevocably singular' that by trying to narrate it, the narrator implies that it is possible for it to be reproduced. Telling illness stories faces similar challenges. The expectation that a patient should narrate a comprehensible account of the experience of her illness presupposes that such experiences can be narrated. Narrating the event does not, I argue, make the experience more legitimate, nor does it help to make sense of the experience overall, but the compulsion to produce narratives — or something akin to narrative — does still hold for many patients and victims of trauma alike. Meretoja's 'narrative hermeneutics' seeks to reconcile this impasse, as it acknowledges the impossibility of subsuming narratives into a 'pregiven mold', while claiming that 'narratives function as a vehicle for genuine understanding precisely when they do not concern the comfortable subsuming of new experiences into what we already know, but rather when they involve a process that entails change'.[45] Within a clinical context the patient is expected to narrate a story which will help the clinician to produce a diagnosis, and while Hurwitz and Charon have emphasised narrative's role in fostering better doctor-patient relationships, the form that this narrative takes — a medical history — inadvertently pushes the patient's story into a clinical pregiven mold. This is not to say that the clinician is unfeeling, nor that she does not care about the wellbeing of her patient, but rather that the clinical pregiven model primarily focuses on a series of diagnostic markers that help to identify a disease. This model does not acknowledge the opportunities that narrative offers to effect change and uncover information and experiences that do not directly point to a diagnosis. When read in a more expansive and humanistic way narrative can, I argue, be a method for discovery that supports interpersonal relationships between doctors and

[44] Meretoja, *The Ethics of Storytelling*, p. 114.
[45] Meretoja, *The Ethics of Storytelling*, p. 115.

patients, and not simply a means of communicating thoughts and events that relate to the biomedical aspects of illness.

It is understandable then, that the patient and the traumatised subject readily move toward silence as a way of navigating or avoiding the challenge of narration. Though this thesis does not advocate for silence in response to trauma and illness, instead it asks that we challenge the ethically compromising view that narrative is the only way that the body can express itself. Illness is far messier and less intentioned than this narrative model allows for. Torn between the horrors of speaking and his need for silence, the narrator of *The Unnamable* determines that: 'this futile discourse […] is not credited to me and brings me not a syllable nearer silence.'[46] This urgent speech is the narrator's attempt to move towards the silence that he longs for, but at the same time, he fears what an eventual silence might bring. Moreover, in trying to unpick the nature of his discourse, the narrator seeks out the definition and function of the language he expresses. This is not so much a question of trying to narrate, but instead, producing narrative(s) that cannot be controlled or understood. This contradiction between intention and automaticity of language is one of the central similarities between aphasic and disordered speech, and the narrator's narration.

The Contingently Ill Body

Within the clinic, narrative is interpreted for diagnostic purposes, and yet this only accounts for intentional speech that intends to communicate. For those who suffer from disordered language and aphasia, language's intentions are clearly unsettled. For Beckett, language is neither purely intentional, nor purely automatic. It is certainly just as 'natural' as other cognitive and motor functions of the body, but it remains a troublesome and self-conscious act. Code and Salisbury tease apart the distinctions between automatic and intentional language, by highlighting the consistently embodied nature of language production in Beckett's writing. They write:

> Beckett's determination that his art should use the emotional and somatic to write language beyond any simple expression of intention and rationality can be historically contextualized and its nuances illuminated by placing it alongside aphasiological understandings of language that demonstrate that much of our speech activity is not under ongoing, moment-to-moment control. And by exploring the meeting within speech and language of the voluntary and the involuntary, the rational and the emotional, the conscious and the unconscious, the representational and

[46] Beckett, *Three Novels*, p. 301.

> the modal, we can perhaps better understand Beckett's vital attempt to write the linguistic self as an insistently psychosomatic entity.[47]

Language's voluntary and involuntary dualism means that it is both familiar and alien, within the bounds of control and intention, while also unstable and unconscious. Forming the foundations of narratives with such a slippery and recalcitrant language, suggests that one can never be certain that what is said is fully representative of the experiences it recounts. Beckett was, they write, preoccupied with 'forms of somatic 'incontinence,' transformed into language', and his language bore 'witness to the compact between intention and automaticity both in and of words. It is precisely in this 'borderland,' we maintain, that Beckett's psychosomatic language stakes its aesthetic claim.'[48] The borderland discussed here will be of greater importance in examining how language is constructed between bodies, and also how language binds them together. Language can be understood as an externalised cognitive tool, but for the moment, the focus remains on how intentional and automatic utterances coalesce.

Frank has written on the infantilising effects of illness. In illness, the body is no longer in control of its boundaries, and cannot regulate what passes between it and the outside world. With this loss of agency, the subject feels both shame and the obligation to restore her body to its supposedly self-contained, prior state. He writes:

> Contingency is the body's condition of being subject to forces that cannot be controlled. The infantile body is contingent: burping, spitting, and defecating according to its own internal needs and rhythms. Society expects nothing more, and infants are afforded some period to acquire control. When adult bodies lose control, they are expected to attempt to regain it if possible, and if not then at least to conceal the loss as effectively as possible.[49]

This ill body is a childish body, one which interacts with the world freely and breeches its own boundaries, spilling over uncontrollably. It is in this way that aphasia can be reintroduced, as it is a condition that can neither be controlled, nor contained. While there are certainly contradictions between the contingent body and the aphasic one: one appears incontinent, the other closed and unbreachable, nevertheless the automaticity and intentionality of language and the body can be viewed through an aphasic lens, so as to examine the spaces that language occupies.

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[47] Salisbury and Code, 'Jackson's Parrot', in *Talking Normal*, ed. by Eagle, pp. 100-23 (p. 110).
[48] Ibid., p. 106.
[49] Frank, *Wounded Storyteller*, p. 31.

In the case of both the ill body and the aphasic subject, it is a question of understanding where the borders of the body and its language lie, and how language is mediated through the body. Aphasia — a condition most commonly caused by stroke and left-hemisphere brain damage — demonstrates the difficulties of language in the sense that for some it can be difficult to speak, and for others, speech flows but is incomprehensible. The subject with Broca's (expressive) aphasia cannot find her words, and is thus unable to utter intelligible sounds. For those with aphasia, for whom expression is not a problem — most commonly referred to as Wernicke's (or receptive) aphasia — the subject speaks in jargonistic and unnavigable streams and does not know that she is incomprehensible, nor is she able to moderate her expression. It is how one masters or does not master expression that both differentiates and likens aphasia to the leaking body of the infantile and contingent patient. The emphasis here is not on what crosses the boundaries of the body, but instead the process of its passing. And, moreover, that which occupies the 'borderland' space Code and Salisbury refer to. The emphasis, according to Frank's account, is on acquiring control, so that the body can be silenced and made invisible once again. Aphasia seems a productive point of study here, as in many ways the condition does not fit the narrative-based model of illness, because the body cannot be relied upon to produce the story of the illness it experiences. In attempting to understand the aphasic experience, it is not simply a case of understanding the patient's story, but rather, the challenge of drawing the story out. Telling the story of aphasia is the event through which the illness is demonstrated and mediated.

Despite the difficulty of narrating his experience, the narrator's language in *The Unnamable* is insistent and throughout the novel he attempts to locate himself more concretely within the world in which his narrative takes place. Again, the expectations of narrative are defied. Neither the narrator's body, nor his location can be determined. 'I like to think I occupy the centre,' he narrates 'but nothing is less certain. In a sense I would be better off at the circumference, since my eyes are always fixed in the same direction.'[50] The centre and circumference of what is never made clear, but his attempt to place himself within some kind of spatial relation, not only to the other characters he narrates, but also his own body, prevents any notion of a stable and located self. The body itself is also difficult to define. Throughout the novel the narrator attempts to determine his physical shape and characteristics, but he never seems sure of where or what he is: whether he is sitting or lying, whether he is 'a ball' or 'a cylinder', or even

[50] Beckett, *Three Novels,* p. 289.

'an egg', or whether his head is raised or bowed.[51] Furthermore, it is unclear whether the narrator is speaking with his own voice, or the voice of the others who have forced him to speak.

Emitted from the mouth, the voice carries forth our language. As Mladen Dolar writes, 'the voice is what language and the body have in common, it is the point of their intersection'.[52] Moreover, it is the mouth, according to Brandon LaBelle, that 'captures and figures the somatic, the alimentary, the resonant, and the viscous as always surrounding language, 'cutting and augmenting meaning,' flinging it all over the place.'[53] In his book *Lexicon of the Mouth,* LaBelle turns to Beckett's *Not I,* and the depiction of the mouth as, '*an irrupting orifice*. This mouth cannot stop and bites down onto language in search of transformation [italics original].'[54] Language is the transformative element and, like the protagonist Mouth in *Not I*, the narrator's compulsion to speak throughout *The Unnamable* is not only an effort to narrate himself into existence, but also to understand the limits of his ability to exist and narrate. His language, like Mouth's 'stream of words', is material.[55] Where Mouth has a 'mouth on fire', the narrator of *The Unnamable,* cannot stop crying.[56] He says:

> The tears stream down my cheeks from my unblinking eyes. What makes me weep so? From time to time. There is nothing saddening here. Perhaps it is liquefied brain. Past happiness in any case has clean gone out of my memory, assuming it was ever there. If I accomplish the other natural functions it is unawares.[57]

It is not language that leaks from him, though later in the novel he does ask: '[w]here do these words come from that pour out of my mouth', rather, in the quotation above it is the brain — the organ that enables language to happen in the first place — that seeps out.[58] In *The Unnamable* language is metaphorized as liquid that seeps out of the body. Like the patient, the narrator is at the mercy of his infantile and uncontrollable body, while also being invaded by a discourse that is not his own. Language has been forced upon (even down into) him and is regurgitated as bodily matter, that is both a symptom

[51] Beckett, *Three Novels*, p. 299.
[52] Mladen Dolar, 'Nothing has changed', in *Beckett and Nothing*, ed. by Daniela Caselli (Manchester: Manchester University Press, 2010), pp.48-64 (p.53) .
[53] Brandon LaBelle, *Lexicon of the Mouth: Poetics and Politics of Voice and the Oral Imaginary* (London: Bloomsbury, 2014), p. 7.
[54] Ibid.
[55] Beckett, *Complete Dramatic Works*, p. 380.
[56] Beckett, *Three Novels*, p. 287.
[57] Ibid.
[58] Ibid., p. 363.

of his disordered language and also a result of the dominant 'they' who control him. The narrator says:

> What I speak of, what I speak with, all comes from them […] It's a poor trick that consists in ramming a set of words down your gullet on the principle that you can't bring them up without being branded as belonging to their breed […] I never understood a word of it in any case, not a word of the stories it spews, like gobbets of vomit.[59]

Stories spew out of the narrator along with bodily waste. Language is now excess and becomes evidence of a more fundamental and involuntary process taking place.

In a letter to theatre director Alan Schneider in 1957, Beckett wrote that his work was a 'matter of fundamental sounds (no joke intended)', and while the joke is told with full knowledge of its cruder implications, Beckett offers an important insight here into the fundamental sounds and actions he produces that are involuntary by nature.[60] In *The Unnamable*, as well as in the two novels that precede it in the trilogy, Beckett's language and bodies are excessive and unruly. Molloy says, 'I had likewise sadly to part my drawers (two pairs). They had rotted, from constant contact with my incontinences', and Malone alludes to times past (of which he does not wish to speak) when he says, 'I go liquid and become like mud'.[61] The body is always leaking and liquefying, defying any sense of a cohesive and contained body. These narrators are committed to their utterances, but the materiality of their form undermines both language and self-control: things cannot be kept inside, and when they pour out of the body they are waste.

However, the body's language need not solely be seen as surplus. While Beckett's language pours out of the body, the philosopher Martin Heidegger envisages language as an integral part of the body and its organs. Heidegger writes that language is encountered through speech and 'the activation of the organs of speech, mouth, lips, tongue'.[62] It is embodied in the body parts that enable speech production, as opposed to the brain where language is constructed. Heidegger's language, like that of the narrator's has a material form, but unlike the excessive liquidity of Beckett's language, its materiality is far more functional. 'Language is the tongue', writes Heidegger. Language has one site and one source.[63] The vocal component of language is significant as it suggests that, at its core, language fulfils a social function as a communicative

[59] Beckett, *Three Novels*, p. 318.
[60] Beckett, *Disjecta*, p. 109.
[61] Beckett, *Three Novels*, pp. 164, 218.
[62] Martin Heidegger, *On the Way to Language*, trans. by Peter D. Hertz (London: Harper & Row Publishers, 1971), p. 96.
[63] Ibid

device. As he attempts to determine the nature of language, Heidegger says, '[w]e speak our language. How else can we be close to language except by speaking? Even so, our relation to language is vague, obscure, almost speechless.'[64] So while speaking implies communicative acts, it in fact moves the subject towards obscurity and silence. Language may manifest itself in the tongue and the larynx, but this is not all that language is. The image of the tongue takes on an altogether more complicated role, as both the tool for speech and the speech act itself.

I want to explore this further in the context of patients with language disorders. However, here it is the implied social element of language construction that warrants further scrutiny. As I argued in Chapter One, the patient is made passive (almost silent) upon entering clinical spaces. Part of the reason for this is that patients are expected to adopt a particular discourse, which may only bear a slight resemblance to her experience of illness. As Brian Hurwitz and Victoria Bates rightly state:

> The passivity that so frequently accompanies severe illness is made all the more profound as a result of the language to which patienthood is subjected by modern healthcare, which has been colonised by objectivist interests and concepts that threaten to eclipse the communal language of the lifeworld, the everyday concerns of bodily and psychic experience.[65]

The lack of a communal language is only one of the problems threatening the clinician and patient in their encounter, though. The 'objectivist' interests that Hurwitz and Bates refer to are damaging, not only because they are the dominant discourse, but also because they elicit a language which is counter-intuitively isolated (or disembodied), despite the body being the primary subject of the encounter. The language that a body produces and the narrative (if any) that it constructs, is not thought of as something which has been mediated by the experiences of the patient, or the contexts in which such stories are told.

There are significant implications for language that is simultaneously embodied and culturally and socially contingent. Bartra writes that we should consider 'the possibility that language forms a part of exocerebral networks that, as such, are not exactly inside the brain, but are not an independent phenomenon disconnected from the nerve circuits either.'[66] Bartra's anthropological study of the brain and consciousness evokes a language, which is a product of the body and its surroundings, that is to say, a language

[64] Heidegger, *On the Way to Language*, p. 58.
[65] Hurwitz and Bates, 'The Roots and Ramifications of Narrative Medicine', in *Edinburgh Companion to the Critical Medical Humanities*, ed. by Whitehead and Woods, pp. 559-76 (p. 568).
[66] Roger Bartra, *Anthropology of the Brain: Consciousness, Culture, and Free Will*, trans. by Gusti Gould (Cambridge: Cambridge University Press, 2014), p. 21.

that reaches into and reaches out of the body to connect the two. Bartra posits the existence of what he calls an 'exocerebrum', made from 'cultural functionalities and capacities', so as to support and augment the deficiencies of cerebral activity.[67] Bartra depicts consciousness as that which sits outside of, or on the surface of the body. It is a skin, similar to 'the exoskeleton of insects and crustaceans', but it is also structured and sturdy like a skeleton or armour.[68] Bartra's rendering of consciousness is not fluid, though he does write extensively on neural plasticity. His choice of metaphor then, is significant, precisely because of its inside-out quality. Bartra likens the exocerebrum to a Klein bottle, whose 'closed non-orientable surface […] can be represented in three dimensions by passing the neck of bottle through its side and joining its end to the hole in the base.'[69] Bartra uses this analogy to argue that, like the Klein bottle whose inside and outside cannot be distinguished from one another, the exocerebrum presents an 'internal-external dichotomy in the cognitive process and in the formation of self-consciousness'.[70] Consciousness and cognitive processes require a movement from inside to outside and back again, but what makes this so striking is that the structure that facilitates this movement is itself a manifestation of consciousness and language too. Both the inside and outside are incomplete and rely upon the existence of a bridging mechanism to fill the gaps.

The neuronal brain, Bartra argues, is an insufficient tool in its natural state. The brain cannot function to the full as it is, and instead operates in much the same way as a 'pneumatic machine'.[71] In order to overcome these shortcomings Bartra proposes that:

> Instead of stopping and remaining stationary in [the brain's] natural condition, this hypothetical neuronal motor creates a mental prosthesis in order to survive despite intense suffering. This prosthesis does not have a somatic makeup but substitutes weak somatic functions […] these extrasomatic prostheses are not thinking substances that are separate from the body nor are they supernatural and metaphysical energies or computer programs […] The prosthesis is actually a cultural and social network of extrasomatic mechanisms closely connected to the brain […][72]

The exocerebrum is a network that sits outside of the brain and feeds back into it so as to enrich our cerebral activity. Bartra looks beyond language to many modes of social engagement including music and dance. Language is a manifestation of the

[67] Bartra, p. 5.
[68] Ibid., p. 6.
[69] Oxford University Press, *OED Online* (n.d.) < www.oed.com/view/Entry/103819> [accessed 7 November 2019].
[70] Bartra, p. 75.
[71] Bartra, p. 5.
[72] Ibid.

exocerebrum and through a 'symbolic substitution system [is] transmitted by cultural and social mechanisms.'[73] Language is not simply situated in the language centres of the brain, but is instead both inside and outside of the body. Bartra claims that our brain's plasticity is further proof of the feasibility of and need for a cultural prosthesis, insisting that the outside world is cognitively and neurophysiologically necessary.

Culture is vital to producing language, as it guides thoughts, creates (or completes) the mind and enables it to function. There is a danger, however, that by focusing on culture's role in providing a supportive and interconnected exocerebrum, we lose sight of the body's significance. Culture is certainly crucial to this discussion, but one should not overlook the importance of the physical and embodied space that the subject inhabits. Neuroscientist Antonio Damasio writes, 'the mind is embodied, in the full sense of the term, not just embrained'.[74] Mind, brain and body are interdependent. Our mind operates beyond the confines of the brain, just like language. Looking at those who have lost language, I want to examine the substitutes and augmentations of communicative language operated through the body, but also consider how difficulties in communication are not simply symptoms of pathological disorder. This is a question of psychodynamics and the tensions between normative and non-normative (or pathologised) affective interactions. Language may be an internal and neurological process on the one hand, but on the other, it also happens and is generated between bodies. Language is dependent upon the leakiness of the body in order to be constructed and shared by subjects, and requires interpretation by an 'other'. This is an affective exchange or transmission between subjects which co-constructs language.

Writing about transmission of affect in the context of mental illness, the philosopher and psychoanalytic theorist Teresa Brennan claims that, according to Western convention, '[i]n theories of psychiatry and psychoanalysis, the healthy person is a self-contained person […] He or she has boundaries.'[75] Brennan writes that a great deal of emphasis is placed upon maintaining the self-contained and boundaried subject that has been established during childhood. Brennan's affective transmission, just like Bartra's exocerebrum, is evidence of non-pathological functioning. Affective transmission is: 'the norm rather than an aberration at the beginning of psychical life.'[76] Brennan reads the transmission of affect as the rule rather than the exception against the Western view of the individual, and argues that, 'the affects of a patient can quite literally enter into

[73] Bartra, p. 7.
[74] Antonio R. Damasio, *Descartes Error: Emotion, Reason, and the Human Brain* (New York: Avon Books Inc., 1994), p. 118.
[75] Teresa Brennan, *The Transmission of Affect* (Ithaca, New York: Cornell University Press, 2004), p. 24.
[76] Ibid.

the analyst or therapist involved' within the psychotherapeutic encounter.[77] Affective transmission — or the acknowledgment of it — I argue, helps to form a communal and co-produced language for the clinician and patient, which is embodied as much as it is culturally and environmentally determined. This is a language of the body (pathological or otherwise) and its role extends beyond that of simple communication and meaning making.

Language may be more than its communicative function, but that is not to take away from the importance of this role, and communicating with others speaks to the predominant externality of language. I argue, however, that internalised language and inner speech remain crucial tools for thinking and communicating, as well as enabling self-reflexive regulation: we know where and what we are through language. In a powerful opening image, Bartra writes:

> I would like to extract this cortex so that, by unfolding the sulci, I could spread it out like a handkerchief over my desk in front of me to examine its texture. If it were possible, a beautiful grey cloth, two or three handspans wide, would now be lying before my eyes. I could run my gaze over the thin surface, looking for signs that would allow me to decipher the mystery hidden in the network connecting billions of neurons.[78]

As though he were able to understand it just by looking at the cortex, Bartra hopes to make invisible neuronal processes visible. By examining the embodied sites of language it seems that one is able to better understand its capabilities and limitations. It is important to note, as I have said, that the bodies that LaBelle, Bartra and Brennan describe are non-pathological, and that the reliance upon other bodies to form a cerebral prosthesis is necessary as part of 'normal' functioning. The subject, the character, and the patient are no longer just a single 'I', but form part of a community of interlocutors whose language is cultivated through the material body, affective transmissions and cultural contexts. Instead of there being evidence of pathological disorder, the body, its language and the conscious mind is inherently incomplete, even when there is no evidence of pathological disorder. Yet, by examining pathologised language disorders such as aphasia, I hope to understand how the materiality of language and its social functions are represented by descriptions and diagnoses of impairment.

[77] Brennan, p. 26.
[78] Bartra, p. 3.

Locating and Narrating Aphasia

> Has my head lost all feeling? Or did I have a stroke, while I was meditating? I don't know. I shall be patient, asking no more questions, on the qui vive.[79]

As the narrator of *The Unnamable* ruminates on the nature of his existence — ever on the lookout for what might have caused him to get into this state in the first place — he wonders whether it might have been a stroke that led him here. Why might the narrator attribute his difficulties to a stroke and how can his representation of the resulting symptoms be thought of as both a representation of disordered language, and the difficulty of narrating the patient experience in language? Here, I explore the limitations and possibilities brought about by aphasic experience. Language, as I have shown, is embodied, embrained and also socially imbricated with the non-pathological body, and yet it may not be so different in pathological cases. I want to understand how language happens within the brain and chart the evolution of locationalist and propositional theories that have attempted to make sense of language disorders brought about by neurological trauma. The various and conflicting positions in aphasiology raise consistent debates between notions of boundaried neurological functioning and a more holistic view of the causes and effects of aphasia and the areas of the brain affected by trauma. Damage to the brain may take place in a particular location, but its effects are experienced by many patients as a blurring of boundaries of the individual, agential self. One loses all sense of herself as an individual and becomes part of a larger and more fluid network of bodies, voices and things. I will use the case of Bolte Taylor and her pathography of her stroke to explore this further, but for now, I wish to begin by examining the dramatic shifts that have taken place in the study and practice of aphasiology. By understanding the schisms in the discipline, it is clear that practitioners and patients alike have faced consistent challenges when trying to write the story of aphasia.

Popular in the nineteenth century, localisationist theories in aphasiology sought to determine specific language centres within the brain and map their connections through diagrammatic schema. Paul Broca (1824-1880), who gave his name to Broca's area (the third frontal convolution) within the brain, was one such locationalist.[80] Carl Wernicke (1848-1905), a physician and neuropathologist who similarly designated a portion of the left hemisphere (Wernicke's area), was another. The pervasive use of locationalist

[79] Beckett, *Three Novels*, p. 338.
[80] Salisbury and Code, 'Jackson's Parrot', in *Talking Normal*, ed. by Eagle, pp. 100-23 (p. 110).

theory within aphasiology can be attributed to prior studies of the brain and head, most notably craniology (later known as phrenology).[81] It was during what Chris Code and Juergen Tesak call the Paris localization debate (1861-1866), 'that modern aphasiology is traditionally considered to have begun in 1861.'[82] Locationalist aphasiological theories, like those adopted by the phrenologists before them, not only emphasised the importance of location, but also crucially visualised areas of the brain and head, creating colourful diagrams to identify and ascribe symptoms.[83] Jacyna questions both the popularity and efficacy of the diagrammatic schema used to map language disorders such as aphasia. He asks:

> What were these diagrams representations *of*? Certainly, they did not stand for the concrete individuals or their lived experience of language in health and disease. The referent of these signs was a reality accessible only to the scientific gaze […] Through the agency of these graphics, language and its disorders were thus consigned to the realm of the other. The stylistic conventions as well as the modes of reasoning associated with the diagrammatic aspects of aphasiology witnessed a faith in the existence of a quasi-mathematical order underlying the phenomenal flux [italics in original].[84]

Attributing language disorder to particular locations in the brain was a means of explaining the origins of language in neurological terms. Jacyna suggests, however, that this had a limiting effect by perpetuating a medical gaze that excluded the patient who was experiencing aphasia. One of the reasons for creating these maps was, of course, to try to determine the various sites of language, so as to account for the myriad symptoms patients might present with. However, it is important to acknowledge the emphasis placed on creating visualisations of damage to the language centres of the brain, during aphasiology's infancy. These efforts were not made for the benefit of explaining the condition to the patient, but rather for the physicians who were attempting to understand it. Thus, the clinical narrative for aphasia not only excluded patients because of their difficulties with language comprehension, but also because the narrative (and its form) was not intended for them.

The result of this exclusion can be likened to what Havi Carel terms 'epistemic injustice' within the clinical encounter.[85] While Carel's work is concerned with

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[81] Juergen Tesak and Chris Code, *Milestones In The History of Aphasia: Theories and Protagonists*, Brain Damage, Behaviour, and Cognition (Hove: Psychology Press, 2008), p. 36.
[82] Ibid., p. 46.
[83] It should be noted that localisationalism continues to be the dominant model in aphasiology and neurology today, albeit refined.
[84] Jacyna, pp. 110-11.
[85] Carel, *Phenomenology of Illness*, p. 180.

contemporary clinical landscapes, I argue that the practises of aphasiology in the nineteenth century exhibit similar epistemic injustices. She writes:

> [T]he structures of contemporary healthcare practice encourage epistemic injustice because they privilege certain styles of articulating testimonies, certain forms of evidence, and certain ways of presenting and sharing knowledge, e.g. privileging impersonal third-person reports, in ways that structurally disable certain testimonial and hermeneutical activities.[86]

The certain styles and forms of evidence that Carel refers to here are similar to those rendered as pictorial, neurological and predominantly negative in early studies of aphasiology, as they create an image of the subject whose brain damage has made them either unable to speak and/or comprehend language, or alternatively articulate fluidly, but incomprehensibly. Mapping a disorder such as aphasia was done in an attempt to deal with the heterogeneity of the condition. The result of the aphasiologist's focus on the pathological cause and effect of brain damage, however, was the occlusion of the patient's subjective experience of her condition. Focussing on pathology alone negates or overwrites what Jacyna terms the 'phenomenal flux' of disorder.[87] The way that aphasia is defined and demarcated in the clinic neither reflects the varied symptoms of aphasia, nor the patient's perspective of aphasic experience. The story that clinical case notes tell has an altogether different agenda and one which may often be guilty of enacting epistemic — or diagrammatic — injustice over the patient.

Aphasiological diagrams were not intended to aid the clinician in communicating with the patient and this remains the dominant paradigm today. Instead, these diagrams depict damage and its negative repercussions, and are clearly only one method for understanding the condition. The British neurologist, Henry Head (1861-1940) was highly critical of these diagrams and referred disparagingly to their creators as 'diagram makers'.[88] Head accused the schema of providing 'simplified assumptions that cannot do justice to the true clinical picture of aphasia. At the same time, the theoretical deductions from these models would lead to simply ignoring essential symptoms.'[89] These diagrams simplified and narrowed the view of both the causes and effects of aphasia. Using images, locationalist aphasiologists built a narrative, which was neither clinically comprehensive, nor fully attuned to the symptoms of the condition. The belief that identifying the location of a disorder can tell us all there is to know about the

[86] Carel, *Phenomenology of Illness*, p. 183.
[87] Jacyna, p. 111.
[88] Tesak and Code, pp. 133-35.
[89] Ibid.

condition is short-sighted, and goes further to supporting an overarching narrative in which the visual takes precedence over the felt and heard. Hughlings Jackson was also critical of locationalist approaches to aphasiology. In the latter part of the nineteenth century, Hughlings Jackson called into question the visual modes by which aphasia was understood, and adopted a positivist position on the capabilities of aphasic patients. As a physician, Hughlings Jackson used the patient's body as his guide, emphasising that, 'the scientific physician should assess the anatomy, pathology and physiology of every case of a patient.'[90] Each case was unique, so while principles for the field were being established, they did not constrict Hughlings Jackson, who was more than willing to replace one method with another if it proved more useful. Hughlings Jackson was particularly concerned with the effects of aphasia on the subject's language production, developing his theory of propositionality, which differentiated between propositional and non-propositional language and made a crucial distinction between words and speech. Hughlings Jackson claimed that it was not words that were lost to the aphasic subject, but rather one's ability to use them voluntarily, and place them in an order. The loss of propositional speech isolates Hughlings Jackson's patient from his surroundings and denies him the ability to draw on the cultural surroundings that Bartra's work offers up as a solution for the body's somatic limitations. The distinction between the 'normal' and the pathological becomes increasingly contested and problematic in Hughlings Jackson's conception of the subject.

Writing about Hughlings Jackson's work, Code and Tesak write: '[p]ropositional speech is under conscious control and non-propositional speech is the product of deeper, automatic processes, which are inhibited under normal circumstances.'[91] In mapping a detailed hierarchy between intentional and automatic expression, Jacyna writes that Hughlings Jackson saw aphasia as 'the tragedy of the speechless *man*. The condition is seen as an encroachment on precisely the powers that define the normal subject.'[92] The 'normal' subject was defined as one (male) who is in control of the language that he expresses, and who is able to propositionalize words into speech. Those who are unable to do so are 'rendered passive [and] impotent', in much the same way as Frank's description of the contingent patient.[93] The subject is made passive by her language loss, as according to Hughlings Jackson, 'the proposition (statement) is a fundamental

[90] George K. York and David A. Steinberg, 'Hughlings Jackson's Neurological Ideas', *Brain: A Journal of Neurology*, 134.10 (2011), 3106–13 (p. 3107).
[91] Tesak and Code, p. 58.
[92] Jacyna, p. 143.
[93] Ibid., p. 140.

feature of language.'[94] With aphasia, then, the patient was left with words, and more specifically disconnected and repetitive utterances. While on the one hand this may have been depicted as tragic, the analysis of these words and the patients who uttered them within the clinic was significant to Hughlings Jackson's work. His polemic was to challenge deficit models by claiming that the production of any kind of language, whether it was right (that is to say accurate) or wrong, should be seen as a success and a means by which to better understand the patient's specific condition. While these utterances were not propositional speech, they nevertheless represented some form of expression. Hughlings Jackson deemed automatic language to be more emotional than intellectual, so while the intellectual faculties of the aphasic were not compromised, the ability to express intellectually was significantly disrupted and colonised by emotional, nonsensical outbursts. As Jacyna writes on Hughlings Jackson's conclusions: 'emotion was thus a thief who stole and misused words that were the intellect's proper mode of expression.'[95] Yet emotional and non-propositional speech was still productive, as it proved language was not altogether lost.

At the beginning of this chapter I cited Woods's call for a reappraisal of the role of narrative. If current thinking on narrative within medicine does more harm than good, I argue that it is not because the belief in narrative itself is dangerous, but rather because a belief in a particular kind of narrative and the form it should take, limits the possibilities of narrative in clinical contexts.[96] While Hughlings Jackson did not concern himself with the narrative put forward by the patient — after all he saw non-propositional speech as an inferior form of communication — he was committed to troubling and challenging the clinical representation of aphasia in ways, which can be expounded so as to rethink communication and storytelling between doctors and patients. Hughlings Jackson's theory of the emergence of non-propositional language as an aphasic symptom shows that, while the patient cannot clearly articulate complete statements and narratives in the traditional sense, her aphasic language reveals the possibility for different modes of expression. It also requires us to seek out alternative methods for constructing and interpreting narratives. Ultimately, aphasia presents the clinician with expressions that defy those specific narrative codes set out by the clinical model, which both Woods and Carel describe.[97]

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[94] Tesak and Code, p. 58.
[95] Jacyna, p. 139.
[96] See also, 'The Recovery Narrative: Politics and Possibilities of Genre' by Woods et al. who cite Galen Strawson's work on the dangers associated with assuming that narrative 'self-articulation' is natural for all (2019).
[97] Citing Strawson's work, Woods questions 'whether narrative should remain the privileged form for the interpretation or restitution of […] self-experience.' She also argues that beyond the clinic 'scholars in the medical

I opened this section with a quote from *The Unnamable* in which the narrator is faced with a series of insistent and dominating voices that he cannot take ownership of, as he wonders whether it is a stroke that has caused his suffering. The horror of the situation lies in the fact that language continues despite its futility; it is violent and strange. The narrator says:

> I can't stop it, I can't prevent it, from tearing me, racking me, assailing me. It is not mine, I have none, I have no voice and must speak, that is all I know, its round that I must revolve, of that I must speak, with this voice that is not mine, but can only be mine, since there is never no one but me, or if there are others, to whom it might belong, they have never come near me.[98]

It is not clear whether it is his language that keeps the narrator going, or whether he continues to exist despite the confusion of language. Through his 'vice-existers' language, voice and speech are no longer owned or produced by a single subject and instead of asserting his identity, his narrative muddles it further: 'voice that is not mine, but can only be mine'.[99] Furthermore, the terror that the narrator feels is caused by his obligation to adopt the dominant voices of others. He is asked to tell a story, which may or may not be his, in a voice which is disconcertingly disconnected from, and yet intertwined with, his own. It is important to note that the narrator discusses voices rather than language and these voices denote speech. Like the speech automatisms that Hughlings Jackson describes, this language is repetitive and revolving. It is certainly more complex in its construction than simple repeated words, but it has a non-propositional quality. Words and phrases emerge without a sense of an ending, and the beginning is similarly hard to identify, so that he appears dislocated within a non-propositional narrative.

The narrator questions his and the other voices, but the voice is never spoken, and so the narrative reads as an internal monologue. Fernyhough, whose work on inner speech with Alderson-Day shall be explored later in this chapter, writes with specific reference to *The Unnamable* that, 'literary texts have the power to elicit inner speech and get us sounding-out its voices.'[100] But the voices in *The Unnamable* are not

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humanities can do more to denaturalise narrative, to acknowledge […] that the attachment to and valorisation of narrativity is not universally shared' (Woods, 2017). Moreover, Carel claims that the clinic enacts 'epistemic injustice' as 'modern healthcare practices privilege impersonal third-person reports and empirical data over personal anecdote and pathographic testimonies, in a way that structurally disables certain testimonial and hermeneutical activities' (Carel, 2016).

[98] Beckett, *Three Novels*, p. 301.

[99] Ibid.

[100] Charles Fernyhough, *The Voices Within: The History and Science of How We Talk to Ourselves* (London: Profile Books Ltd, 2016), p. 97.

sounded-out in the strictest sense — they are both voice-like and silent — and as I shall show, share similar characteristics to inner speech and its disturbance. In the following sub-sections I address distinct aspects of inner speech function, to explore how they are affected by stroke, and consider their implications on storytelling and narrative subjectivity within *The Unnamable.*

(i) 'I don't know where I end': Inner Speech and Sense Over Meaning[101]

In his paper 'Self-awareness deficits following loss of inner speech: Dr Jill Bolte Taylor's case study', Alain Morin examines the testimony of Jill Bolte Taylor who suffered a stroke in 1996. Bolte Taylor's case shows the significant effect that stroke has on the production of inner speech, and without it she lost her self-awareness. Morin explores the role of inner speech as a means of supporting self-awareness and argues that both internal and external speech is essential to one's ability to engage with the world. Morin writes:

> [I]nner speech can be seen as a cognitive process that may (1) internally reproduce social mechanisms leading to perspective taking, (2) create a psychological distance between the self and mental event it experiences (thus facilitating observation), (3) operate as a problem solving device where the self constitutes the problem to be solved and self-information the solution to the problem, and (4) verbally label aspects of one's private life that would otherwise be difficult to objectively identify.[102]

As a neuroanatomist, Bolte Taylor was only too aware of how her nervous system enabled her to process information and fulfil cognitive tasks. After her left-hemisphere stroke, her speech was immediately impaired, and with it, her ability to distinguish herself from other people and entities that surrounded her. She writes: 'I was not capable of experiencing separation or individuality.'[103] Alderson-Day and Fernyhough write, 'inner speech plays an integral role in certain higher cognitive processes', and 'self-regulation of cognition and behaviour'.[104] For Bolte Taylor, the loss of inner speech meant that she could no longer see herself as existing independently of other bodies and things.

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[101] Beckett, *Three Novels*, p. 339.
[102] Alain Morin, 'Self-Awareness Deficits Following Loss of Inner Speech: Dr. Jill Bolte Taylor's Case Study', ed. by B. Bridgeman, *Elsevier*, Consciousness and Cognition, 18.2 (2008), 524–29 (p. 524).
[103] Jill Bolte Taylor, *My Stroke of Insight: A Brain Scientist's Personal Journey* (London: Hodder & Stoughton, 2008), p. 70.
[104] Ben Alderson-Day and Charles Fernyhough, 'Inner Speech: Development, Cognitive Functions, Phenomenology, and Neurobiology', *Psychological Bulletin* 141.5 (2015), 931-65 (pp. 938, 956).

Just like the narrator of *The Unnamable* who admits: 'I don't know where I end', Bolte Taylor acquired a sense of connectedness to all that surrounded her.[105] In her memoir *My Stroke of Insight*, she writes that while her sense of self was depleted, 'an unforgettable sense of peace pervaded my entire being and I felt calm.'[106] The narrator of *The Unnamable* feels no such sense of peace, though by continuing to narrate he shows that despite his difficulties with language, language persists. Moreover, where Bolte Taylor loses her 'brain chatter' as a result of her stroke, the narrator's own internal and narrated voices remain insistent.[107] In this sense, the experience of the narrator in *The Unnamable* differs from the aphasic's, and yet the tumult of voices he hears shows that non-pathological language function also challenges the notion of what is deemed 'normal'. Furthermore, the narrator also wonders whether he might be better off adopting language that is akin to aphasic utterances in order to better understand the role his mouth (and voice) moght play in determining his current state. He says: '[w]ould it not be better if I were simply to keep on saying babababa, for example, while waiting to ascertain the true function of this venerable organ?'[108] The ways in which the narrator describes his difficulty with language and the challenges he faces in describing himself are seemingly belied by the sophistication of his language and thinking throughout the novel, and yet it would seem that by seeking out aphasic articulations he hopes escape the narrative quandary he finds himself in.

Bolte Taylor's lack of inner speech, as a result of her stroke, not only blurred the boundaries between her body and the world around her, it also meant that word finding and interpretation were significantly disrupted. In order for the subject to process and understand language, signs must go through a constant process of translation. Signs, be it marks on the page or sounds, are translated into meaningful symbols which can be used to communicate either with oneself (through inner speech), or with others. For patients like Bolte Taylor with Broca's aphasia, the translation of such signs is interrupted. Language is no longer recognisable or accessible to the patient. As she describes in her memoir:

> I remember her showing me an 'S' and saying 'This is an 'S'.' and I would say 'No Mama, that's a squiggle.' And she would say, 'This squiggle is an 'S' and it sounds like 'SSSSSS'.' I thought the woman had lost her mind. A squiggle was just a squiggle and it made no sound.[109]

[105] Beckett, *Three Novels*, p. 339.
[106] Bolte Taylor, p. 70.
[107] Ibid., p. 32.
[108] Beckett, *Three Novels*, p. 302.
[109] Bolte Taylor, p. 101.

Bolte Taylor attempted to decrypt the simple 'S' sign, but could not because the sign no longer had a sound associated with it. Goldfarb and Halpern write that in cases of Broca's aphasia 'language production is characterised by confusions of phonological form'.[110] The Broca's aphasic loses both her inner speech and inner ear and so, as Bolte Taylor describes, in order to find the right word and decode the symbol, she went through a process of rerouting. She had to find the word through some new means, but in order to do so she still relied upon her prior knowledge and understanding of language based on sounds, shapes, images and associations. She likens the process to trying to access different files that contained the word she was trying to find, or the question she was trying to answer.[111] This task was unsurprisingly exhausting, as she tried to find meaning within meaningless signs, having lost all frames of reference.

Bolte Taylor's attempts to translate signs suggest that while she was eventually able to reacquire her inner speech, her language was fractured and non-propositional. According to Vygotsky, internalised language takes on a 'note-form' quality that can be seen as a form of thought which is both expansive, in that it extends beyond the language that is used to describe it (i.e. incorporates multiple associated meanings and associations), and is also truncated, as the language itself is note-form (or seemingly incomplete).[112] On the one hand, it is thought that has a syntactical and grammatical basis, but on the other, it is language stripped of the usual version of these structures. Alderson-Day and Fernyhough write:

> Vygotsky identified three main semantic transformations accompanying internalization: the *predominance of sense over meaning* (in which personal, private meanings achieve a greater prominence than conventional, public ones); the process of *agglutination* (the development of hybrid words signifying complex concepts); and the *infusion of sense* (in which specific elements of inner language become in-fused with more semantic associations than are present in their conventional meanings) [italics in original].[113]

Internal speech does not rely upon the same syntactic and grammatical structures as external speech, but this does not make it nonsensical. In fact, the 'note-form', or paratactic quality of inner speech is similar to aphasic utterance. It is as though all language production, both internal and external, were in some sense aphasic. I am struck by the emphasis on meaning as part of the communicative act, which relies upon

[110] Robert Goldfarb and Harvey Halpern, 'Impairments of Naming and Word-Finding', in *The Characteristics of Aphasia*, ed. by Chris Code (Hove: Lawrence Erlbaum Associates, Publishers, 1991), pp. 33-52 (p. 37).
[111] Bolte Taylor, pp. 48-49.
[112] Alderson-Day and Fernyhough, p. 932.
[113] Ibid.

making meaning in order to be successful. This view would seem particularly pertinent to clinical discourse. I want to pose an alternative and move away from meaning-making and move towards sense-making.

Vygotskian sense-making and the infusion of sense enriches the speech act and encompasses multiple associations and implications within a single word. The 'S' in Bolte Taylor's case could then take on all manner of meanings, sounds and images. Fernyhough and Alderson-Day give an example of the difference between meaning and sense in non-pathological language functioning:

> For example, a word like 'interview' might have a clear referent (an upcoming appointment), but its sense could mean much more when uttered in inner speech: worry, performance anxiety, hopes for the future, or the need to prepare.[114]

Sense-making rejects simplistic cause and effect/back and forth definitions of communication and instead provides an opportunity to explore the loss or adaptation of language according to the terms set out by the person with aphasia. Within a clinical context, our ability to communicate in non-traditional forms needs to be explored further. In contrast to those traditional narrative-based approaches adopted by clinical medicine today, supposedly non-normative forms of expression should be accounted for. The seeming incomprehensibility of inner speech does not mean that it lacks sense, nor does it mean that it lacks cognitive relevance, so expressions, which are infused with sense, are just as important as normative meaning-making in speech.

By examining aphasiology's development and practice to better understand the core characteristics of aphasia, I have sought to unpick the problematic relationship between those that suffer from language disorders and their language, the ways in which they communicate the experience, and how others understand this experience. This provides a vital opportunity to consider new methods of communicating and listening within the clinical encounter, when language no longer fulfils those functions we have come to expect of it and, moreover, reveals that pathological language disorder shares fundamental characteristics with normative language function.

Dysfluent Storytelling

So far, this chapter has argued that *The Unnamable* can be used to challenge traditional narrative-based approaches to medicine. In Hughlings Jackson's work on

[114] Alderson-Day and Fernyhough, p. 932.

propositionality he argues that higher functioning language and speech places language in an order, and narrative medicine has adopted a similar definition of narrative as the assimilation patient stories into a coherent order. The problem with these two definitions of higher functioning language and narrative respectively are that they assume a unified definition of what constitutes order and, moreover, what constitutes a narrative. Narrative, I argue, is contingent upon embodied subjects, the social, cultural environment and temporal space in which it is constructed. It is defined by both the events that are recounted and the conditions under which this recounting takes place. By exploring evidence of non-pathological functioning, such as inner speech and Bartra's exocerebrum, my aim has been to trouble the distinction between pathological disorder and so-called 'normal' functioning. I now want to reconsider how language disorder is understood through the lens of Disability Studies, in order to claim that Beckett's *The Unnamable* can help to challenge dichotomous representations of normative and non-normative health and behaviour.

In recent years there has been a growing concern, and widening academic interrogation of issues associated with communication impairments, in what Eagle has called, 'Dysfluency Studies'.[115] The development of Dysfluency Studies is the result of a growing desire by patients (and an increasing number of practitioners) to move away from labelling various language disorders as disabilities.[116] Yet, by associating disorder with disability, one runs the risk of overlooking the 'shortcomings' of the body in its supposed 'natural' state. I have already shown that the so-called normative body is incomplete and must draw support from the outside world in order to function effectively. The medicalised view of the body is temporally linear and I wish to trouble this claim by showing that the healthy body does not exist in constant equilibrium as might have previously been assumed.[117]

The relationship between the subject and the past, present and future instance of her body is turbulent. In 'What Can a Body Do?' Deleuze writes that:

> [W]hile our body exists, it endures, and is defined by duration; its present state is thus inseparable from a previous state with which it is linked in a continuous duration. Thus to every idea that indicates an actual state of our body, there is necessarily linked another sort of idea that involves the relation of this state to the earlier state.[118]

[115] Eagle, 'Introduction', in *Talking Normal*, ed. by Eagle, pp. 1-8 (p. 3).
[116] Ibid., p. 7.
[117] Canguilhem, p. 40.
[118] Gilles Deleuze, *Expressionism in Philosophy*, p. 220.

The present state of the body, he claims, is comprised in relation to all other temporalities that the body occupies and, as such, the body cannot be understood in any one moment but is instead defined by its duration in time. The body cannot be deemed at one time well and at another ill, but instead operates in a continuum of non-binary flux in which both (or all) states are present and inform one another simultaneously. The clinical encounter is inherently chronic in the sense that it both takes time, and takes place over time. Moreover, the clinical encounter's chronicity can be defined in relation to the clinic itself and the bodies that engage with it. Chronicity, then, is a chronic state with a duration that spans multiple temporalities. The chronicity of the clinical encounter should, I argue, take the durational state of the body into account. In her study of illness narratives, Woods questions the extent to which illness changes one's temporal and narrative orientation. She writes:

> Does illness propel us in the direction of diachronicity, forcing us to mourn a healthy past which cannot be recuperated and a future which feels more fraught, more finite? Or is it the case that illness demands instead that we attend to the right now, either because pain returns us to the immediacy of the body, or because the uncertainty of the future encourages us to invest more intensely in the self-experience of the present?[119]

In response to Woods's questions, I claim that all these temporalities and more are at play within the illness narrative. It is not simply a case of a diachronic before and after (or future), or even a focus on the 'now', but rather, it is also all the time(s) experienced within illness itself. Furthermore, I want to question the sense of a coherent before. As I shall examine in Chapter Three, before can take place more than once. It may be before a diagnosis, as opposed to before an illness. Before may also be before a symptom has presented itself, or before treatment has begun. Indeed, it could also be before the first consultation with a clinician. The patient might experience a series of before(s), and how each of these is narrated is affected both by the experience being recounted and the experience of recounting it. The body exists before its diagnosis and telling the story of the body is located within a specific temporal space. In *The Unnamable*, the before and indeed the after, are not easy temporalities to locate. The narrative does not question what the subject was before narration, but each narrative thread becomes its own temporal strand, so that narration is multi-chronic, while remaining consistently in the present. The narrator says:

[119] Woods, 'The Limits of Narrative', p. 75.

> For to go on means going from here, means finding me, losing me, vanishing and beginning again, a stranger first, then little by little the same as always, in another place, where I shall say I have always been, of which I shall know nothing, being incapable of seeing, moving, thinking, speaking […][120]

Continuing in this vein, the narrator wonders where these stories are taking place. He asks whether they are new or old and worries that they will do damage to the refuge he has made for himself. Furthermore, he questions whether these stories are being told inside, or outside of, his skull.[121] Grappling with the location of his narrative, the narrator is fixed in the present, but remains fearful of the pasts he recounts and the futures he anticipates. He is bound to his narration of the event and in doing so he oscillates between real but uncertain presents, and many awaited but illegitimate futures. This internalised musing on where, who and what the narrator is, is never answered, and so instead he is left dislocated within his own story and the process of telling it.

Losing language can be a traumatic and disorientating experience. The challenge for many people with aphasia is that their impairment is unseen. While they may be able to move in the world, their ability to understand and interact with it is drastically altered. While language is significantly disrupted for the aphasic patient, I argue that we can better understand her experience durationally in Deleuzian terms. Language is not simply impaired, it takes on new qualities and becomes visible in a way that it was not before, and this new visibility should be understood in light of myriad states in which the body previously found itself. As the narrator in *The Unnamable* says:

> One starts things moving without a thought of how to stop them. In order to speak. One starts speaking as if it were possible to stop at will. It is better so. The search for the means to put an end to things, an end to speech, is what enables the discourse to continue. No, I must not try to think, simply utter.[122]

Hughlings Jackson's writings on speech automatisms are relevant once again, as the language that emerges from the subject appears to occupy an altogether different space to that of propositional language in the functioning body. To 'simply utter', as the narrator vows to do, is not to disregard meaning altogether, but rather to try to find new meanings in repetitive utterances. The jarring nature of this language opens language up

[120] Beckett, *Three Novels*, p. 296.
[121] Ibid., p. 297.
[122] Beckett, *Three Novels*, p. 293.

for new associations and articulations, though it should be noted that for the narrator, these utterances remain largely private. Unlike narratives constructed within the clinic, this narrative does not appear to have a listener or a known reader, and as such the narrator does not anticipate the responses of an interpreter. Narratives change when there is someone present to receive them. Carel writes that the patient's relationship to her illness changes once it enters the social sphere, and she notes that this transition most commonly takes place at the point of diagnosis. The transition of illness from the private to the public redefines both the illness itself and the way it is subsequently told. Carel writes:

> The time of diagnosis is the time in which the illness becomes known by others and by the ill person as disease. It becomes objective (and often objectified) and subjected to medical management, labelling, and so on. This movement from a private, subjective experience to an objectified disease, which continues to be experienced as symptoms by the ill person, is a significant transition. The illness is no longer a private musing on the nature of an unexpected bodily change, but an item in a medical vocabulary and ontology, to which shared meanings and knowledge are attached.[123]

In diagnosis, the illness is given a new narrative structure and is taken away from the ill person. This is no longer her story, but one that is constructed by the clinic. Contrary to Charon's notion of co-constructed narratives, this story is colonised and over-written in a different and oftentimes alien language to the one used by the patient. One of the challenges for the narrator of *The Unnamable* is that he finds himself narrating a story in a language which is not his own, but it now appears to be the only language he has access to. It is a new discourse that has forced aside other means and modes of expression, in much the same way that medicalised jargon does for the patient. In this way, the 'narrative wreckage', which illness brings about — that I examined in Chapter One — is the result of the medical colonisation, discussed by Hurwitz and Bates, just as much as it is due to the difficulty of expressing one's experience in the first place.[124] In submitting to the clinical discourse of disease, the patient is no longer the expert on her own condition. Moreover, what constitutes a patient expert in the clinical sense is the ability to employ medical and scientific language to describe and narrate disease. This by no means confirms the patient's status as an expert, but rather proves her ability to

[123] Carel, *Phenomenology of Illness*, p. 69.
[124] Frank, *Wounded Storyteller*, p. 55.

mimic (or perform) the expertise of her clinician so as to conform to the overriding medicalised discourse available.[125]

When we go to the doctor or the hospital with a complaint, we are often required to narrate our story multiple times. The consultation begins with: 'What brings you here today?' 'What seems to be the matter?' These might seem to be constructive and open questions with which to begin, but the implications of each, and the response that the patient produces, undoubtedly changes with each retelling of the story. The patient quickly learns what is important to her clinician. As I showed in Chapter One, the subject adopts the role of patient upon entering the clinical space and it does not take long for the patient (particularly one with a chronic condition) to become au fait with various practitioners and her relative position within the medical hierarchy. Similarly, with the practise and formation of storytelling, the patient soon learns what to include, what the clinician found significant last time, and what was ignored in prior consultations. The patient's story may grow based on how long she has had the condition and how often she has had to visit the clinic, but each time her story will go through a process of editing, be shaped by the present state that the patient is in, and be overwritten and truncated based on what seemed to hold the clinician's attention. Chapter Three will explore listening practises within the clinic further, but here I want to understand the way the patient's narrative is informed by the anticipated reactions of the listener, as well as how the narrator's condition is perceived, based upon her ability to narrate according to normative expectations.

Returning to Dysfluency Studies, Joshua St. Pierre explores the role that the listener plays in both shaping patient narratives and diagnosing disorder, by placing stuttering within the scope of Disability Studies. St. Pierre's primary assertion is that it is the person who engages with the stutterer who defines stuttering as a disability. St. Pierre argues that because there is still a firmly held belief that 'hearing is passive and speaking is active […] it is easy to understand why stuttering is seen as an individual problem of a *speaker* […] any difficulty in understanding accordingly falls upon the active speaker, not the passive hearer [italics in original].'[126] This means, not only does

[125] Carel's writing on 'patient experts' is particularly useful here, as she raises the question of whether those patients who are classed as experts are not in fact able to be experts of their conditions on their own terms. Instead these patients have more readily adopted the biomedical language required to communicate their condition within clinical contexts. While the authority given to the 'patient expert' may go some way to freeing the patient from the epistemic injustice of the clinical encounter, Carel rightly highlights that without a broader shift in the epistemic framework of the clinic, the expert role remains tokenistic at best. I argue that at worst, this role is a damaging one, as it gives higher status to those who are willing (and more importantly able) to submit to the narrative demands of their clinicians (2016, 188-89).

[126] Joshua St Pierre, 'The Construction of the Disabled Speaker: Locating Stuttering in Disability Studies', in *Talking Normal*, ed. by Eagle., pp. 9-23 (p. 13).

the listener have the power to diagnose and disregard the speaker, she also bears none of the responsibility for the fact that she perceives the speaker's language as disordered speech. Because speech is a social act, any failure to communicate to the supposedly passive and objective listener is a burden that the disabled speaker must bear alone. This dilemma is clearly identified in the case of stuttering, as it is audible and public, but the same can also be said for the aphasic, whose 'speech automatisms' and inability to find the right words are produced by the speaker, not the listener.[127] Moreover, stuttering is presented as a disability that must be remedied for the sake of the listener, and not the stutterer herself. St. Pierre writes:

> If listening is not a passive process, but the active *collection of information,* based upon expectations and former experience, then hearing cannot retain the position of a neutral recorder but is implicated in the highly politicized practice of defining and enforcing normalcy of speech based upon normalized expectations of hearing [italics in original].[128]

Stuttering, therefore, should no longer be characterised as an example of non-normative speech but instead as a challenge to the normative expectations of the hearer. Here, St. Pierre turns away from a clinical model of representing disability by suggesting that it is in the environment in which the stutterer stutters that disables her. He writes:

> Stuttering as a communicative action is a distinctly social phenomenon that cannot properly be reduced to the physical difficulty of producing sounds, but must be situated within its social fabric. Paralleling the way in which speech has no meaning outside of an interpretive context involving a hearer, so stuttering cannot be understood apart from expectations of 'normal' hearing.[129]

Stuttering, like aphasia, is both a physical difficulty and a social phenomenon. Indeed, the notion that speech of any kind is meaningless without an 'interpretative context', alludes to the internality and externality of language production and loss, and suggests that a listener is necessary regardless of whether it is another person or the subject herself. Writing within a Disability Studies framework, St. Pierre's chapter challenges received notions of dysfluency by taking the responsibility for the condition away from the stutterer and transferring much of the onus onto the listener, or 'fluent' speaker. He

[127] Tesak and Code, p. 239.
[128] St Pierre, 'The Construction of the Disabled Speaker', in *Talking Normal,* ed. by Eagle, pp. 9-23 (p. 13).
[129] Ibid., pp. 11-12.

asks: '[w]hat if we saw stuttering as constructed by the hearer prejudiced to 'broken' speech as well as its speaker, and thus as a product of ableism?'[130]

St. Pierre's assertion that those who are differently-abled remain unheard clearly has implications for social and clinical models of care, and moreover, society as a whole, in which fluency takes precedence. The society that St Pierre describes is one that creates exactly the kind of environment that similarly isolates those living with conditions such as aphasia. The aphasic experience of dysfluency is not understood in its entirety, nor is there any sense of urgency to try to understand. St. Pierre challenges the ableist view of communication and questions how important it really is for expressions to make meaning. Beckett exercises a similar approach in *The Unnamable*, and across his oeuvre, by writing narratives which are not prejudiced against disordered and interrupted speech, but rather embrace this aesthetic to break language open.

Perhaps though, the question of disordered speech needs further clarification. The narrator of *The Unnamable* certainly seems to display symptoms analogous to those experienced by people with aphasia such as an inability to self-regulate, a distrust in his ability to use language properly and, like Bolte Taylor, significant confusion about his position in the world, the boundary of his body and his relation to both. His language, however, is often fluid despite its constant assertion / negation and his dizzying contradictions. It is significant that one example Salisbury and Code identify as characteristically aphasic in Beckett's work is speech automatisms, which remain syntactically sensible. Drawing on Hughlings Jackson's work, Code and Salisbury highlight the emotionality of speech automatisms which include 'cursing, swearing, rote learnt activities such as automatic counting, nursery rhymes and prayers, clichés, and idioms', and argue that these forms of speech have been preserved but that they are no longer propositional as 'elements within such speech are not newly or individually generated in each utterance'.[131] Ultimately the phrase is sensible but its usage is not. While Salisbury and Code cite a number of examples of speech automatisms within Beckett's work such as his persistent use of idiom and cliché, the most pertinent example for my own reading of *The Unnamable* is:

> [Beckett's] propensity for using the most commonly observed aphasic lexical automatism — pronoun plus modal or auxiliary verb constructions […] Towards the end of *The Unnamable*, the pronoun plus modal/ auxiliary verb construction indeed begins insistently to appear, though, crucially, in a negative form. As the desperate, futile attempts to

[130] St Pierre, 'The Construction of the Disabled Speaker', in *Talking Normal*, ed. by Eagle, pp. 9-23 (p. 12).
[131] Salisbury and Code, 'Jackson's Parrot', in *Talking Normal*, ed. by Eagle, pp. 100-23 (p. 112).

> articulate a voice which isn't simply the voice of others, or otherwise give up on speaking completely, are ratcheted up, "I" (the most common word in the largest corpus of aphasic speech automatisms compiled in English) begins to cascade down the page, with comma splices invoking a sense of both interruption and urgent propulsion. [132]

Speech automatisms thus occupy the border between speech acts that are characteristic of non-pathological functioning, while also being evidence of pathological language disorder. The reader of *The Unnamable* is put in the uncomfortable position of trying to make sense of a narrative that does not ask to be understood in such terms. Rather, the text rejects traditional narrative tropes and expectations, and leaves its readers to persevere with their own lack of understanding. In fact, readers may even be punished for attempting to make meaning from what they read. This is not always a case of interrupted speech and language at the level of lexis or semantics, but Beckett's 'stylistic obsession with the complex manipulation of idiom and cliché' disorientates the reader who is urged to look anew at phrases whose meaning has hitherto appeared self-evident, while also attempting to navigate the myriad voices which create and erode a sense of a coherent 'I'.[133]

Writing to Alan Schneider about *Endgame* (1957), Beckett said: '[i]f people want to have headaches among the overtones, let them. And provide their own aspirin.'[134] It is the job of the Beckettian reader, then, to force herself to be comfortable — or more accurately resolute — in her discomfort, when faced with seeming nonsense and uncertainty. Moreover, the reader must take responsibility for her own discomfort, but this discomfort can also be seen as productive. Deleuze claims that a great writer — of which he saw Beckett as one — must become a '*stutterer in language* [italics in original]', whose shudders and stutters should produce 'an affective and intense language.'[135] By adopting the tropes of speech and language impairment, Beckett was able to challenge the belief that language produces meaning, arguing instead that language is the barrier to it. This stuttering aesthetic, like that of the aphasic, subverts the formal expectations and capabilities of narrative, drawing our attention to how something is expressed rather than what is expressed. Again, this is a question of form as content and content as form, as I discussed earlier in this chapter. Entangling form and content here is symptomatic of a literary style most commonly associated with

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[132] Salisbury and Code, 'Jackson's Parrot', in *Talking Normal*, ed. by Eagle, pp. 100-23 (pp. 113-14).
[133] Salisbury and Code, 'Jackson's Parrot', in *Talking Normal*, ed. by Eagle, pp. 100-23 (pp. 112-13).
[134] Beckett, *Disjecta*, p. 109.
[135] Gilles Deleuze, *Essays Critical and Clinical*, trans. by Daniel W. Smith and Michael A. Greco (Minneapolis: University of Minnesota Press, 1997), p. 107.

modernists such as Joyce, and it is also one which Eagle claims is particularly fertile for study within the context of Dysfluency Studies. He says that 'the interaction between literary practice and speech pathology becomes apparent when one considers the list of prominent modern authors whose works portray clinical speech disorders' and highlights the 'parallels between speech pathology and the experimental [modernist] styles of writers such as Gertrude Stein and James Joyce'.[136] Beckett's practice was similarly informed by these modernist approaches, which sought out a material language that rejected narrative expectation, and Beckett's obsession with the impossibility and necessity of expression evokes what Salisbury has called an 'aphasic modernism'.[137]

Having completed his 1988 poem *Comment Dire* ('What is the Word'), Beckett was asked by critic and good friend, Ruby Cohn, if he would translate the poem into English for the playwright and director Joseph Chaikin.[138] Salisbury writes that, while this poem was written at a time when Beckett was experiencing aphasic symptoms, the style is curiously similar to that of his earlier works. She writes that his 'aphasic modernism':

> Remains bound to a recognition that language has a materiality, and that language as matter has a history. Repeating its traumas and losses alongside the possibilities of the new shapes of experience it traces out, the aphasic symptom in Beckett's work indeed speaks one of the key discourses within modernity.[139]

Language's materiality extends beyond the internal neuronal space of the skull toward the cultural and material world outside. It is at once both outside and in, bridging the liminal body, and in so doing, creates its own pathway by which to navigate and understand language. Beyond the aphasic aesthetics of Beckett's language that Salisbury identifies, however, I argue it is the unsettling (or stuttering) of narrative sequence within Beckett's *The Unnamable* that strengthens his position as a dysfluent storyteller of others' dysfluent stories. Furthermore, while Beckett's language is material, it is also representative of non-pathological language.

Salisbury's work is vital to my reading of Beckett's aphasic aesthetic and the tensions between automatic and intentional utterances. Yet, unlike my own reading, Salisbury's work is primarily informed by the modernist influences on Beckett's style: his transcription work for Joyce's 'Work in Progress', his work with Eugene Jolas's and

[136] Eagle, 'Introduction', in *Talking Normal*, ed. by Eagle, pp. 1-8 (p. 5).
[137] Salisbury, 'What Is the Word', p. 120.
[138] Chaikin, who incidentally suffered from aphasia as a result of complications during open-heart surgery, could not read or speak French (Salisbury 2008, 120).
[139] Salisbury, 'What Is the Word', p. 120.

other modernist contemporaries in the circle around *transition*, and in particular his preoccupation with the notion of a language whose origins are rooted in 'the specific cultural conditions of European modernity'.[140] Moreover, in her essay '"What is the Word': Beckett's Aphasic Modernism', Salisbury focuses her reading of aphasic modernism on the end of Beckett's career, with one of his final poems. By contrast, throughout this thesis I read an array of Beckett's long-form works and his writing for radio and theatre, from across his oeuvre. Furthermore, through her analysis of *Comment Dire*, Salisbury explores the conditions of modernity and the relationship forged between the artist and language. She claims that the complications of subjectivity reveal themselves most keenly in illness, and that Beckett's use of aphasic symptoms speaks to the concerns and discourses associated with creative production in modernity.[141] While I am in agreement with Salisbury, I argue that Beckett's aphasic aesthetic can also be placed in dialogue with some of the key discourses within contemporary clinical practice and clinical communication skills. Fundamentally, this thesis shares a source base with Salisbury's work, and yet I mean to use this to different ends. Where for Salisbury Beckett's work sheds light on the materiality of language within modernism, my reading moves away from the late modernist context in which Beckett was writing, to consider the applications of this reading to contemporary clinical encounters that are concerned with interpersonal communication and the systemic structures of the clinic. Furthermore, I have focused on aphasia precisely to trouble the notion that ill health illuminates the conditions of language for those who experience pathological disorder, and instead wish to use it to reveal the aphasic nature of all language production.

Indeed, in *The Unnamable*, it is not that the narrator is aphasic, but that all language production shares characteristics with aphasia. Beckett's work does not only speak to the challenges of modernity as Salisbury claims, it is also relevant to contemporary narrative-based practices within the clinic that seek to pathologise seemingly non-normative expression, which may in fact more closely resemble language production more broadly. This is achieved by making the familiar alien, or as Deleuze puts it, '[a] great writer is always like a foreigner in the language in which he expresses himself, even if this is his native tongue', so that the writer 'carves out a nonpreexistent foreign language within his own'.[142] Writing about Beckett and Kafka's works, Deleuze claims:

[140] Salisbury, 'What Is the Word', p 89.
[141] Salisbury, 'What Is the Word', p. 120.
[142] Deleuze, *Essays Critical and Clinical*, pp. 109-10.

> They do not mix two languages together […] rather, [they] invent a *minor use* of the major language within which they can express themselves entirely; they *minorize* this language, much as in music, where the minor mode refers to dynamic combinations in perpetual equilibrium. They are great writers by virtue of this minorization […] [italics in original].[143]

Beckett's *The Unnamable* demonstrates this alienation and distance, not simply through the minorization of a language, but through the layering of characters, as each of them transforms into the one that follows. Minorized characters are always and forever informing the movements and lives of others, and this network extends across Beckett's body of work.[144]

The narrator of *The Unnamable* relies upon a catalogue of voices in order to function, so that while he appears to be isolated, these multiple voices create an entanglement of language that passes in, and out, and through him. He says:

> It must not be forgotten, sometimes I forget, that all is a question of voices. I say what I am told to say, in the hope that some day they will weary of talking at me […] Is it possible certain things change on their passage through me, in a way they can't prevent.[145]

The narrator's existence is founded within his language and the language of others, but the language and voices he creates remains alien to their creator. The interrelation of narrative and language structure operates as an exocerebrum in the trilogy, and beyond into Beckett's later works. A single work cannot function alone, and so all of Beckett's works become 'vice-existers' of one another. Moreover, those 'vice-existers', be they texts or subjects, all feed back into the narrator whose experience is simultaneously temporally determined and dislocated. Near the close of the novel the narrator reflects on the stories he has told when he says:

> [A]ll these stories about travellers, these stories about paralytics, all are mine, I must be extremely old, or it's memory playing tricks, if only I knew if I've lived, if I live, if I'll live, that would simplify everything, impossible to find out, that's where you're buggered.[146]

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[143] Deleuze, *Essays Critical and Clinical*, pp. 109.
[144] The clearest example of this is in Beckett's trilogy, in which protagonists become minorized characters in later novels. Molloy and Malone are found in the later novels, often described as peripherally present. Beckett's use of Doppelgängers and couples remains a distinctive feature throughout his works, including the eponymous Mercier and Camier (1970), and Vladimir and Estragon in *Waiting for Godot* (1955). Reader and Listener in *Ohio Impromptu* are also another example of coupling, which has been explored in this thesis.
[145] Beckett, *Three Novels*, p. 339.
[146] Beckett, *Three Novels*, p. 405.

Coming so close to the conclusion that all the stories he has told have been his, the narrator is denied absolute certainty. He is neither sure that he has experienced all those things that he has tried to narrate, nor that he ever lived at all. This narrative is frail. By adopting a dysfluent style, both in its use of language and narrative structure, *The Unnamable* does not exemplify a narrative which has 'shrunk to nothing' (as Connor writes), but rather an overwhelming abundance of narrative.[147] As narratives are temporally implicated, this profusion of narrative threads leaves nothing out; all possibilities and eventualities are considered, undone and re-written. The narration is always 'now', but now is situated within a durational continuum, informed by 'then', and looking towards a future now. By reading *The Unnamable* through the lens of Disability Studies and the growing field of Dysfluency Studies, it is clear that pathologising discourses have a colonising effect on those whose language is impaired. Moreover, the emphasis placed upon language's communicative function (that is to say, communicating disease or disorder) has a similarly damaging effect on the subject.

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Exploring language through language is inevitably problematic, even for the able-bodied subject who appears to have language at her disposal. Heidegger rightly asks: '[h]ow are we to put questions to language when our relation to it is muddled, in any case undefined?'[148] This chapter has traced the definitions, roots, manifestations, and wanderings of language, to argue that current narrative-based approaches to medicine fail to recognise the nuances and challenges of constructing narratives both in health and illness.

Language is located and happens within the brain, the body and the environment. It sits beyond the traditional signs of speech and the written word, extending into and drawing upon a cultural framework. Bartra writes:

> An organism's individuality is not solely defined by the epidermis […] in order for an individuality to be able to define its inner world, it is also necessary for this world to be external and exposed to the inclemency of the social climate. [...] conscious space is not found in its entirety within the brain.[149]

We now need to rethink the construct of this social and cultural space that completes the exocerebrum, ensuring that it is supportive of, and makes space for, new kinds of articulation. This chapter has borrowed from Disabilities Studies' social model of care

[147] Beckett, *The Unnamable*, p. xviii.
[148] Heidegger, *On the Way to Language*, p. 71.
[149] Bartra, p. 74.

approach that sees the social environment as disabling. While narrative-based methodologies have thus far attempted to aid better communication and support the patient within the clinical encounter, it is imperative that the motives for doing so be scrutinised. As I argue, this model falls short of its aims, by investing too much in a narrative form that is not reflective of experience. By altering the approach to narrative within the clinic, I have argued that losing language would no longer be synonymous with loss and isolation, but rather could open up the opportunity for patients to explore and share in being a foreigner in their own language. It has become clear that there is no unitary definition of language and, indeed, no one place in which it takes place.

I have examined the ways in which language can be thought of as an apparatus for speech, which is manifested in the physical body: from the mouth to the brain, to tears. What I find here is language that operates as a network that cannot be contained within the body's boundaries. Instead, language is entangled. Language operates as a bridge that links the neurophysiological to the social and environmental and these are made of that very same language that connects them, each utterly interdependent in order to support their functioning. The shortcomings of language and expression in Beckett's work have been explored here as both symptoms of the influence of literary modernism (in which Beckett's work can be placed), and a representation of narrative-based contemporary clinical interactions. Expression is symptomatic of human experience, despite all that prevents it and its inevitable failure once expressed. Language brings the subject into being, at the same time as unravelling her sense of self.

In Beckett's work then, one's relationship with language is troubled from the outset. The aphasic qualities found in his characters are not the product of a sudden trauma; they are the symptoms of an unsettled interaction with language, as part of the creative process. The so-called 'normal' or 'healthy' subject is aphasic from the start. Heidegger writes that the word gives, that 'the word itself is the giver' and primarily a giver of being. Yet, in *The Unnamable*, the word, having been given, still leaves subjects uncertain about their own being.[150] The word might be better understood not as 'being' but as a substitute for it, and the word does not give being, but rather it gives a substitutive means of exploring it. Indeed, Beckett's 'vice-existers' in *The Unnamable* represent an example of this very substitution: no sooner have they been brought into being to substitute the narrator, than they are replaced by another of their kind. As soon as language asserts, it also retracts. The narrator says: '[a]bout myself I need to know nothing. Here all is clear. No, all is not clear. But the discourse must go on. So one

[150] Heidegger, *On the Way to Language*, p. 88.

invents obscurities. Rhetoric'.[151] His discourse must continue, but not as a means of finding or creating meaning. Meaning and communication in these terms is not important to Beckett, instead it is language's opacity, the very fact that it eludes and obfuscates, that makes it an apt medium with which to express.

[151] Beckett, *Three Novels*, p. 288.

Chapter 3

‘Just been listening to an old year’: Chronic Listeners and Beckett’s ‘heartsink’ Patients

It is 9am. You knock and wait. The door is thick so that you barely hear the 'come in' from the other side. Sounds from the waiting room compete for attention: the telephone at reception is ringing; a harried septuagenarian insists on a non-emergency, emergency appointment; a little girl is playing a noisy game on her mother's phone.

The doctor sits at her desk behind a large computer screen. 'How can I help?' asks the screen and its crown of curly hair. You've not sat down yet, but you're deciding where to begin. Begin at the beginning? Begin at the now? As you walk around the side of the desk the doctor still looks at the screen. She's scrolling through what you assume are your notes, and says again: 'Good morning, how can I help?' There's a clock in the corner of the room which is ticking loudly and there is a whirring: the air-conditioning, perhaps. You begin at the beginning, you stumble over your words, you use phrases like 'the pain began six months ago,' and she starts typing. 'I've been to see a private physio who's given me some exercises,' *tap tap tap*, and 'the pain gets worse for no reason', *tap tap tap*. You're finished. Now she turns to you. She asks you what you've taken for the pain and if you understand what it is that you are suffering from. She prints out an explanation: 'to read at home'. She refers you for an ultrasound and says there may be steroid injections: 'they can give them to you then and there'. You're not sure what the injections do. Of course they're for the pain, but you're not sure what they do. 'I'm going to examine you now', she says. Her hands are cold and clean. Thin sunlight seeps through the blinds and the sky is a clear autumn blue. You can hear the heavy sound of footsteps outside the door as people come and go. It's not clear what she's feeling for. 'There's not much hard skin. The ultrasound should be able to confirm your diagnosis. Seeing as you've had it for six months it's quite likely that you'll get the steroid injections. The referral will come in the post. I would recommend also taking a full course of anti-inflammatories. See if that helps.'

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For those of us who are lucky, a visit to the doctor is a relatively infrequent occurrence. Our individual expectations and experiences of going to the doctor may differ, but this rather unremarkable account of a clinical encounter may strike many as familiar. What has happened? A patient has entered a room and is unsure of how to effectively tell her story. She has faced an unspoken battle to draw the doctor's attention away from a screen, and has left with subsequent procedures in place and treatment outlined (even if some of this remains rather unclear). The structure of this encounter follows the standard pattern of a doctor-patient consultation in primary healthcare. The surgery is noisy and the day has only just begun, but it is soon to be filled with appointments, and

during each consultation the doctor is asked to listen to her patient. Conversely, the patient will expect to be heard but might worry that she has not been listened to. The computer screen clearly inhibits listening, and yet, as the medical interview progresses, the doctor's typing indicates that the clinician has interpreted whatever the patient is saying. The patient has been recorded. What can we learn from this encounter? Who listens and who acts?

This chapter examines the ways in which clinical listening takes place, how the use of various media and the aurality of our environment affect our ability to listen, and produce various affective and embodied forms of listening. Where chapters one and two have considered the problem of articulating illness, these final two chapters explore the difficulties of clinical listening. Within the clinical encounter, listening represents an active process that asks the clinician not only to listen actively to what is said, but also expects her to take subsequent action. Listening — in much the same way as narrative — has been embedded into the clinical encounter as a means of diagnosis, treatment and care giving. We live our life in stories and these stories are made manifest by their narrativisation and through those that listen to them.

In the late nineteenth century, physician William Osler — now considered the father of modern medicine and medical education — called for his medical students to: '[l]isten to your patient, he is telling you the diagnosis.'[1] Listening according to clinical practice is a vital diagnostic tool. Is this mode of listening enough? I want to ask, what happens to patients as they are listened to? As the scene above suggests, listening involves at least two interlocutors. But beyond the confines of the doctor's consulting room and, further still, beyond the walls of the surgery, clinical listening is mediated through — and comprised of — a series of agents and institutions that impact how and to whom we listen. The clinician Jerome Lowenstein writes that:

> Physicians have always known that imbedded within the patient's narrative are words and phrases that direct the listener to the general or even the very specific medical problems of the patient. Interviewing a patient requires the physician to pay close attention to a unique detailed sequence of events while interweaving a series of directed questions that lead from the imbedded clues to the formulation and exploration of differential diagnosis.[2]

[1] Cheryl Krasnick Warsh, 'Sir William Osler 1849-1919', *The Royal Society of Canada (RSC)*, 2018 <https://rsc-src.ca/en/voices/sir-william-osler-1849-1919> [accessed 8 November 2019] (para. 10).
[2] Jerome Lowenstein, *The Midnight Meal: And Other Essays About Doctors, Patients and Medicine* (London: Yale University Press, 1997), p. 71.

The problem, however, is that Lowenstein's depiction of the doctor-patient encounter is predicated on the belief that everything that can be gleaned from the consultation lies at the surface: the argument being, that it is only a matter of asking the right questions in order to elicit and understand the patient's experience.

This chapter attempts to illuminate the problems of clinical listening by using Beckett's radio drama *All That Fall* and theatre play, *Krapp's Last Tape* — in which a tape recorder is central to the drama — to show how Beckett's sounds construct bodies. By exploring the theories and questions of listening in both sound studies and Beckett studies, I argue that we can better understand the interpersonal challenges faced by clinician and patient in clinical encounters. Using Beckett as a translational tool, as is my methodology throughout this thesis, we come to understand the dynamics of listening as an active and embodied process that carves out networks between people, institutions and technologies.

My aim has been to entangle questions raised within the medical humanities to the same ends as Fitzgerald and Callard who seek to: 'characterise the affective relations and discontinuities between human bodies and other entities'.[3] In the context of this chapter, these 'other entities' are founded in recording and broadcasting media, and more specifically how Beckett uses these media to present listening as an uncomfortable, conditional, invasive and embodied act. So far, this thesis has explored narrativised selves within documentation, stage and prose. In this chapter, the word and stage become heard and imagined spaces. I argue that listening requires active participation. It is a process that takes in information, but also produces it by manipulating and reifying what has been listened to into a series of translations. Moreover, listening is challenging. Its challenges are manifold for the clinical and radio listener alike, be it due to: distraction or disorientation; the interruption or misinterpretation of a signal; the emotional and affective difficulty of listening to pain and illness; or the unreliability of the machines we use to listen to recordings and transmissions.

Listening technologies and modes of recording and producing sounds are thus used to read the challenges of the clinic, through their manipulation in Beckett's works. With this in mind, I begin section one, 'Radio and Its Listenership', with an explanation of the cultural context out of which Beckett's works for radio are born, specifically those commissioned and produced by the BBC. Understanding the dynamics of radio and

[3] Fitzgerald and Callard, 'Entangling Medical Humanities', in *Edinburgh Companion to the Critical Medical Humanities,* ed. by Whitehead and Woods, pp. 35-49 (p. 38).

broadcasting at the beginning of the twentieth century leads me to consider radio's compression of a community of listeners, comingling with the individualised listener. I argue that the identity of the individual is culturally codified as part of a disparate imagined community of radio listeners. This listenership is constructed by a technology (the radio) through which its subjects listen and so pre-supposes a particular mode of listening. In turn, as I shall explore in section two, 'Entangled Listeners', the process of listening to the radio is further mediated through a collective identity that is bound up in the institutional and cultural contexts in which listening takes place. Similarly, the characteristics of the clinic both aid and inhibit effective clinical listening, bringing together disparate individuals into a collective patient identity.

In order to treat a patient, a clinical community is founded between the primary, secondary and tertiary carers. This notion of a clinical collective identity — one comprised of multiple healthcare providers and experts — is not as cohesive as it might at first appear. The opening passage of this chapter depicted a scene within a primary healthcare setting, which represents the patient's entry point into the healthcare system as a whole. The interaction between clinicians, from primary, to secondary, to tertiary care remains relatively fragmented, often to the detriment of the care the patient receives. Competition exists between clinicians regarding the diagnosis and treatment offered. Furthermore, treatment and decision-making can be stalled due to the constant deferral to other specialists. Michael Balint refers to this phenomenon as the 'collusion of anonymity'.[4] The introduction of further specialist opinion into a patient's case causes an unsettling dynamic between the various caregivers and the patient. No one clinician is solely responsible for care, and so the autonomy of the medic is called into question, both by her colleagues and the patient. Citing a case in which a patient is passed through a 'galaxy of specialists', Balint writes:

> Who was now responsible for the patient — the general practitioner, the surgeon, the two physicians, the psychiatrist, or his two chief assistants? I wonder how many of the specialists involved in this treatment took the trouble to follow up the results of their recommendations.[5]

Judgements are made at each stage, but the question remains as to whether and how these judgements listen and respond to one another. Listening to one's peers proves to be problematic, beyond simply listening to the patient and her case.

[4] Michael Balint, *The Doctor, His Patient and the Illness*, Second (London: Pitman Medical Publishing Company Ltd., 1957), p. 75.
[5] Ibid., pp. 75-76.

In the third section, 'Hearing Bodies', I consider how radio's attempts to represent the body, the noises it produces and its environmental soundscapes identify listening as a contradictorily embodied and invisible encounter. Using *All That Fall* as a case study, I argue that by removing the body from view, the subject becomes more embodied as she is listened to, and the challenges increasingly associated with listening to the body are also those that bring the body into being.

Finally, just as I have explored the chronicity of storytelling, I explore the chronicity of listening through sound recording in Beckett's *Krapp's Last Tape*. Listening in *Krapp's Last Tape*, like storytelling, is a chronic encounter in which the eponymous Krapp listens at length to multiple time periods and compulsively returns to the different stories he has recorded at different times. I shall compare the apparent immediacy of the listening experience with the temporal lag between recording and listening: a theme that Beckett uses in *Krapp's Last Tape* to depict the various narratives of an aging speaker, who in turn becomes his own listener. While this form of recording is different to that of the clinic, primarily because it is recorded in sound not writing, *Krapp's Last Tape* stages a chronic and frustrating dialogue between the present Krapp and his younger selves, which proves productive when considering the nature of long-standing relationships between clinicians and their patients. The machine (both the radio and the tape recorder) is a speaker/listener that in Beckett's work comes to represent the difficulty of listening and the troubling experience of revisiting aural (i.e. recorded) representations of the self. In Chapter One, I claimed that within the clinic written documentation problematizes the patient's attempts to make meaning. Narratives are retrospectively created. Patient articulations are reordered and fed back in different documented forms, and through each retelling the story is distanced from the subject who articulated it. Moreover, narratives are frozen in time and thus fail to reflect the current state of the patient.[6] In clinical terms this results in stories that no longer accurately represent a patient's experience and can in fact influence the doctor-patient interaction through anachronistic readings of the patient's current condition.

One of my criticisms of current clinical perspectives has been to challenge their belief in narrative's potential to offer a better way of relating to (and diagnosing) a patient. These narratives take various forms: the patient's 'history', the doctor's notes, and the documenting of encounters during a consultation (as I illustrated in the opening of this chapter). These captured narratives, I argue, are questionable, as they are self-

[6] Poirier, 'Voice in the Medical Narrative', in *Stories Matter*, ed. by Charon and Montello, pp. 41-58 (p. 51).

contained and fail to reflect the changes and inconsistencies of chronic illness.[7] Here, in this chapter, it is through aural media that I find similarly anachronistic and problematic renderings of subjective experience. These prove productive as a means by which to explore the difficulty of listening to the body.

Capturing oral histories through recorded media presents many challenges. How one listens to the audio recording of a patient, and how one's reading of it changes over time will be examined here. The body may be removed from view, but I argue, in doing so one is alerted more to the dynamics of listening. Connor writes that:

> Beckett's radio worlds are indeed highly interior, and many critics have been tempted to see the principal use of the sensory deprivation or sensory concentration of radio as affording Beckett an opportunity to focus undistractedly on the interior workings of the mind.[8]

While this is arguably the case, this chapter looks to broaden the scope of analysis of Beckett's audio works to incorporate his formal, technological and institutional commentaries on the radio listenership and the listening subject. By entangling the radio and clinical listener through Beckett's drama we can not only identify the problems of listening, but also offer alternative modes of listening that may inform the clinical encounter, so as to redress and overcome these challenges.

Radio and Its Listenership

Let me begin, then, with the critical and cultural contexts of the radio and radio listening. From its infancy, radio has functioned as a mass communication system with the ability to influence, unite and coerce its listeners. David Hendy writes that public service broadcasting is an 'infinitely extendable, shareable resource, a medium for spreading ideas far and wide, for transcending physical and political barriers, for uniting the hitherto disunited.'[9] The radio listener can listen in from the privacy of her own home, while at the same time being connected to a multitude of other listeners, in other households across the country.

In early twentieth-century Britain, radio played an integral role in fostering a cultural and national identity for its listenership. From the beginning, the social and

[7] Josie Billington rightly questions the repercussions of formally integrating narrative-based practices within the clinic. She suggests that while an appreciation of the patient's story should be welcomed, the move towards creating a 'formal discipline with its own general principles' is ill-fitting with an approach that was based upon seeking out, and attending to, the particularities of each patient's case and each clinical encounter (2016, 65-66).
[8] Steven Connor, 'I Switch Off: Beckett and the Ordeals of Radio', in *Broadcasting Modernism*, ed. by Debra Rae Cohen, Michael Coyle, and Jane Lewty (Florida: The University Press of Florida, 2009), pp. 274-93 (p. 275).
[9] David Hendy, *Public Service Broadcasting* (London: Palgrave Macmillan, 2013), p. 12.

moral responsibility of radio broadcasting was implicit in its productions, programming, and the ideological leanings of its creators, namely Lord John Reith, the first General Manager of the BBC.[10] Reith saw radio as the means of elevating the masses and improving popular culture, and famously developed the pithy ideology that continues to underpin the ethos of the BBC today: to inform, educate and entertain.[11] Entertainment was perhaps the least important of Reith's aims at the BBC, but it nevertheless remained essential to ensuring a listenership that might help fulfil his other two precepts. The power of the radio for Reith lay in its scope, yet while the corporation continued to grow, Reith's focus remained on the interpersonal quality of radio. In an internal memo, written in November of 1936, Reith wrote: '[t]he BBC is one Corporation and can only be thought of by the listener as individual. It has many voices but one mouth.'[12] The radio (specifically the BBC) consists of many voices, one mouth and a seemingly endless number of listeners. These many voices formed a single mouthpiece for a nation that spoke back to itself — speaking and listening at the same time — enabled by radio technology. The interpersonal exchange between one speaking mouth and one listening ear is both broadened and condensed through the radio apparatus. It not only offered a technological means for speaking and listening on a national scale, but it also materially represented the act of listening itself.

Where is the listener located within this exchange? Is she the passive receiver of information or an active participant in the broadcast? It seems likely that she is both. Indeed, the radio is experienced as ambient sound for many auditors at one time or another. Additionally, a considered engagement with its output relies either upon the sheer compelling force of what is heard as one passes by the radio, or by making an active decision to sit and listen. Even listening to the radio in one's own home does not guarantee that we experience it from a fixed location. The listener might wander about the house, listening but also distracted, she does not have to conform to any clear practice of listening.

The modes of clinical listening that I explore in this chapter differ in some senses from the kind of Reithian listening practice I have outlined here. Instead, clinical listening predominantly relies on interpersonal exchanges, more often than not comprising of at least two bodies occupying the same space. Clinical listening relies on bodies, which can see one another, have the ability to touch one another, and are

[10] Hendy, p. 22.
[11] Ibid., p. 14.
[12] Debra Rae Cohen, 'Annexing the Oracular Voice: Form, Ideology and the BBC', in *Broadcasting Modernism*, ed. by Rae Cohen et al., pp. 142-57 (p. 145).

physical forms that share the same physical space. The interaction between clinician and patient, like the one depicted at the opening of the chapter, requires both clinician and patient to listen and display their listening in visual and oftentimes tactile terms. Listening is enclosed within a single physical site: the consulting room shut away from the cacophony of the public waiting room that lies outside. Yet, these encounters do incorporate multiple other listeners, be they medical students, consultants or family members. What remains imperative, however, is that speaking and listening is necessarily private and confidential.

In 1959, the producer and director Donald McWhinnie writes, '[r]adio at its best is a private experience'.[13] Drawing upon his collaboration with Beckett at the BBC, McWhinnie's radio drama manifesto contradicts the main thread of much of the writing on radio, which emphasised the collective and unifying qualities of radio broadcasting, and instead suggests a mode of listening more akin to that within the clinical encounter. McWhinnie claims, 'we are only as far from the speaker as he is from the microphone — in other words that he is speaking secretly into our ear.'[14] While he acknowledged the scope of radio's listenership in a given moment, he also stressed the concentration of an audience into a single listener or small group. The experience of radio drama was, he argues, most effective when undertaken alone, but of course not truly alone, as the listener is always accompanied by the voice of the radio. This depiction brings us closer to the clinical model of listening, and yet it still denies the need for bodies to be in the same room. It is the distinction between listening to bodies that are present and listening to remote bodies through the radio, that McWhinnie deems as the potentially productive and most unsettling qualities of radio. He writes:

> [F]or most of us hearing is an extraordinarily misleading faculty. We like to look at the person who is talking to us; we get help and stimulus from his facial movements, his gestures. Listening is too highly specialised a technique; to all intents and purposes we have abjured the use of our ears, simply because the experience, if any, transmitted through them to the mind has proved inadequate, or the effort demanded too exacting.[15]

Seeing interferes with our ability to listen properly, and our reliance upon seeing a body and its actions now inhibits our ability to listen to what that body says. The radio, then, must produce bodies and images in different ways, so as to hold the attention of the listener.

[13] Donald McWhinnie, *The Art of Radio* (London: Faber and Faber, 1959), p. 11.
[14] Ibid., p. 57.
[15] Ibid., p. 22.

Hearing is challenging, according to McWhinnie, precisely because the listener lacks the commitment to truly listen. Similar challenges have been raised within the medical humanities. Asking 'is medicine is capable of listening?', Winning highlights the 'predominance of the visual in medical culture and clinical practice', and claims that the challenge remains to construct an encounter, in which all senses are deployed in aid of better communication and understanding between clinicians and patients.[16] Clinical listening, like radio listening, is hard precisely because the visual has always taken precedence. Moreover, McWhinnie writes that '[l]istening is a difficult business, more difficult every year in a world which is geared to the quickest and easiest communication possible.'[17] McWhinnie made this claim in 1959, and speed and ease of communication remain a priority, not only in the consumption of culture, but also in terms of an overall emphasis on efficiency. Time, that is the time taken to listen, has been reduced in part because of our reluctance to make the effort to do so. I shall explore chronicity in more detail in this chapter, but for now I return to radio culture at the time of McWhinnie's writing. I am struck by McWhinnie's description of listening as 'too highly specialised a technique', which suggests that listening, unlike seeing, requires an active engagement with that which is being perceived.[18] Listening takes work and while in other interactions sight can support encounters, the radio alerts its struggling listeners to the difficulty of a medium that relies upon sound alone. Through the radio, listening is in some senses made 'visible' and, as such, reveals the difficulties of listening to the listener. The radio device is a physical marker of a listening encounter as it sits between speaker and listeners, regardless of how far apart from one another they might be. For McWhinnie, the dramatic and sonic potential of the radio promised drama that could offer a commentary on listening through listening itself.

It is out of this context that Beckett's works — written specifically for the radio — emerge. While it is widely understood that *All That Fall* was Beckett's first piece for radio, the BBC had previously aired a series of readings of Beckett's prose works in the year prior, along with a somewhat unorthodox adaptation of *En attendant Godot* (1953), in French, on the Third Programme. Following the success of Beckett's French stage production of *Godot*, the BBC's Third Programme became increasingly interested in commissioning Beckett to produce work for the radio. Where the BBC had initially backed away from a radio production of *Godot*, due to the lack of English translation

[16] Winning, 'Afterward', in *Edinburgh Companion to the Critical Medical Humanities*, ed. by Whitehead and Woods, pp. 325-35 (p. 331).
[17] McWhinnie, p. 21.
[18] Ibid., p. 22.

and doubts about an interested listenership, by the time the play had been performed in London to great acclaim, as Erik Tonning describes it, 'the BBC began actively to woo Beckett'.[19]

Beckett's prose, Peter Fifield writes, was well suited to the radio. The trilogy, with its first-person narration, 'means that every reading is always and unavoidably a dramatization, with the speaker playing the character at the centre of the story.'[20] Fifield describes Beckett's relationship with the radio at this time as curiously at odds with the received Beckettian dogma that opposed adaptation from one genre or form to another. Beckett was only too happy to adapt these works Fifield argues, so as to make them available to a much wider audience. However, as he notes, the correspondence between McWhinnie and Beckett always refers to these prose productions as 'readings', clearly rejecting any association with dramatization and adaptation of the work.[21] The material was to remain the same, while the medium changed.

These novels were also well suited to radio, Fifield writes, because, while 'transferal from stage to radio or vice versa involves the appearance or disappearance of an actor, the prose, just as much as the radio writing, is work for voices, not bodies', thus lending itself to easy adaptation from print to audio recording.[22] In Beckett's works written specifically for the radio, however, the body is made present (which is to say audible) through the sounds (both intentional and unintentional) that it produces. The construction of bodies in sound and through listening alone will be explored later in this chapter in section three, 'Hearing Bodies'. For now though, a comment on the presence and absence of body and voice serves to help contextualise the development of Beckett's radio drama through his prose works, from what might cynically be seen as a self-promotional tool to a dramatic style, which not only experimented with the technological capabilities of radio, but also produced work that incorporated the subject of radio into its very fabric.

These dramatic works began to ask questions of the radio that the radio (and the BBC) was asking of itself. Connor writes that, 'Beckett's work for and with the idea of radio reactivates an earlier tradition in which listening to the radio was an active,

[19] Erik Tonning, 'Mediating Modernism: The Third Programme, Samuel Beckett, and Mass Communication' in, *Samuel Beckett and BBC Radio: A Reassessment*, ed. by David Addyman, Matthew Feldman, and Erik Tonning, New Interpretations of Beckett in the 21st Century (New York: Palgrave Macmillan, 2017), pp. 59-79 (p. 66).
[20] Peter Fifield, ''Switching on and off': Beckett's Prose on the Radio', (presented at the Samuel Beckett Summer School, Trinity College Dublin, 2013).
[21] Ibid.
[22] Ibid.

absorbing, and laborious undertaking.'[23] Beckett's radio drama, which made this already strange genre stranger, seems to epitomise the BBC's Reithian ideology that aimed at creating a thinking listenership. The practice of listening was to become the subject of Beckett's radio drama, but more importantly, he depicted an art form within which the practice of listening through a medium was contingent upon the technologies and infrastructures that enabled it. 'Radio', writes Connor, 'can come out of nowhere only because it passes between.'[24] The message produced by the radio needs to be mediated through an apparatus in order to be heard, or rather the information transmitted must be translated in order to be understood. This draws a striking resemblance to the necessary translations that take place when adapting works from one form into another. With this view of the radio comes the construction of a third space, which sits between broadcaster and listener and entangles the experience of listening with both the aesthetics of radio drama and its practicalities.

Entangled Listeners

The interpretive acts required of the listener by Beckett's radio works provide us with particular insights into the challenges clinicians and patients face when trying to listen to, and represent experience. Within clinical medicine the emphasis remains on the visual, to the extent that understanding and empathy are discussed in visual terms: we claim to 'see' when we comprehend.[25] To listen and to understand are confounded in the clinic by myriad institutional and infrastructural distractions. Seeing and hearing become interdependent and, furthermore, touch offers an additional dimension through which the doctor and patient interact. Listening is ultimately entangled in these senses.

In *The Skin Ego*, Didier Anzieu locates the function of sound within a plethora of sensations that aid the development of the infant Ego. One's sense of self is founded through sounds and her relationship to them. He writes:

> At the same time as the boundaries and limits of the Ego are being established as a two-dimensional interface leaning anaclitically on tactile sensations, the Self is constituted by introjecting the world of sound — and taste and smell — as a pre-individual psychical cavity endowed with a rudimentary unity and identity.[26]

[23] Steven Connor, *Beckett, Modernism and the Material Imagination* (Cambridge: Cambridge University Press, 2014), p. 68.
[24] Steven Connor, *Beckett, Modernism and the Material Imagination*, p. 67.
[25] Winning, 'Afterward', in *Edinburgh Companion to the Critical Medical Humanities*, ed. by Whitehead and Woods, pp. 325-35 (p. 332).
[26] Anzieu, p. 173.

Referring to the work of English psychoanalysts Bion and Donald Winnicott, it is important to note Anzieu's use of the word 'introjecting' here. The development of the infant Ego is contingent upon taking in sounds. Sounds play a crucial role in the way that the infant comes to understand her position in the world. Sounds exude from the child, but they are also brought inwards. Before sounds acquire any semantic meaning, the child finds itself in what Anzieu refers to as a 'bath of sounds'.[27] The product of this 'bath of sounds' is three-fold:

> (i) a common volume-space which permits bilateral exchanges (whereas breast feeding and evacuation involve a one-way flow); (ii) the child's first (spatio-temporal) image of its body; and (iii) an actual bond of fused reality with the mother (without which the later imaginary fusion with her would not be possible).[28]

It would seem, then, that sounds not only represent a means by which to understand the self in space but also as a way of relating to others, specifically the mother in this case, who functions as the blueprint for all future interactions and attachments. The infant experiences sounds that come to her, but she also releases sounds of her own. Anzieu cites Winnicott's work on the function of babbling as a 'transitional phenomena' enacted by the child. Before sight, comes hearing and the 'bath of sounds', that the mother produces for the infant, 'offers its first mirror of sounds'.[29] Anzieu's work does not deny the importance of sight, but rather dislodges it. He argues for the intermingling of sight and sound, and also for the prominence of sounds in the initial stages of development. Prior to the visual signals received by the infant, then, comes a 'mirror of sound or an auditory-phonic skin'.[30] It is this 'audio-phonic skin' that plays a vital 'role in the psyche's acquisition of the ability to signify and later to symbolise.'[31] The metaphor of skin proves particularly useful as it denotes an encasement that is physically attached to what is held within it. Sound is on the outside but at the same time constitutes part of the subject. Thus, the subject understands herself through the sounds she produces and the sounds that she induces in others. She wears these sounds like a skin, but she is also submerged in them.

The sources of sounds, and the meaning that is attributed to them, however, cannot be so easily understood. 'The space of sound' writes Anzieu, 'is the earliest psychical space: noises from outside which cause pain when they are loud or sudden, gurgles from

[27] Anzieu, p. 184.
[28] Ibid.
[29] Ibid., p. 186.
[30] Ibid., p. 174.
[31] Ibid.

inside the body that are disturbing because it is not clear where they are coming from', suggest that sound comes from, traverses, and contains outside and inside.[32] Sound thus produces additional dimensions: 'the dimension of space (orientation, distance) and the dimension of time.'[33] Hearing places us within spatial and temporal dimensions, which the subject must also navigate. It is particularly in these dimensions that I want to consider the affects of radio listening on the notion of self.

Radio compresses many sounds into a single source, but it also fragments them across time. Radio's simultaneous compression and fragmentation of spatial and temporal dimensions or, as Connor puts it, its 'dispersal of all punctualities and particularities, of space and time', unsettles the listening subject — the sounds we hear are not always to be trusted.[34] Rather than locating the subject in space and time, radio sound dislocates. Its dispersal of sound and instance means that the listener is stripped of the audio-phonic skin that grounds her. I see this as precisely the result of a listening situation that is fragmented, and in which bodies remain absent. The clinical encounter sits in contrast to this primarily because clinicians and patients tend to occupy the same physical space in clinical consultations. Radio is most useful as a point of comparison because of its seeming differences to these clinical interactions as unlike the clinical encounter, listening is made the explicit point of focus for the radio broadcaster and listener. The fragmentation of both the radio speaker and listener means that they cannot be understood within a cohesive and unified spatio-temporal whole, but listening is what binds these disparate subjects together in a way that can be productively applied within the clinical consultation. If the clinic side-lines listening in lieu of the fact that subjects share the same physical space, then examining listening through a medium (the radio) designed solely for that purpose alerts us to the ways that listening, and most importantly the difficulty of listening, can be interrogated in the clinic to consider the ways that radio produces forms of embodied communication. Moreover, with an awareness of embodied listening, clinicians might thus be better able to communicate with their patients and further reflect upon their own reactions to patients within the clinical encounter. The radio reaches outwards, but the identity and presence of a listener cannot be assumed. While this may be unsettling to the listener, we might ask what radio offers in the way of a mode of listening and speaking that brings together interlocutors through the physical radio apparatus. Here clinical and radio listening are read as embodied processes which create bodies through the act of listening, and by

[32] Anzieu, p. 188.
[33] Anzieu, p. 173.
[34] Connor, *Beckett, Modernism and the Material Imagination*, p. 65.

reading listening in this way I argue that we are able to understand some of the reasons why listening might have, heretofore, remained a particularly difficult and invisible practise to the listener.

By contesting the 'predominance of the visual in medical culture,' as Winning calls us to do, she writes:

> [I]t would seem timely to ask how we transform biomedicine back into a sensately fluent discipline. Indeed, we might say this is one of the most pressing requirements of the medical humanities: to find a way to create a productive interface between critical theory and clinical practice in order to restore biomedicine to a more holistic sense of the human body.[35]

So far, in this chapter I have outlined the context of radio broadcasting, so as to highlight that listening is conditioned by structural and formal modes of reception. By removing the body from sight, radio calls our attention to the sound that the body produces. The listener becomes more attuned to both the sounds of bodies and the sounds of the radio itself. Beckett's radio work, in particular, speaks to Winning's call to arms and, I argue, offers a method for understanding the listening challenges of the clinical encounter. What distinguishes Beckett's work in this sense is his marked choice to conjure more embodied and situated subjects. Their bodies' sounds fill the soundscape, making them all the more tangible through their invisibility, and all the more sensate by their absence. Thus, to entangle the listener of Beckett's radio and the clinical listener is to offer a case study for an embodied subject that stages her call to be heard through the medium used to initiate her call.

Because the clinical encounter largely relies upon bodies occupying the same space, we might have assumed that clinical listening is easier.[36] With bodies in close proximity to one another, 'punctualities and particulars' are not dispersed, but are instead brought together and visibly embodied.[37] Yet I argue that nevertheless listening in the clinic is no easier. Indeed, the embodiment of the patient within the clinic can be — and often is — denied in lieu of the narrative put forward by the patient. The clinician may be listening, but this listening is concerned with what lies on the surface, by which I mean the immediate content of the patient's narrative. Moreover, clinical listening also

[35] Winning, 'Afterward', in *Edinburgh Companion to the Critical Medical Humanities*, ed. by Whitehead and Woods, pp. 325-35 (p. 329).
[36] There are undoubtedly exceptions, as an increasing number of clinical encounters take place through phone calls, letters between clinicians concerning a patient's case, letters between clinicians and their patients, and Internet and video call consultations. Moreover, cuts to health care budgets in the UK have led to a development in services like NHS Direct, to manage non-emergency enquiries and offer medical advice without patients having to visit their GP practice.
[37] Connor, *Beckett, Modernism and the Material Imagination*, p. 65.

attempts to hear past the presence of a physical body and so ignores multiple non-lingual modes of embodied listening.

In his TED Talk 'A Doctor's Touch', the physician Abraham Verghese discusses the implications of excluding the physical body and touch from the clinical encounter. His talk explores the repercussions of clinicians' reliance upon testing the patient using technologies, scans and samples, as opposed to examining the patient using their hands. He states that in this new paradigm, the body of the patient has been replaced with a technologically constituted 'iPatient' who is contained within the computer. By sacrificing the physical exam, we are not only putting the patient at risk, he claims, but we are also 'losing a ritual.'[38] Furthermore, he argues, we are denying the 'power of the human hand, to touch, to comfort, to diagnose and to bring about treatment.'[39] With the development of technologies designed to see inside the body, the surface of the body is now bypassed. Verghese begins his talk by citing the work of eighteenth century physician Leopold Auenbrugger who developed the technique of percussion — 'the ultrasound of its day' — to determine 'organ enlargement, fluid around the heart, fluid in the lungs, abdominal changes' in patients.[40] It was through a combination of touch and sound, that Auenbrugger began to understand the goings-on within the body. Never before had such a practice taken place, and the surface of the body no longer represented a barrier to understanding its inner workings, instead it was vital to the clinician's ability to see, or hear inside it. For Verghese this paradigm shift in the way doctors interact with their patients represents more than another method of diagnosis. Touch, is an alternative means of communication that incorporates looking and listening.

Verghese says that his approach to medical consultations includes two staggered appointments with his patients. The first 45-minute session is devoted to the patient speaking, while the clinician, he says, must suppress the compulsion to interrupt the patient. The second session consists of a physical examination of the patient. By ordering his appointments in this way, Verghese believes that he has taken the time to hear the patient story and thus 'earned the right' to examine his patient.[41] He has fostered a trust and a bond between himself and the patient, and earning the patient's trust is imperative to the second consultation, which relies predominantly on touch.

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[38] Abraham Verghese, 'A Doctor's Touch', *TED - Ideas Worth Spreading* (2011) <https://www.ted.com/talks/abraham_verghese_a_doctor_s_touch/transcript#t-1092727> [accessed 11 November 2018].
[39] Ibid.
[40] Verghese.
[41] Ibid.

Touch and listening are thus bound together as vital communicative tools within the clinical encounter. This forms the basis of a ritual between the clinician and patient and the importance of this ritual should not be underplayed. In his lecture, Verghese emphasises the importance of the interplay between listening and touch, as an enactment of clinical care which need not focus attention on treatment and cure. Touch operates as an exchange from clinician to patient and patient to clinician. An interpersonal intimacy and honour is exercised through listening and touch. This is a wholly sensate approach to communication, which feels and hears past the purely visual without denying the body (or bodies) in the room.

The percussionist, Evelyn Glennie, who is profoundly deaf, has likened hearing to a 'specialized form of touch', claiming that even those who are totally deaf are able to 'hear/feel sounds.'[42] Sound is a form of vibration; it touches us. Barry Blesser and Linda-Ruth Salter write:

> In our scientific society with its emphasis on physical explanations, the categories for sensing the external world are mostly sorted by the combination of biological organs and physical stimuli: ears are for hearing sound, eyes are for seeing light, and skin is for touching surfaces (Ackerman, 1990). Yet even with this bias toward concrete labelling, our culture takes no notice of the many different kinds of information processing that actually compose a single sensory modality. For example, the tactile modality — touch — includes independent sensors for vibration, texture, temperature, movement, and so on. Our very concept of the senses arises from our cultural biases.[43]

The world is understood through our interaction with it, not simply through the reception of it, as we interact with the space and subjects around us, using the complete range of our sensory capabilities. Through her music Glennie is also touching and being touched by the sounds she creates. Here, there is an intimacy in sound-making unlike that depicted in clinical literature. In his portrayal of radio drama, McWhinnie evokes a similarly intimate quality in listening to Glennie, using metaphors of touch to emphasise the closeness of broadcaster and listener. Unlike theatre performances and cinema screenings, McWhinnie writes:

> Suddenly the performance comes to *you*, privately and personally, in your own room. It is designed specifically for you, it is an individual communication from writer to listener. The total audience may be larger

[42] Anahid Kassabian, *Ubiquitous Listening: Affect, Attention, and Disturbed Subjectivity* (Berkley, California: University of California Press, 2013), p. xvi.
[43] Barry Blesser and Linda-Ruth Salter, *Spaces Speak, Are You Listening? Experiencing Aural Architecture* (Cambridge, Massachusetts: The MIT Press, 2007), pp. 3-4.

> than any theatre could possibly accommodate, but it is an audience of individuals or small groups, whose reflexes are individual, not collective [...] the writer can speak literally into the ear of his listener [italics in original].[44]

Sound is spoken into the ear of the listener: it touches the listener. The listener is a hearing device and her personal reactions to sound are reflected back, much in the same way as the sound that envelops the subject in Anzieu's exploration of subjectivity through sound. What the listener hears is of interest not only in terms of its content, but also because it alerts the subject to her as a listening and sound-producing self.[45]

Where the surface of the body was previously thought to mark the distinction between what can be heard on the outside and what can be heard on the inside, touch has the ability to transcend the surface and to be both inside and outside at the same time. Glennie claims that because hearing relies on vibrations against the body's surface and within the body itself, to listen is to be touched and the listener hears sounds from the outside world, within her own body.[46] Touch functions as a way of perceiving the outside and imagining the inside. There is an act of imagination, which must take place in order for us to hear what lies within.

Jonathan Sterne also believes listening to be an imaginative act, and like Verghese he focuses on the process of percussion, and particularly 'mediate auscultation as a technique of listening', enabled by the invention of the stethoscope.[47] The stethoscope becomes a vital technology to the clinician, both for the purposes of diagnosis and as a form of exchange between clinician and patient — it is a physical marker of the clinical exam — and the connection between the interior workings of the patient's body and the clinician's ear. Sterne writes:

> [T]he stethoscope was not so much an inversion of the hearing aid as the generalization of its principle. One early model of the monaural stethoscope, called the 'conversation tube,' made the equivalence clear: the stethoscope was also usable as a hearing aid.[48]

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[44] McWhinnie, p. 34.

[45] In Beckett's radio play *Embers* (1959), the protagonist Henry conjures up memories, by producing bodily and non-bodily sounds. The play begins with the sound of the sea, which is a disorientating sound at first in the BBC production, as it sounds more mechanical than natural. Narrated in the second person, Henry narrates to his father and yet because his father remains a silent presence throughout the play, it is as though Henry were speaking to the radio listener. *Embers* is a particularly pertinent example of sound's ability to traverse the inside and outside of the subject. Sound enables Henry to transcend temporalities and reorder his experience of his own past.

[46] One can also consider that we hear another person's voice inside our heads more than the speaker hears it in hers. Moreover, we do not experience our own voices in the same way as others hear them. This movement and experience of sound blurs the distinction between inside and outside through speaking and listening, in much the same way as we have seen with touch.

[47] Jonathan Sterne, 'Mediate Auscultation, the Stethoscope, and the 'Autopsy of the Living': Medicine's Acoustic Culture', *Journal of Medical Humanities*, 22.2 (2011), 115–36, p. 115.

[48] Ibid., p. 118.

Listening through the stethoscope was not simply unidirectional. The name 'conversation tube' suggests that the stethoscope enabled communication between clinician and patient, but that both agents did not experience this communication in the same way. The hospital and clinic contain numerous apparatus through which one can see and hear the patient. Monitors, echocardiograms, the Boyle's machine, all aid the clinician in her delivery of care, using sound to signify the internal operations and reactions of the body. It is the stethoscope, however, that offers the clearest example of a sonic lead, connecting clinician to patient. Sterne writes that 'despite early resistance, the doctor's hearing tool became the symbol of a profession'.[49] This symbol of clinical professionalism would appear to signify more than the clinician's credentials, instead it functions as a prosthetic ear that enables the doctor to hear inside the body and, moreover, hear sounds the patient (who is producing them) cannot. The clinician hears beyond the surface of the body and has privileged access to sounds the patient unconsciously produces. These sounds are interpreted and translated by the clinician to ascertain a diagnosis. The stethoscope is particularly pertinent in this sense, in that it has been designed to capture and record — at least in the case of breathing — a process that takes place both in and outside of the body.

Carel and Jane Mcnaughton write 'that breathing is not only both 'inside' and 'outside' ourselves, but also acts as a conduit and a connection with the world around us.'[50] The stethoscope is able to, if not contain, at least capture this movement in progress. Moreover, separate from the clinician and patient, the stethoscope links both subjects together and yet what can be heard is only audible to the clinician.. As I shall explore further in the following section, breathing plays a central role within the soundscape of Beckett's *All That Fall* and the radio is the apparatus that links the sounds of Maddy's breath to the radio listener. The radio, then, is the connecting device or the medium that enables us to listen to the body and alerts us to that experience of listening. Maddy's breathing is a sound effect that creates a body struggling with the exertion of her journey, but it is one which Maddy herself does not directly acknowledge. Taking the phenomenological concept of the *habitus*, Carel and McNaughton write that 'the contexts in which we find ourselves, our physical surroundings, and the ways in which the body is acted upon by those surroundings […]

[49] Sterne, p. 116.
[50] Jane Mcnaughton and Havi Carel, 'Breathing and breathlessness in clinic and culture: using critical medical humanities to bridge an epistemic gap', in *Edinburgh Companion to the Critical Medical Humanities*, ed. by Whitehead and Woods, pp. 294-309 (p. 304).

actually change the body.'[51] In radio drama the body and the physical surroundings that influence the body are both invisible. Yet, while 'breathing and breathlessness are comparatively invisible', Maddy's breathing and her physicality, as imagined by the listener, are by no means less embodied.[52] The imagined physicality and the invisibility of breathlessness as phenomena are made visible in part by the technologies (the stethoscope and the radio device) that are used to hear them. These technologies are thus a physical representation of privileged aural interiority, which in the case of the stethoscope can prove troubling for the patient who cannot hear herself. I should return, then, to the question of what happens to the body that is listened to. That there is something to listen to, which cannot be heard, further complicates the subject's position as an autonomous and contained individual who can produce and withhold sound at will.

In a collection of lectures entitled *Silence*, the musician John Cage recounts a disquieting experience upon entering an anechoic chamber, in search of a silent space:

> [A] room without echoes. I entered one at Harvard University several years ago and heard two sounds, one high and one low. When I described them to the engineer in charge, he informed me that the high one was my nervous system in operation, the low one my blood in circulation. Until I die there will be sounds.[53]

Within the anechoic chamber the subject becomes aware that her body constantly generates sounds that cannot be heard in everyday life. This uncanny experience of hearing something which until now has been unheard and unknown, is evidence for Cage that there is no such thing as silence. Within the anechoic chamber the body makes itself known to the subject in a way that it is not usually perceived. Of course, visual images of our organs or our brains might elicit the same effect to a certain degree. Drew Leder claims that while I may be able to see my organs, their 'processes still elude experience from within […] The mystery of my body is only heightened by the very strangeness of the organ before me, its phenomenological noncoincidence with my body-as-lived.'[54] The difference between the seen body and the heard body is not that part of its workings must always be imagined, indeed in both the case of Cage and Leder's bodies something remains out of reach. But it is the case that through the aural perception of the body, we hear processes which elude visual representation, and as

[51] Mcnaughton and Carel, 'Breathing and breathlessness', in *Edinburgh Companion to the Critical Medical Humanities*, ed. by Whitehead and Woods, pp. 294-309 (p. 295)
[52] Ibid., p. 295.
[53] John Cage, *Silence* (London: Calder and Boyars, 1968), p. 8.
[54] Drew Leder, *The Absent Body* (London: The University of Chicago Press, 1990), p. 44.

such the call to imagine these processes, and be aware of that act of imagination would seem to be stronger. Furthermore not only do bodies produce inaudible sounds from invisible organs, they are also unable to determine how these sounds are heard and read by others. The anechoic chamber alerts Cage to unintentional sounds that cannot be modified and that persist in a body with no control over them. It seems no one has ownership of these sounds as they are produced, once they have been emitted they are there to be read in whichever way the listener decides, and so leave the body that has produced them vulnerable.

In its infancy, the radio and its broadcasters were concerned with the ways in which the listening public might receive broadcasts. Once a programme was aired, it seemed that there was nothing to be done but wait and see how it was interpreted (if, indeed, it was listened to). The BBC was particularly interested in gathering public opinion through audience polls and through its weekly publication of *The Listener* magazine, which enabled a somewhat disjointed dialogue with its listenership. Beyond the concerns of the corporation, presenters too seemed concerned with how their programmes and voices might be received. Throughout his BBC broadcasts, which spanned some 35 years, the writer and cultural commentator E.M Forster contemplated how the audience listened to him, offering, as Fifield writes, an 'imaginative engagement with his listening audience.'[55] Fifield claims that 'early radio broadcasters, eager to make their programming effective, were profoundly engaged with understanding the constitution of their audience.'[56] Imagining the listener, Forster demonstrates a key concern of the BBC to attend to the listening public, while guiding their listening.[57] It is as though by conjuring up the unseen and unheard listener, the radio broadcaster attempts to mitigate the uneasiness of being listened to in spaces where she is not and cannot be. Fifield goes on to say:

> [The] BBC frequently combined two distinct forms, responsive to the different experiences of the radio for the listener and the speaker. The first, closer to the experience of the listener, was a conversational form as if one individual were in dialogue with another in a room of the listener's house. The second, more faithful to the reality of the speaker, was a broader, lecture-like address, speaking without receiving a response, to an anonymous audience of indeterminate size.[58]

[55] Fifield, ''Switching on and off': Beckett's Prose on the Radio'.
[56] Ibid.
[57] Similar preoccupations continue to this day, with programmes such as BBC Radio 4's 'Points of View,' which encourages the radio listenership to engage with content and offer opinions or comments on the programmes that they hear.
[58] Peter Fifield, ''I Often Wish You Could Answer Me Back: And So Perhaps You Do!' E.M. Forster and BBC Radio Broadcasting', in *Broadcasting in the Modernist Era*, ed. by Matthew Feldman, Henry Mead, and Erik Tonning, (London: Bloomsbury Publishing, 2014), pp. 57-78 (p. 58).

While Forster's broadcasts might seem different to Beckett's radio drama — Forster is broadcasting himself, not a fictional work — the concern of how one is heard is frequently played out in Beckett's works for radio. Characters throughout Beckett's radio plays, from Animator in *Rough for Radio II* who insists that Stenographer has 'fresh pad, spare pencils' at the ready, to Henry in *Embers* (1959), who demands that Ada 'listen to it', are keen to be heard and to incite their companions to listen.[59] For others in Beckett's works, their role is defined by their insistence on listening, such as She in *Rough for Radio I*, who claims from the very beginning that she has 'come here to listen'[60] and again Stenographer, who not only listens, but also records (as her name would suggest) what she hears. Beckett's radio work is preoccupied with the listener as an interpreter of the speaking subject. Yet, what is listened to, and how the listener listens cannot be fully controlled however hard the characters, presenters or broadcasters may try to curate a satisfactory listening experience.

Hearing Bodies

In 1957, Beckett wrote to his publisher Barney Rosset, opposing a staged adaptation of his radio drama *All That Fall*, claiming that the piece was for 'voices not bodies… coming out of the dark.'[61] The absence of bodies was precisely the point. The act of imagination required by listening to the radio was a way into the drama itself, a way into the action, but also into the very insides of his characters. Martin Esslin writes that it was through his works for radio that Beckett was able to 'eliminate much that was superfluous about his work, in favour of a privileged interiority.'[62] While Beckett's radio drama may offer Esslin 'a privileged interiority', I argue that the radio provides Beckett with a privileged *materiality*. Beckett's insistence on 'voices not bodies' is not a denial of the body, but rather a body that is made manifest through the sounds it produces.

This section will focus on Beckett's first radio piece commissioned by the BBC. Unlike the prose readings of Beckett's work on the radio that came before it, *All That Fall* concerns itself with the tropes of radio drama, which were only then being established. McWhinnie's *The Art of Radio* argues that radio listening is both strange and hard, and his position both informed Beckett's own radio drama and was informed by his close working relationship and collaboration with Beckett for the BBC. The radio

[59] Beckett, *Complete Dramatic Works*, pp. 275, 258.
[60] Ibid., p. 267.
[61] *The Letters of Samuel Beckett Volume III: 1957-1965*, ed. by George Craig, et al. (Cambridge: Cambridge University Press, 2014), p. 63.
[62] Ulrika Maude, *Beckett, Technology and the Body*, p. 48.

genre thus becomes a central focus for Beckett in a play where the body occupies the central soundscape, despite being absent from sight.

Indeed, while radio appears to fragment its audience and disembody its actors, I argue that there is a heightening of embodiment played out through the radio performance and experienced through listening to it. *All That Fall* begins Beckett's exploration of the role of the listener as a vital player within the radio drama: the listener both completes the performance and is expected to submit and adapt so as to receive it. Just like the voice in Beckett's television drama *Ghost Trio* (1976) insists: '[m]ine is a faint voice. Kindly tune accordingly', the listener is expected to attune her listening, so as to receive the drama. Listening is not a passive and unthinking process; rather, it takes work. Moreover, without the help of the visual the radio listener must not only tune her device accordingly, she must also tune herself.

Radio emerges according to Connor, 'from nothing and nowhere', and so '[i]t is in radio that Beckett seems to have found the possibility of writing without ground — that is to say, writing in which the spoken words are at once figure and ground.'[63] Articulation gives the voice form and listening produces the body as a result of the aural interpretation. This relationship is further complicated by the fact that not only does the absence of a body alert us to the voice and the presence of a disembodied subject in sound, but it also draws our attention to the media through which we identify this voice. The device becomes another body with which to interact. LaBelle writes:

> The voice draws my attention to the radio object for instance, the speaker in the corner, from which a voice arises; or from the puppet, the machine, or the digital device that speaks to me — even such seemingly inanimate objects from which the voice appears and which comes to lend animation to its surfaces and its thingness. Is this not the power of ventriloquy and radiophony, to draw us toward a thing which suddenly speaks? That thing: *the mouth* [italics in original].[64]

LaBelle's emphasis on the 'surface' and the 'thingness' of the voice can be thought of in radiophonic terms, as he suggests that the device — both technology and mouth — become a new thing or new body through which to perceive sound. That 'surface' and 'thingness' — what might also be thought of as embodiment — is brought about by listening, and strikes significant contrasts between speaking and listening subjects within clinical encounters. Where the aim of the clinical consultation might be to animate the listener and speaker through voicing concerns and symptoms, the voice and

[63] Connor, *Beckett, Modernism and the Material Imagination*, p. 67.
[64] LaBelle, p. 7.

body may in fact be bypassed, rendering the subject voiceless, unheard and inert. Winning writes:

> The roles of 'doctor' and 'patient' require apparently clear-cut bodily behaviours and locations, most often reinforced by the material space — ward, clinic, surgery, operating theatre — in which the encounter takes place. Moreover, biomedical discourse […] has already defined and situated the body as a set of signs and symptoms that can be read and treated. A docile body in this context might be said to be one that has lost full use of its sensory organs.[65]

Where the radio device in LaBelle's reading is metamorphosed into an animated body and becomes a visual signifier of the voice, for Winning, the body of clinician and patient are inanimate in the clinic — transformed into docile, self-contained devices through which exchange becomes so challenging, precisely because the sensory nature of the subject has been denied. By viewing the patient's body as a catalogue of 'signs and symptoms', the body is occluded, overlooked and listened past.

All That Fall opens with a series of '*rural sounds*' shortly followed by Maddy Rooney's '*dragging feet*'. From the very beginning the listener is situated in a rural space, but shortly following this aural contextualisation, the first sound is not a voice, but instead the unintentional sounds of a body whose mobility is compromised. Throughout the radio play Beckett foregrounds incidental, fundamental, musical and mechanical sounds. Writing on Beckett's radio drama, Maude cites a letter written by Beckett:

> [T]o Nancy Cunard in July 1956: 'Never thought about Radio play technique but in the dead of t'other night got a nice gruesome idea full of cartwheels and dragging feet and puffing and panting'. As his letter implies, Beckett was fascinated by the opportunity radio provided to experiment with non-verbal sounds such as animal noises, music, footfalls, murmurs and laughter — all of which figure prominently in the final version of the play.[66]

Maude also observes that Beckett's work for radio 'goes against the essentially speech-based tradition of radio drama', in so far as it does away with traditional narrative conventions and instead devotes much of its airtime to embodied and inarticulate outbursts.[67] As I have already noted, Beckett's work situates itself strangely within the

[65] Winning, 'Afterward', in *Edinburgh Companion to the Critical Medical Humanities*, ed. by Whitehead and Woods, pp. 325-35 (p. 329).
[66] Ulrika Maude, 'Working on Radio', in *Samuel Beckett in Context*, ed. by Anthony Uhlmann (New York: Cambridge University Press, 2013), pp. 183-91 (p. 184).
[67] Ibid.

radio drama genre, which at this stage is still rather strange to its listeners, to the extent that any expectations the listenership may have had are cast aside for a seemingly unmediated cacophony of non-verbal sounds.

While many of the characters in *All That Fall* do speak at length, it is often un-intentioned or unconscious sounds that bring them into the drama, and the radio listener is forced to sit uncomfortably close to the non-verbal sounds these bodies produce. Beckett's emphasis on Maddy's 'puffing and panting' brings me once more to a reading of a body labouring under the weight of its invisible physicality. Maddy is keenly aware of her physical restrictions and her inability to carry on her journey when she exclaims: 'Oh let me just flop down flat on the road like a big fat jelly out of a bowl and never move again'.[68] Here the body makes itself felt, and on the radio the struggling body makes itself heard. Leder writes that 'the painful body emerges from disappearance to become a thematic object. Pain exerts a power that reverberates throughout the phenomenological field, shifting our relations both to the world and to ourselves.'[69] In *All That Fall* the altering of this phenomenological field spans even wider, as it is not only the body in pain that is changed by being made aware of its physicality, this body also affects others that listen to it. The listener's proximity to bodily sounds and the listening practice required here provide an opportunity to fill the gaps within a medical vocabulary that, until now, has foregrounded the visual. Moreover, like the anechoic chamber, Beckett's radio drama brings a heightened awareness to the body as a sound producing entity, both for the listener and the body that produces the sounds. The embodied and aurally sensate encounters that we hear through the radio can be enlightening to our understanding of how doctors and patients interact with one another and furthermore how patients interact with their own bodies. By forcing us to listen to the body that does not ask to be heard, and by listening to other listeners, the radio listener is placed in a privileged position in which she is able to listen to both the inside and outside of the subject. As though the listener were eavesdropping in on the characters, she hears the panting and scraping of Maddy's body up to Bog Hill station and is party to her many conversations and private musings along the way. The radio audience is able to travel through various layers of the soundscape to hear what others cannot or choose not to hear.

[68] Beckett, *Complete Dramatic Works*, p. 174.
[69] Leder, p. 79.

In addition to the sounds of bodies, it is important to consider Beckett's use of recorded music to bring bodies into the play's soundscape. In the opening and closing scenes, Maddy passes her neighbour's house on her way to and from Bog Hill station:

> MRS ROONEY *advances along country road towards railway station. Sound of her dragging feet.*
> *Music faint from house by way. 'Death and the Maiden.' The steps slow down, stop.*
> MRS ROONEY: Poor woman. All alone in that ruinous old house.[70]

At the end of the play as Maddy returns with her husband Dan, she notes: '[a]ll day the same record. All alone in that great empty house. She must be a very old woman now.'[71] These two fragments conjure the image of an isolated and aging woman whose image is formed through music and Maddy's reaction to it. Maddy's interpretation of the woman is evidence of her own listening process, but it also creates a subject who is manifested in both the music, and the reproduction of music through recorded sound. The nature of Maddy's listening is also to be considered, as the music that she hears is ultimately overheard. The music may come to her, but by listening to the music, which is not intended for her ears, Maddy becomes an eavesdropper and her listening is invasive. Maude writes that in *All That Fall* music produces a fourth spatial dimension. She describes what happens when Maddy overhears the music coming from the old woman's house:

> Maddy herself is transported by sound alone into the 'ruinous old house' in which 'Death and the Maiden' is played [...] For the listener of the radio play, the house therefore constitutes a fourth-degree spatial dimension: two removes from the location Maddy herself happens to be in, and one remove from the things Maddy sees as well as hears.[72]

Maddy's listening, however, is only invasive in as far as she listens-in to the music seeping out of the house. Sounds transport Maddy, but in turn sound is also transported. The spaces in which sounds are created in *All That Fall* are not self-contained, rather, they leak sounds that are not produced for those that overhear them, nor indeed are they meant to be listened to. The old woman in the house does not intentionally offer up what is given away by the sound of 'Death and the Maiden'. If the recording of

[70] Beckett, *Complete Dramatic Works*, p. 172.
[71] Ibid., p. 197.
[72] Maude, *Beckett, Technology and the Body*, pp. 51-52.

Schubert's quartet is intended to tell the listener that the old woman is inside her house, she does not know that she is being listened to. To return to LaBelle, we can read this encounter with the phonograph as the animating of an inanimate subject through sound that is overheard. Listening transports the listener into other spatio-temporal environments, as it draws Maddy into the house, and creates an imagined body (and subjectivity) for the one who is listened to: the subject situated on the inside. I asked earlier, what happens to the body as it is listened to? It would seem in this case that the body is heard in ways that it cannot comprehend or control, which thus generates a perception of its embodiedness, or rather alerts the listener to the existence of a body. For some the effect of being heard can be reassuring, for others it is exposing.

Charon has written extensively on her approach to listening within clinical consultations. In the quotation below, she begins her first consultation with a new patient by asking what it is that the patient thinks she should know about his 'situation.'[73] Charon writes:

> I listen not only for the content of his narrative but for its form — its temporal course, its images, its associated subplots, its silences, where does he choose to begin in telling of himself, how he sequences symptoms in other life events. After a few minutes, the patient stops talking and begins to weep. I ask him why he cries. He says, 'No one has ever let me do this before.'[74]

It is the space Charon gives to her patient that brings him to tears. Charon's listening is not a foreclosed form of diagnostic listening. Instead, she listens broadly, expanding the scope of her listening beyond those 'signs and symptoms that can be read and treated', to examine the form of what is said, in addition to its content.[75] The philosopher Jean-Luc Nancy writes:

> We listen to someone who is giving a speech we want to understand, or else we listen to what can arise from silence and provide a signal or a sign, or else we listen to what is called 'music' [...] In the latter case, that of music, it is from sound itself that sense is offered to auscultation. In one case, sound has a propensity to disappear; in the other case, sense has a propensity to become sound. But here there are only two tendencies, precisely, and listening aims at — or is aroused by — the one where sound and sense mix together and resonate in each other, or through each other.[76]

[73] Charon, 'Where Does Narrative Medicine Come From?', in *Psychoanalysis and Narrative Medicine*, ed. by Rudnytsky and Charon, pp. 23-36 (p. 23).
[74] Ibid.
[75] Winning, 'Afterward', in *Edinburgh Companion to the Critical Medical Humanities*, ed. by Whitehead and Woods, pp. 325-35 (p. 329).
[76] Nancy, pp. 6-7.

With each depiction of listening, Nancy claims that listening's central role is as an act of interpretation. Listening is both an interpretation of lingual and non-lingual sounds and a translation of them all into what he calls 'sense'. To listen is thus to make meaning. As I showed in Chapters One and Two, the clinic defers to traditional conceptions of narrative as a means of making meaning, but this meaning making can only be effective when there is a listener present (indeed, not just a listener, but a witness). Nancy's definition makes reference to music as a sound that is 'offered to auscultation.' Listening is thus a form of demarcation that seeks out sense at the same time as hearing sounds. To sidestep the focus upon auscultation, and instead listen within the context in which the listening and speaking act is taking place, I argue, emphasises that the clinical encounter is a single event that takes place between two or more bodies in a room. The clinician in such an instance acts as a collaborator within the clinical encounter, whose active participation in the construction of stories enables experiences of illness to be better articulated, shared and listened to.

Anahid Kassabian distinguishes hearing from listening by arguing that hearing is passive. She writes:

> The connotation of passivity in the term *hearing* is precisely why I prefer *listening*. To the extent that *hearing* is understood as passive, it implies conversion of sound waves into electrochemical stimuli (i.e., transmission along nerves to the brain) by a discretely embodied unified subject (i.e., a human individual) [italics in original].[77]

Kassabian uses this distinction to define hearing as a process that relies upon a 'discretely embodied' and most importantly 'unified subject'. This definition similarly foregrounds hearing as contingent upon a particular encounter through which it can take place. Yet the use of the word passive is surely wrong. Instead, I want to consider the ways in which this seemingly unintentional process (hearing) is activated.

The purpose of listening needs to be better defined to determine whether different modes of listening are required in different clinical contexts. Charon's listening adopts what she calls 'the diastolic position', an embodied listening — 'relaxed, absorbing, accepting, oceanic, filling. Like the heart, this position alternates with and mutually requires the systolic position—vectored, muscular, propulsive.'[78] Diastolic listening, then, cannot function as the only approach to listening. Rather, the systolic position, more akin to traditional clinical listening and history-taking — which seeks out

[77] Kassabian, p. 8.
[78] Charon, 'Where Does Narrative Medicine Come From?', in *Psychoanalysis and Narrative Medicine*, ed. by Rudnytsky and Charon, pp. 23-36 (p. 23).

symptoms and listens so as to diagnose and treat disease — is also needed. The importance of listening to diagnose should not be denied — after all the clinician would not be fulfilling her role if she were to so do — but Charon's incorporates both open and directive listening, neither of which can survive or succeed without the other.

Beckett's radio can be used to question the interdependence of these two positions. Charon adopts a psychoanalytical approach to listening within her consultations to account for what she terms the 'heteroglossic' nature of the body, which is neither completely silent in health, nor cacophonous in disease.[79] There is, then, a third position whereby the body can be comprehended, narrated and heard in *both* health and illness. Indeed, it occupies a space, which transcends these binaries. The body's heterogeneity and duplicitousness is productive. This stands in stark contrast to the search for intelligible and translatable (diagnosable) narratives within clinical encounters. If we establish that the form of the narrative is as important as its content, it would seem that Charon allows space in her consultations for the meanderings and inevitable dead-ends which are necessary for the patient to convey something of her experience. The problem still remains, however, that intelligibility is expected from both the patient and clinician.

In *All That Fall*, Maddy is concerned with her own intelligibility. At the beginning of the play, she asks Christy:

> Do you find anything … bizarre about my way of speaking? [*Pause.*] I do not mean my voice. [*Pause.*] No I mean the words. [*Pause. More to herself.*] I use none but the simplest words, I hope, and yet I sometimes find my way of speaking very … bizarre.[80]

Maddy worries that her intentional speech is difficult to understand. Her anxiety is compounded by the fact that the other characters' (Mr Tyler, Mr Barrell and Miss Fitt) do not listen to Maddy properly and are repeatedly frustrated by her outbursts. While Maddy claims that she attempts to use the simplest words in order to communicate, there is a disjuncture between the intention and reception of her speech. Maddy, like Charon's patient, is unsettled by her speech. However, for Charon's patient the emotional effect of being able to speak at length is empowering, it opens out into more speech, which will establish his long-term relationship with his clinician. For Maddy, those that listen to her offer her no such reassurance. While this does not quieten Maddy — she remains verbose throughout the play — from the very beginning Maddy

[79] Charon, 'Where Does Narrative Medicine Come From?', in *Psychoanalysis and Narrative Medicine*, ed. by Rudnytsky and Charon, pp. 23-36 (p. 24).
[80] Beckett, *Complete Dramatic Works*, p. 173.

aggressively demands that she be heard and that her presence be acknowledged even when she is silent. It seems, then, that her speech is unsettling because it is never received in the way that she hopes it will be. In contrast, the sounds Maddy creates un- or pre-consciously, seem to go unnoticed by her and her companions. For the radio listener, however, these bodily sounds create the richness of *All That Fall*'s soundscape. Their duplicity, and the varying ways in which they might be read, as listeners listen to them, cause Maddy's body to take on more complicated characteristics. Many of the sounds that are amplified are uncontrollable or overheard — just like the music emanating from the 'ruinous house' of Maddy's elderly neighbour, sound leaks out of Maddy. This time, however, it is the radio listener whose listening is invasive.

In *All That Fall* sounds are often employed for comic effect. The double entendre of Maddy's bodily and verbal outbursts bring to mind quite different acts to those that we know her to be capable of, suggesting a young and more virile body. As Maddy clambers into Mr Slocum's van she exclaims: 'Oh! … Lower! … Don't be afraid! … We're past the age when … There! … Now! … Get your shoulder under it! …Oh! … [*Giggles*.] Oh glory! … Up! Up! … Ah! … I'm in!'[81] While the humour of this scene lies in equating sounds of a struggling overweight and aging body with that of a sexually active, younger and indeed more dominant one, this scene also brings about the sounds of a body, which does not ask to be listened to. The image created in the listener's mind's eye is both distressing and funny, a combination of struggle and smut, but Maddy and Slocum do not mean to be funny. The humour of their act is inaudible to them. The radio listener is once again placed in a privileged position in which she is offered access to the whole soundscape of the radio drama, and is made aware of her ability to interpret what she is in visual terms.

Don Ihde writes that '[a]n enquiry into the auditory is also an inquiry into the invisible. Listening makes the invisible *present* in a way similar to the presence of the mute in vision.'[82] However, as Maddy Rooney shows, the silent radio subject does not disappear simply because she is silent. As Maddy exclaims to Miss Fitt, Mr Tyler and Mr Barrell: 'Do not imagine, because I am silent, that I am not present, and alive, to all that is going on.'[83] Her insistence on being present, even in silence, appears as much to be a comment on the radio form as it is on the interaction between these three acquaintances at the train station. To be present within the drama of a radio play, one

[81] Beckett, *Complete Dramatic Works*, p. 178.
[82] Don Ihde, 'The Auditory Dimension', in *The Sound Studies Reader*, ed. by Jonathan Sterne (Abingdon, Oxon: Routledge, 2012), pp. 23-28 (p. 25).
[83] Beckett, *Complete Dramatic Works*, p. 185.

must be heard, and silence leaves one vulnerable to being forgotten or excluded. Just like the old woman in her 'ruinous house', Maddy cannot exist without sound.[84] Maddy is concerned that she is unseen and unheard by those around her, as she incessantly alerts her companions and the audience to her presence. Hoping for Tommy's assistance to get out of Mr Slocum's van, she moans: 'Don't mind me. Don't take any notice of me. I do not exist. The fact is well known.'[85] Later, she asks Miss Fitt: 'Am I then invisible, Miss Fitt? Is this cretonne so becoming to me that I merge into the masonry? […] That is right, Miss Fitt, look closely and you will finally distinguish a once female shape.'[86]

The auditory may well lend itself to invisibility, but through her body's sounds, Maddy continuously contests invisibility, giving shape to her form. This section has examined the materiality of body that is heard and made manifest through the process of listening to it. The first thing the listener hears of Maddy is her body. Her '*dragging feet*' evoke laboured movements that identify Maddy's physical shortcomings, which will continue to be signposted throughout the play.[87] Maddy is first a body, then a voice. Her lack of mobility is aurally manifested through her body before she speaks of her age or infirmity, so that from the very beginning, her body's sounds tell the listener what kind of woman Maddy is. Later these sounds will develop into panting and breathlessness, further signs of her aging body and its inability to move with ease within the world. These unrelenting sounds are difficult to listen to, and are made all the harder in contrast to the fast movement of those machines and characters that Maddy (and Dan too) come into contact with. In the closing scene a series of sounds are layered upon one another: '[*Silence*. JERRY *runs off. His steps die away. Tempest of wind and rain. It abates. They move on. Dragging steps, etc. They halt. Tempest of wind and rain.*]'[88] Just like the beginning of the play, the various bodies moving through the scene punctuate a combination of natural sounds. The play finishes before the end of Maddy's journey, so that despite her having travelled a long way, it seems that there is more travelling for her to do. The pain of walking continues beyond what the listener hears, making the experience all the more arduous. The audience has not accompanied Maddy to the end of her journey and so the listener is left wondering how the story ends. This journey is in some senses a failed quest. Maddy has collected her husband but she has not yet

[84] Like the old woman in *All That Fall*, Dick in *Rough for Radio II* remains mute throughout the play and the only sounds to signify his presence are the '*swish and thud of pizzle on* [Fox's] *flesh*' (Beckett 1990, 277).
[85] Beckett, *Complete Dramatic Works*, p. 179.
[86] Ibid., p. 182.
[87] Ibid., p. 172.
[88] Beckett, *Complete Dramatic Works*, p. 199.

safely returned home. There is more of the story to be told and the cyclical narrative is incomplete. It is significant that this encounter is open ended. Charon's description of her relationship with her new patient similarly signals towards the chronic or long-standing nature of the clinical relationship, and yet Charon's depiction looks forward to the bonds that will be established between herself and her patient, whereas what persists in *All That Fall* is the repetitive movement of Maddy and Dan's bodies, with no abatement or relief. Listening, for the radio audience, is not rewarded but instead leaves us unsatisfied, uncomfortable and impotent. Listening, for the clinician is ongoing and similarly unsettling. Neither Maddy nor Dan hears their physical efforts in the same way as the listener, but they nevertheless remain concerned with how they are perceived. Maddy's fear that she is not being listened to or being paid attention to in the way she wants is distressing for her. Yet her inability to mediate and control how she is heard, when she is, is also disquieting and exposing. Beckett's radio produces an aural body and his focus on the difficulties of listening through listening media can, I have argued, help to uncover the challenges of listening within the clinic. By turning away from the visual, which has hitherto occupied a privileged position within the clinic, this reading of listening through radio emphasises the importance of other more affective modes of communication like those of hearing and touch.

The primary focus of this section has been listening to, and listening by, others. I now ask, how might our attempts to hear ourselves alert us to the difficulties of listening? In the final section of this chapter, I argue that listening to oneself proves as problematic as listening to others. Moving from the radio to stage, I turn my attention to the tape recording device that Beckett uses to foreground the act of listening. This time listening takes place in isolation and stages a dialogue with several incarnations of a single subject.

Krapp's 'heartsink'

In March 1958, Donald McWhinnie received a letter from Beckett, requesting a user manual for a magnetic tape recorder. Beckett had in mind a piece for theatre '(definitely non-radio)': a dramatic monologue for one of his favourite actors, Patrick Magee.[89] Soft spoken, with eyes saturated with tears that always threatened to spill over, Patrick Magee seemed the perfect choice for Beckett's audio archivist, Krapp. This was to be,

[89] Craig et al., p. 115.

at Beckett's own admittance, a 'rather s[e]ntimental affair in my best original English manner.'[90]

That Beckett chose to write specifically for Patrick Magee is significant. Writing *Krapp's Last Tape* in 1958 (just a year after the production of *All That Fall*), Beckett's connection with the BBC was by now firmly set, and his previous work with Magee had involved prose readings on the radio, including sections of the trilogy and *From an abandoned work*. Audience reaction to Magee's readings (though I should also like to call them performances) was less than favourable. Fifield writes:

> Numerous audience members surveyed by the BBC audience research department mentioned how difficult it was to make out the words because of his deeply cracked voice, which seems to have been made more cracked still in an effort to imitate the speaker's sore throat in *From an abandoned work*, which is born of 'too much talking'.[91]

Hard to speak and hard to listen to, Magee's voice epitomised the problems of radio performance and radio listening. Unlike the narrator of *From an abandoned work*, whose monologue trips over itself with his insistence to tell his story, Krapp appears comfortable with silence. The first productions of the play made much of the silent opening scene, which Beckett initially wanted to be played clownishly.[92] Lingering over eating his bananas and slipping on the skins, Krapp is silent for a large portion of the play's opening, and when he does finally begin to speak, it is to hunt down a particular tape from his extensive archive of audio recordings.

Krapp is preoccupied and consumed with listening, but it is the media that he uses to listen, and the way that this media is used that is just as important. Krapp is the editor of his past, ordering and re-ordering experience every time he comes to revisit it. Listening to the tape, which he has painstakingly selected, Krapp listens to a version of his past self, which in turn, recounts another past self. The tape says, '[j]ust been listening to an old year, passages at random. I did not check in the book, but it must be at least ten or twelve years ago.'[93] We can infer, then, that the Krapp we hear on tape is describing another recording from almost thirty years prior. Krapp's choice to listen to 'passages at random' seems at odds with the careful selection he makes at the beginning of the play. The way that he chooses to listen has changed as the years pass — it is now more directed and more particular — as the content and choice of what to listen to has

[90] Craig et al., p. 115.
[91] Fifield, ''Switching on and off': Beckett's Prose on the Radio'.
[92] *The Faber Companion to Samuel Beckett*, ed. by Ackerley and Gontarski, p. 100.
[93] Beckett, *Complete Dramatic Works*, p. 218.

increased. Krapp's choice of tape is also significant, as it is through this recording that he is able to revisit multiple time periods, playing out recollections, which have been piled onto previous recollections. Using magnetic tape as his form of recording, however, contradictorily challenges Krapp's ability to easily revisit the past. As Connor writes:

> The tape instantiates and occupies a space that does not so easily surrender or reduce to visuality. It is a soft, semi-imaginary space. The obvious disadvantage of tape […] is that it locks one into the continuum of recorded sounds, making it hard to get from one part to another except by going through the sequence once again, like someone trying to remember a line from the middle of a song. But this disadvantage is in fact a hidden opportunity; for the plasticity and mutability of tape means that it allows one to rework, to work against or work across its given conditions, to overcome or outwit its resistances.[94]

Beckett's need to review the manuals on how to use magnetic tape and a recorder also illustrates that the apparatus is far from intuitive. Unlike the vinyl record, which Connor references, one cannot simply flip the tape reel to play the other side. Its contents are not visually inscribed, so in order to locate a particular moment on tape, the user has to negotiate the mechanics of reel and tape player.[95] It is curious that Beckett should select this recalcitrant material. Listening is not only challenging because Krapp struggles to listen to earlier versions of himself, but also because locating the right moment within a recording on magnetic tape is materially challenging.

In the opening of this chapter, I argued that Beckett's works for radio — which made the radio (already strange), stranger still — used the medium to alert its listeners to the practice of radio listening through listening itself. Here, I argue that Beckett's use of magnetic tape functions in the same way. *Krapp's Last Tape* is set on a '*late evening in the future*.'[96] Beckett's choice to locate his play in the future is governed by the need for the magnetic tape recorder to be a well-established technology that Krapp has used over the many years that he has recorded himself. We can assume, then, that the medium and its technique were potentially unfamiliar to the audience, or at least that the intricacies of the apparatus may not have been widely understood. Moreover, as Connor suggests, the tape recorder might now appear similarly strange and even unrecognisable to a contemporary audience, 'so abrupt has the eclipse of tape been, and so imminent

[94] Connor, *Beckett, Modernism and the Material Imagination*, p. 87.
[95] Ibid., p. 86.
[96] Beckett, *Complete Dramatic Works*, p. 215.

does its absolute extinction appear to be.'[97] Furthermore, the way magnetic tape operates, and how information is accessed from it, is not all that clear. As a means of narrative construction, then, the tape recorder and its magnetic tape, offers Krapp a way to inscribe and overwrite his story, making it a consistent challenge to revisit this recording.

Listening to the tape recorder is thus a matter of restructuring the process of listening to the past and I want to explore how these recordings are listened to. The way that Krapp listens to the tape, I argue, illuminates the problems associated with listening over an extended period of time and the effects of chronic listening on speaker and listener alike. Connor writes, '[t]ape embodied not just the stopping of time, but the spreading and thickening of the present moment.'[98] The material qualities of sound are thus amplified through recorded and editable sound, as through tape Krapp is not only able to capture narratives, but also to reorder them and impose retrospective meaning onto what has been taped. Moreover, he can also exclude elements of narrative that he does not wish to hear, as he does throughout the play, by fast-forwarding and rewinding the tape repeatedly. The 'plasticity' of tape means that listening can be altered and structured according to the listener's preference.[99]

Within clinical medicine, practitioners have aimed to categorise modes of listening as a way of structuring patient consultations. It seems that even those clinicians who are concerned with the problems of listening within the clinic, still lean toward a description of listening that is as much about what one should not listen to, as it is about listening to the patient. Practitioner Simon Cocksedge writes that listening is a matter of choice and choices are made concerning when and how to listen within a clinical encounter. In his book *Listening as Work in Primary Care* he unsettlingly titles one of his chapters, 'Choosing not to listen'.[100] How might we read this choice and what are the justifications for making it? Furthermore, why is listening seen as 'work' in the way that Cocksedge's title suggests?

As I argued in the first section of this chapter, choosing to listen and choosing not to listen to the radio may be largely governed by how engaged the listener is with the radio broadcast, either because listening to the radio is a conscious decision, or because a particularly compelling programme catches the listener's attention. For Krapp, the choice to listen is actively made, and what to listen to is specifically selected. Unlike the

[97] Connor, *Beckett, Modernism and the Material Imagination*, p. 84.
[98] Ibid., p. 89.
[99] Ibid., p. 87.
[100] Simon Cocksedge, *Listening as Work in Primary Care* (Oxford: Radcliffe Publishing Ltd, 2005), p. 29.

radio, Krapp's listening is not a chance encounter and, given that he listens to a recording, it can be repeated and operated by the listener. In the opening lines of the play, Krapp searches for a tape: 'Box … three … spool … five […] Spool! […] Spooool!'[101] Unlike the radio listener who has no control over what is played on the radio, Krapp curates his listening by selecting a specific spool, located in a specific box. Eventually he finds the box and spool in question amongst a collection of many others, and this recording opens the play onto a series of recollections that portray listening as an active and material process. Krapp's use of listening and recording technology draws our attention to the modes in which we listen to recorded sound. Krapp's character is made manifest through the tapes he listens to. Moreover, the repeated images and recollections narrated in Krapp's tapes illustrate those persisting and insistent memories that Krapp is unable (or unwilling) to forget.

Just like the clinician, Krapp makes the choice between listening and not listening — perhaps more so than the clinician in that he has the ability to bypass certain narratives completely — moving his tape forward without having to encounter certain elements of the story. Krapp's tapes chronicle his life over many years and offers insight into how Krapp responds to the younger self that he listens to on tape. Reproaching his younger self for his naiveté and ignorance, he says: '[j]ust been listening to that stupid bastard I took myself for thirty years ago, hard to believe I was ever that bad.'[102] Krapp spends much of his time listening and reflecting upon the time that has elapsed between each of his recordings and instances of listening. The chronicity of his listening, that is to say, the temporal and durational nature of listening, remains central to the play. Listening takes time, takes place over time, while also spanning across multiple temporalities. Connor writes that when the idea for the play first came to Beckett, he had intended to have 'Krapp simply listening to a series of separate instalments from different moments of his life.'[103] I shall return to this note from Connor, as I think Beckett's choice to incorporate live speaking as well as listening into the play is an important one, particularly in light of the relationship that is staged between the speaking and listening Krapp. At this point, however, I read Beckett's initial focus on chronic listening as one that would help Beckett to stage the choice to listen or not listen through a device intended specifically for the purpose of listening. Listening across time, alerts us all the more, to the time devoted to listening within the play.

[101] Beckett, *Complete Dramatic Works*, p. 217.
[102] Ibid., p. 222.
[103] Connor, *Beckett, Modernism and the Material Imagination*, p. 90.

Time remains the primary concern and determiner of whether or not to listen within the clinic. Cocksedge quotes one of his colleagues, who stated in an interview that: '[l]istening consultations tend to be long.'[104] Aside from the obvious question of what a non-listening consultation might actually look like, what is most surprising about this claim is the clinician's acknowledgement that in order to save time, one can forgo listening. Time constraints undoubtedly mean that the patient lacks the time to give a full account of her experiences in a single sitting. It seems shocking, however, that the patient should be ignored while disclosing information about her experience or symptoms. Cocksedge seems to suggest that clinicians should close down conversations, as opposed to ignoring ones that are already underway. At the beginning of the consultation, he writes, '[o]nce it is identified that listening is needed, a choice has to be made (to 'pick up or ignore') which is central to the listening work of the GP'.[105]

In contrast, the psychoanalytic method relies upon listening in all manner of ways in order to work effectively. Psychoanalyst Patrick Casement describes his mode of listening as 'unfocused listening.' While this might suggest listening that does not fully attend to what is being said, in fact, Casement writes:

> I regard [unfocused listening] as the first step beyond that of the familiar 'evenly suspended attention', with which analysts are encouraged to listen to the over-all drift of a patient's communications. When I think I am beginning to understand what is being communicated in a session, I find that it helps me to avoid pre-conceived ideas about this if I first abstract the recognizable themes from what a patient is saying, and hold these provisionally away from the overt context.[106]

Based on a Winnicottian approach, which incorporates the notion of play into analysis, Casement emphasises that the 'therapist can share in the patient's creativity' through play, and thus navigate the line between understanding 'the nature of the unconscious and the pitfalls of premature assumption.'[107] Psychoanalysis, then, crucially remains wary of making assumptions about the patient through foreclosed modes of listening.

The interaction between analyst and analysand, like that of clinician and patient, is an interpersonal exchange. The analyst and/or clinician appears as a blank canvas on which the analysand/patient can project her narrative, having it reflected back in hopefully productive and restorative ways. As Cocksedge's work highlights, however,

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[104] Cocksedge, *Listening as Work in Primary Care*, p. 33.
[105] Ibid., p. 29.
[106] Patrick Casement, *On Learning from the Patient* (London: Routledge, Taylor & Francis Group, 2014), p. 33.
[107] Ibid., p. 31.

the clinician has a subjectivity of her own.[108] This relationship is not a simple one. Bion writes that the analyst must contain those aspects of personality and narrative put forward by the patient and is responsible for holding the patient's 'projective identifications'.[109] Adopting the Kleinian term 'reverie', Bion likens reverie to a process of containment. *The New Dictionary of Kleinian Thought* describes the process as follows:

> [A] state of mind that the infant requires of the mother. Mother's mind needs to be in a state of calm receptiveness to take in the infant's own feelings and give them meaning […] The idea is that the infant will, through projective identification, insert into the mother's mind a state of anxiety and terror which he is unable to make sense of and which is felt to be intolerable (especially the fear of death). Mother's reverie is a process of making some sense of it for the infant.[110]

The means by which anxiety is quelled, then, relies upon taking in the infant's projected anxiety, giving it meaning and thus nullifying its impact on the child. This anxiety is not conscious. Bion writes:

> A well-balanced mother can accept these [infant's anxieties] and respond therapeutically: that is to say in a manner that makes the infant feel it is receiving its frightened personality back again but in a form that it can tolerate — the fears are manageable by the infant personality.[111]

Bion writes that when working with adult patients, the analyst has a responsibility to be aware of that which the patient cannot comprehend, and is not conscious of: '[a]s the analyst treating an adult patient I can be conscious of something which the patient is not conscious.'[112] Bion's definition of being conscious is aligned with the Freudian notion of consciousness as a 'sense-organ for the perception of psychic qualities'.[113] It is significant that consciousness is defined by its embodied qualities. Rather than being intangible, consciousness takes on a bodily form: it is an organ with a capacity for sense. Consciousness might thus be conceived of as an ear, even a sense of touch. It is through psychoanalytic listening that the analyst comes to hear what the patient cannot hear for herself. Consciousness' sensory nature suggests that it has an interpersonal

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[108] Josie Billington writes that in Balint Groups, clinician's were 'encouraged from the beginning to include as full an account as possible of their emotional responses to the patient and the patient's problems' (2016, 53). Balint Groups, like Tim O'Dowd's, lunchtime sessions at his practice appear then to offer a space in which clinician's might be able to share their concerns and emotional responses so as to deliver better care to their patient.
[109] Wilfred R. Bion, *Learning From Experience* (London: Psychoanalytic Electronic Publishing, 1962), p. 21.
[110] Elizabeth Bott Spillius et al., *The New Dictionary of Kleinian Thought* (Hove: Routledge, 2011), p. 475-6.
[111] Wilfred R. Bion, *Second Thoughts : Selected Papers on Psychoanalysis* (London: Karnac Books Ltd., 1984), pp. 114-15.
[112] Bion, *Learning From Experience*, p. 34.
[113] Bion, *Second Thoughts*, p. 115.

quality, which relies upon an 'other' in order to be sensed. In *Krapp's Last Tape* listening is most certainly chronic and the 'other' that is sensed by Krapp is a recorded version of himself from the past. So while the analyst's ability to perceive psychic qualities suggests that being conscious means being able to reach inside to hear, feel, and see the subject, so as to get at (and into) the patient's anxieties, for Krapp this is a fragmented exchange, albeit a chronic one, in which the listener can perceive a subject, but he cannot engage with him.

The analyst hears differently from the clinician. Listening through the narrative the analyst hears, and containing it within a separate site inside her, she subsequently reintrojects the 'corrected' or altered anxieties back into the patient. Containment proves a productive method of interaction between patient and analyst, not only in a therapeutic sense for the patient, but also as a way for the analyst to deliver care, while remaining suitably separate from the patient. This is an emulation of the relationship between mother and baby through the breast, and yet it remains more distinct and separate than that. The anxiety flowing between analyst and analysand exists primarily in language, not through bodily matter. Furthermore, the analyst remains protected from taking on a patient's anxiety to the extent that it becomes her own.

This dynamic in the psychoanalytical relationship has been co-opted by some clinicians as a means of aiding clinical communication. Balint discusses the use of psychotherapeutic methods in general practice, exploring their dichotomously productive and troublesome effects. This psychotherapeutic approach should be adopted so as to improve the care of the patient, but it also carries with it the danger that the clinician may overwrite or undercut the experiences of the patient by attributing symptoms to psychological distress (thus ignoring important physiological symptoms). In one of his clinical case studies Balint writes:

> We must realize that *the patient's 'functional' illness is not the problem, and* a fortiori *not a psychological problem either*. A 'functional' illness means that the patient has had a problem which he tried to solve with an illness. The illness enabled him to complain, whereas he was unable to complain about his original problem [italics in original].[114]

Balint posits that the reasons for this might be associated with shame, embarrassment, fear, or a difficulty in expressing something so unpleasant. These patients need time. Balint suggests that general practice offers the time required to explore such conditions.

[114] Balint, p. 273.

This is a long way from Cocksedge's concerns about time and chronic consultation. Balint goes on:

> He [the GP] will have a much wider range of possible relationships with his patient than is available in any of the other branches of medicine […] he need never be in a hurry. This does not mean free licence for procrastination, but it means that he need never be pressed for time; if the patient's resistances are too great, there is no need for him to accept the battle there and then; the patient will come back.[115]

Balint, thus, looks forward to the patient's return to the clinic. There is more work to be done, and instead of the sense of getting nowhere — that the clinicians in Cocksedge's groups articulate — here, there is always something to look towards. There is always some other work to be done.

The process of listening in the clinic calls us toward an action. What is happening now, and what must happen next, are the central questions and necessary outcomes of a clinical encounter. Both find themselves comfortingly realised in a diagnosis, and the narrative structure of such a consultation is, according to Balint, reassuring, as it confirms the expectations of the clinical interview. He writes, 'diagnosis has as reassuring an effect on the doctor as on his patient. The present attitude in medicine is that treatment should not be started before having arrived at a diagnosis.'[116] The point at which the diagnosis is arrived at may take some time to reach, but it is at this point that a result of some kind and a decision about the progression of the clinician and patient's relationship is understood more clearly. Yet the clinical encounter does not begin and end with the diagnosis. Rather, the diagnosis sits within a continuum of encounters with specialists, carers, family members and one's own changing relationship to her body in illness.

As the opening of this chapter demonstrated, a treatment plan may be determined prior to the diagnosis, as the clinician might predict the patient's course of treatment before a diagnosis has been confirmed. The chronology of a single (or series of) clinical encounters cannot be assumed to fit a linear narrative, and instead action — or the suggestion of action — takes place within the various folds of an encounter and subsequent consultations, meaning that the narrative structure of the clinical encounter is already out of kilter before a diagnosis has been found. Balint writes that, similar to their search for a diagnosis, both patients and clinicians seek the comfort of a name for a collection of symptoms, but the name is also only one instance within the narrative.

[115] Balint, pp. 274-75.
[116] Balint, p. 41.

While naming a condition might influence the course of action taken and the type of care delivered, it does not — as might be assumed — end encounters within clinical spaces.[117] Moreover, a diagnosis does not remain static. Even for those patients who experience long-term chronic conditions, changes can be identified, and the ways in which the clinic impacts on the patient is still subject to change. In the case of chronic patients, this change may not be felt as subsequent positive developments in their conditions, but rather a series of frustrations. Patients might feel anger at what feels like worsening symptoms, or indeed confusion as to how to reconcile their view of their bodies now in the midst of illness. The subject's relationship with the chronicity of her illness is cultivated through the process of listening. Listening to chronic illness, however, might prove to be just as challenging as one's attempts to narrate it. While the patient attempts to find a language and method for telling her story, the clinician-as-listener faces similar challenges in processing the narrative that she hears (or does not hear). Listening is burdensome and is most distressing due to its chronicity. In *Krapp's Last Tape,* Krapp bears the burden of listening to himself — which he is compelled to do — but the act of listening leaves him simultaneously frustrated, nostalgic and consumed by self-loathing.

In *Krapp's Last Tape*, listening listens in on itself. Krapp is both speaker and listener, staging the difficulties of speaking and listening alike, but despite this, Krapp is still persistent in his attempts to listen. Connor notes that the play ends with Krapp 'sitting to silence, and the audience listening to the empty tape running on — until presumably, it runs off its reel, cutting through the thread of continuity, and the liberated spool starts its blind, fluttering freewheel.'[118] The recording device has remained central to the play and has enabled listening (Krapp's own listening and the audience's, too) to take place. The play ends with the audience listening to a technology in operation and an absence of narrative. The fact that the tape has 'run off its wheel' means there is no more listening to be done (or at least this portion of listening has ended). The content of the tapes — which has been the focus of the audience and Krapp's listening — is now missing and yet the technology itself continues to make a sound. The play ends with the stage directions: 'KRAPP *motionless staring before him. The tape runs on in silence*.'[119] Krapp cannot stop listening, even when there is seemingly nothing to listen to, but this is not an illuminative or therapeutic listening. In Bionian terms Krapp may indeed appear to be conscious of that which his past

[117] Balint, p. 41.
[118] Connor, *Beckett, Modernism and the Material Imagination*, p. 101.
[119] Beckett, *Complete Dramatic Works*, p. 223.

(recorded) self is not, and his dialogue with the recorded tape suggests that Krapp can acknowledge both the anxieties and the naiveté of his past self. Yet unlike the psychoanalytic encounter that Bion describes, Krapp is unable to contain these anxieties or indeed provide a more tolerable version of them for both his present self and the recorded version of himself from the past. What is being listened to is absorbing and all encompassing for Krapp but it is equally infuriating, primarily because he cannot fully be in dialogue with a version of himself that is temporally fragmented.

As the tape that Krapp listens to concludes, the Krapp on tape makes reference to the tape's location within his archive: 'Box – [*Pause*.] – three, spool – [*Pause*.] – five.'[120] Returning again and again, both to his recordings and his recollections within those recordings, Krapp becomes increasingly stuck and fragmented in multiple temporalities. There are three narratives taking place in a single instance. The first is his present act of listening, the second his previous instance of recording and finally, the narrative that he recollects in the recording itself. It is significant that Krapp selects particular parts of his history to listen to. His obsession with archiving his recordings and categorising them narrows his opportunity to listen to them, while at the same time enabling him to access those recordings with greater ease. The taxonomy of Krapp's archive remains relatively unclear. A simple numbering system helps him to identify the recording in line with his ledger, which he consults after he has selected his chosen spool. Moreover, the synopsis of the tape written in the ledger, only confuses Krapp's recollection of his recordings: 'Equinox, memorable equinox. [*He raises his head, stares blankly front. Puzzled.*] Memorable equinox? … [*Pause. He shrugs his shoulders, peers again at ledger, reads.*]'[121] It would appear that despite having documented each of his recordings in his ledger, Krapp is still confused by what he hears. The chronicity of his storytelling and his overlaying of recollections within the numerous recordings leaves Krapp disorientated and frustrated by his own story. Throughout the play, Krapp revisits a particular recollection: 'I lay down across her with my face in her breasts and my hand on her. We lay there without moving. But under us all moved, and moved us, gently, up and down, and from side to side.'[122] Within this recollection, which Krapp returns to almost three times, (at one point, on its second playing the tape is interrupted, the third comes at the end of the play), Krapp and his lover act and are acted upon. As they lie in their boat they move and all moves them, but their movement does not seem to get them anywhere. 'Up and down, and from side

[120] Beckett, *Complete Dramatic Works*, p. 223.
[121] Beckett, *Complete Dramatic Works*, p. 217.
[122] Beckett, *Complete Dramatic Works*, p. 223.

to side', they are perpetually in motion, but never progress.[123] What moves beneath them and what moves them is out of their control. It is significant that Krapp returns to this particular image. Beckett's use of repetition across his oeuvre often depicts bodies that are in limbo: stationary but unsteady, and always insistent despite their weakened states. Revolving this moment again and again, Krapp tortures his listening self. Getting nowhere but forced to listen all the same.

In clinical contexts, the patient who continues to return to the clinician with persistent complaints has been referred to as the 'heartsink' patient. In his 1988 paper, Tim O'Dowd claims the majority of clinicians in primary healthcare have encountered 'heartsink' patients who 'evoke an overwhelming mixture of exasperation, defeat, and sometimes plain dislike that causes the [clinician's] heart to sink when they consult.'[124] Indeed, even if the management of 'heartsink' patients' conditions change, the 'heartsink' patient engenders a frustrating stasis during her interactions with the clinician. Defining the 'heartsink' patient, O'Dowd writes, is challenging due to the heterogeneous reasons that cause a doctor's heart to sink. 'Doctor's hearts', he writes 'do not sink for the same reasons'.[125] In this account, O'Dowd emphasises the diversity of clinicians and not their patients, homogenising the patient population to suggest that there is a single motivation for patients, contrary to the myriad objectives of the clinical community. This is clearly an oversimplification, and the destructive and damaging power of this term should not be overlooked. It is important to note, however, that patients are categorized within the clinic, not only according to their pathological diagnosis, but also according to the effect that they have on their clinicians. Commenting on O'Dowd's paper, the general practitioner Andrew Moscrop sees this categorisation another form of diagnosis, which in fact lays blame on the patient, and not on the clinician who experiences the symptom. He writes, 'it is the doctor's heart that sinks, but it is the patient who receives the label.'[126]

I argue that by labelling subjects as 'heartsink' patients, clinicians run the risk of foreclosing listening within the clinical encounter to the detriment of the on-going care delivered to patients. In O'Dowd's study, he identified:

> [A] group of patients who were causing stress to the practice. These patients seemed to be dissatisfied with the services provided, placed

[123] Beckett, *Complete Dramatic Works*, p. 223.
[124] Tim O'Dowd, 'Practice Observed: Five years of heartsink patients in general practice', *British Medical Journal*, 297 (1988), 528-30 (p. 528).
[125] O'Dowd, p. 528.
[126] Andrew Moscrop, ''Heartsink' Patients in General Practice: A Defining Paper, Its Impact, and Psychodynamic Potential', *British Journal of General Practice*, 61.586 (2011), 346–48 (p. 346).

> many demands on the practice, and were often frequent attenders with seemingly endless complaints. This group of patients caused a feeling of 'heartsink'.[127]

According to O'Dowd, these patients have a broader impact than simply affecting the immediate clinical encounter, as they begin to alter the stress levels of an entire practice. The frequency with which such patients attend the clinic is also deemed to be problematic, and while reducing the frequency of their visits is not O'Dowd's primary aim (he claims), it would appear that by implementing a series of lunchtime meetings between various healthcare professionals within the practice, the eventual consultation rates were reduced.[128] The purpose of these meetings was to offer a space in which to:

> [S]hare information, define apparent problems, formulate a plan of management, and provide support for the professional who was to deal most with a particular patient. The management plan was then entered in each patient's notes. In addition, at each meeting follow up information was presented on cases already discussed.[129]

These groups, like those initiated by Balint in the late 1950s, gathered together GPs to share information and reflect upon their encounters with patients.[130] Beyond the initial encounter between doctor and patient, this wider group would play an important role in the subsequent care and management of the patient and her condition (despite never being seen by the patient). Listening is vital, not simply within an encounter between clinician and patient, but also in group discussions between clinicians. Clinicians listening to one another recount their patients' stories, which they have at one time or another listened to. These collectives function as a reflective and potentially therapeutic space for clinicians, outside of their relationships with their patients.

Balint adopts psychoanalytical methods both in his treatment of his patients as well as his engagements with colleagues. However, while aspects of psychoanalysis prove productive for Balint in primary care work, he emphasises the importance of remaining mindful that, '*he* [the doctor] *is a family doctor and not an amateur psychiatrist* [italics in original].'[131] The consultation must strike a balance between 'keeping pace with the patient', but also never hurrying the patient.[132] All clinical work in this regard 'needs

[127] O'Dowd, p. 528.
[128] Ibid., p. 529.
[129] Ibid., p. 528.
[130] Josie Billington, *Is Literature Healthy?* (Oxford: Oxford University Press, 2016), p. 52.
[131] Balint, p. 275.
[132] Ibid.

tact, patience, and time.'[133] Time remains a critical factor in the delivery and reception of care and, it could be argued, the medic's 'heartsink' might in fact be a result of increasing time pressures and patient turnover imposed on her by the practice and resource limitations that the health service faces. Furthermore, the lack of time available to listen to one another as fellow professionals may also affect the clinician's ability to listen to her patients effectively.

In an attempt to 'leave 'heartsink' behind' Cocksedge explores alternative phrases that arose within sessions with his trainee doctors. While many of his GP registrars were quick to disregard the term 'heartsink' for fear of its 'derogatory and demeaning' associations, other terms arose: ''troublesome', 'chronic', 'not getting anywhere', and 'challenging' cropped up'.[134] These alternatives, however, still run the risk of negatively impacting upon future consultations between the clinician and her patient as these labels persist. Moreover, the substitutes offered by Cocksedge fail to include any reference to the clinician, while the 'troublesome' patient conjures images of a wilfully difficult subject. At least with 'heartsink' the affective and emotional qualities of the encounter are implied. Regardless of this, each term appears problematic precisely because the judgement is recorded.

What makes clinical encounters with these patients so challenging is their chronicity, as 'heartsink' patients consume and occupy extended periods of a clinician's time. Long-term relationships between patients and their doctors often lead to doctors feeling as though they are 'on a treadmill, heavily leant on by their patients and unable to make progress. There is a general resignation to the responsibilities and burdens of such patients,' who refuse to, or are unable to recover from their symptoms.[135] The clinician's feelings should not be denied, but it seems that clinicians assume that patients are content to maintain these repetitive and unproductive relationships. Yet, as I have argued in previous chapters, the weight of chronic illness is felt just as keenly by the patient, who is often similarly aware of, and frustrated by, her inability to recover. Failure to recover, however, should not just be seen as the patient's condition remaining static and unchanged. Chronic illness contains ever-changing threads of experience, which can fade and re-emerge over the life of the ill patient.

Returning to Charon's first consultation with a new patient, Charon writes, the consultation marks the beginning of a relationship that will extend over a number of years. She asks herself:

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[133] Balint, p. 276.
[134] Simon Cocksedge, 'Let's Leave 'Heartsink' Behind', *BMJ*, 351 (2015) (para. 5).
[135] Cocksedge, *Listening as Work in Primary Care*, p. 55.

> What will my [patient] and I do together? My pact is that I will husband his health while I offer an absorptive space and reflective surface to try to *represent* him for his view […] What we generate together in our relation is something of substance, a 'special trophy,' an 'absolute possession' for both of us that matters, that counts, that contributes to his health and well-being and, as a dividend, to mine [italics in original].[136]

Within the consultation, Charon adopts the role of safe-guarder and mirror to her patient's health. Showing the patient a version of himself, 'for his view', establishes a relationship between the two, akin to that of the analyst and analysand. The doctor's and patient's co-produced narrative is generated, exchanged and held between them and 'functions as a playground, a Winnicottian transitional object, allowing True Self to emerge from False Self and enabling the teller to navigate the shoals between self and non-self.'[137] It is important to note the tangible form that these communications take on through both narration and listening, creating 'something of substance' through their relationship with one another. Charon goes on in her essay to explore the function of clinical narrative writing as a means by which to develop this relationship further. She writes:

> Whether as a transitional object or through another mechanism, we find that narrative writing enables health professionals and patients to join together collaboratively, to build community, to enter affiliation with one another toward the work of healing.[138]

Charon suggests clinical writing might function as way of navigating the clinical relationship. This proves just as productive for the clinician as it does for the patient, namely because the writing offers a space for the clinician to reflect on encounters and thus deliver a better quality of care. This approach is similar to the ones adopted by Balint, Cocksedge and O'Dowd. Here, however, the emphasis is on written narratives. Writing creates a tangible space in which to hold interactions and reflections, in similar terms to Bion's notion of containment. In addition to clinical writing and reflective work, however, the clinician might also be considered a transitional object for the patient. Casement writes that:

> As far as possible, the therapist's presence therefore has to remain a transitional or potential presence (like that of a mother who is non-

[136] Charon, 'Where Does Narrative Medicine Come From?', in *Psychoanalysis and Narrative Medicine*, ed. by Rudnytsky and Charon, pp. 23-36 (p. 35).
[137] Ibid., p. 26.
[138] Charon, 'Where Does Narrative Medicine Come From?', in *Psychoanalysis and Narrative Medicine*, ed. by Rudnytsky and Charon, pp. 23-36 (p. 26).

> intrusively present with her playing child). The therapist can then be invoked by the patient as a presence, or can be used by the patient as representing an absence.[139]

In psychotherapeutic terms, the embodied presence of the therapist is vital to the success of the encounter. She is both productively present and absent: at hand and distant at the same time. In *Krapp's Last Tape*, the tape recorder fulfils a similar function as a transitional object which forces upon its listener (and its recorder, too) the opportunity to reflect. But the ability to reflect seems to be inhibited by the fact that the device — as a transitional object — cannot reflect in and of itself and the only reflection possible must come from the body on stage. What is the purpose of these audio recordings? Are they merely aural diary entries, or is Krapp attempting to use these recordings as a form of therapy? It would seem that Krapp's interpretation of what has been recorded represents the therapeutic dimension of this encounter, but he is unable to correct or contain these narratives and so they do not fulfil their therapeutic intention. The tape recorder plays the sounds of bodies, at the same time as alerting the listener to the absence of those bodies, but unlike the radio, the audience does see a body on stage.

Kassabian writes that, 'the development of recording technologies in the twentieth century disarticulated performance space and listening space'.[140] This has enabled what she describes as 'ubiquitous listening' and, more specifically for her thesis, 'ubiquitous musics.' She writes that these ubiquitous musics saturate our everyday life and:

> [F]ill our days, are listened to without the kind of primary *attention* assumed by most scholarship to date. That *listening*, and more generally input of the *senses*, however, still produces *affective* responses, bodily events that ultimately lead in part to what we call emotion [italics in original].[141]

By dislocating performance space from listening space, listening is both ubiquitous and embodied. In *Krapp's Last Tape* the recording device forms a bridge between these two seemingly disparate locations. Listening is everywhere, but it is also concretely manifested in the device. Beckett collapses performance and listening spaces (as well as recording spaces). Despite spanning several decades, the narratives the audience (and Krapp) hears are contracted and constructed into a new unified encounter and presenting Krapp's body on stage is vital to achieving this. As Connor claims, the play was initially intended to stage a series of listening encounters in which Krapp would

[139] Casement, p. 25.
[140] Kassabian, p. 10.
[141] Ibid., p. xi.

remain wholly silent on stage.[142] Beckett's decision to stage a conversation (however fragmented) between tape recorder and Krapp makes the disarticulation between speaker and listener all the more stark. Furthermore, the audience is able to better understand how the present Krapp (on stage) listens. The disjointed and contradictory dialogue generated between the machine and the man on stage, highlights to the audience the difficulties in listening over time and dramatizes a problematic interaction between speaker and listener, which we have seen in so many instances within the clinical encounter.

I have spoken about the disjuncture between doctor and patient expectations within the clinical encounter. I now want to consider how the individual may face similar challenges when listening to herself over an extended period of time, during which, her own expectations and agendas may have changed. This is a matter of (self-)reflexivity for both the patient and the clinician. In *Krapp's Last Tape*, the listener and speaker are one and the same person who has been separated by temporal gaps. While I have argued that there is a challenge within the clinical encounter associated with narratives — which are frozen in time through clinical documentation and patient notes — it seems that Krapp's recordings suffer from the same anachronism, as he replays and listens to them. Moreover, the depiction of listening throughout *Krapp's Last Tape* is inherently chronic, not only because the listening takes time, but also because the in order to listen to these narratives a significant amount of time needs to have elapsed. Krapp is moved towards anger, frustration, nostalgia and seemingly heartache, and his present day recordings both disregard and incorporate what he has listened to. In this sense, Krapp's recorded self becomes the 'heartsink' narrator to his present self, and his listening reconstructs the narratives and experiences of the Krapp that the audience can only hear. By placing the past Krapp on stage — in the form of a tape recorder — the voice the present Krapp listens to is all the more dislocated from his present self, as the tape recorder comes to represent a separate body. Just as we saw with the radio device, the tape recorder/player is a signifier for listening and this relationship is further complicated by the tape recorder's ability to take in sound as well as emit it. The tape recorder is able to capture the present, while also being able to emit the past. Like the clinician, the tape recorder stores information, which can then be processed and revisited. The tape recorder documents audio narratives, as opposed to written ones, which means that unlike the clinician's notes, what is recorded is not subject to the same level of mediation or interpretation when it is produced. However, this narrative is

[142] Connor, *Beckett, Modernism and the Material Imagination*, p. 90.

similar to written notes, as the way in which it subsequently received appears to alter dramatically with each re-playing. Krapp's recorded interpretations of previous tapes complicate this auditory loop. Present Krapp is both the patient who reacts unfavourably to the information that has previously been recorded, and also the clinician, unwilling to listen to the narratives of a chronic and insistent patient. Listening in on listening and speaking over speech, his tape recorder represents a technologically embodied Krapp who is in fact his own 'heartsink' patient.[143]

For Krapp, however, this does not stop him from listening. Throughout the play, he 'assumes [a] listening posture as he leans towards the tape recorder, cupping his ear as though he were trying to bring the sound closer to him.[144] The chronic nature of Krapp's narrative makes the process of listening to it challenging. Listening is necessary and compulsive, even if it proves unproductive. Indeed his own narrative causes Krapp's heart to sink and yet despite this he is compelled to do so. Listening is uncomfortable precisely because there is no end to listening.

The play ends with Krapp listening as the 'tape runs on in silence', but the audience can infer that the playing of a new tape might shortly interrupt this silence. This is not to say that the sinking of Krapp's heart will be appeased, but instead may give rise to further difficulties, as he forces himself to listen to a failing narrative yet again.

*

This chapter has explored the body that is listened to, and the body that listens. While listening may be thought of as an invisible process, it is through Beckett's works for radio and his use of recording media on stage that I hear (and see) a visualised listening practise that is made tangible through the technology required to make listening possible. In *All That Fall* the body becomes more than a voice; embodied sounds leak out of it, just as sounds invade it. Beckett's work written specifically for the radio pays close attention to the strangeness of the radio form and radio listening. By forcing the listener to listen to a body in pain, the listener herself is made culpable through her listening. We may not be asked to act on the suffering that we hear, but, as we are

[143] It is important to note that while Krapp's narrative reflects on his passing years and inevitable aging, Krapp is not a patient, nor does he appear to exhibit any pathological symptoms in the same ways as some of Beckett's other characters. Krapp is not ailing like the other characters explored throughout this thesis (though his alcoholism is evident). In this chapter, I read Krapp's characterisation as analogous to both doctor and patient roles and the relationship between the two. *Krapp's Last Tape* can be read as a staging of the difficulties of listening within the clinical encounter (and primary healthcare in particular). The chronicity of Krapp's tape recordings also offers an analogous portrayal of long-term care, which is not always concerned with the pathological.
[144] Beckett, *Complete Dramatic Works*, p. 217.

presented with access to what I have described as a privileged materiality, the listener becomes acutely aware that Maddy in particular is a body before she is a voice.

Listening is always difficult, even when we are required to listen to ourselves. Krapp's recording on his thirty-ninth birthday begins with his confident assertion that he is 'sound as a bell', but is soon followed by the somewhat foreboding comment, 'intellectually I have now every reason to suspect at the […] crest of a wave.' When the audience meets Krapp he finds himself on the other side of the wave. He is left with only the recollections and recordings of a past self, which he cannot help listening to despite the unease and anger it brings him. Krapp is compelled to make his own heart sink, and like the clinician whose patient continues to demand more and more attention and attending, he must soldier on, even when time is running out. There is no end in earshot.

Carel writes that the experience of illness is a 'systematic transformation of how the body experiences, responds, and performs […] The change in illness is not local but global; it is not external, but at the core of the self', as one tries to come to terms with the experience of ill-health.[145] As the patient tries to narrate her experience, there must also be someone to listen to it. This chapter has shown how sound recording and radio broadcasting constructs and unsettles listening practises which traverse the global and local dimensions of illness, and furthermore, helps the listener to pass between the external (the outside) and the core (the inside) of the body that makes a sound.

[145] Carel, *Phenomenology of Illness*, p. 65.

Chapter 4

Listening In: Samuel Beckett's Reluctant Voice-Hearers

> A lot of the work I did for Beckett from now on seemed to derive from Not I [sic] — consisting entirely of spoken thought, or of thoughts overheard — never presented in recognisable dialogue, but taking an audience into one's most private, unformed, semi-conscious, uncensored thoughts. It also seems to me that Mouth was not going out to an audience; the audience had to be sucked into this rioting, rambling hole.[1]

*

Listening in is both aural and spatial. To listen in, the listener must acknowledge the existence of an inside which can be listened-in to. By investigating this process, what is discovered on the inside can be better understood as an inner sounding out. Beckett's characters are forever listening in: listening in on themselves, like *Not I*'s Mouth and her 'buzzing' brain, or listening in to others, like Woman's Voice in *Footfalls*, who listens to May's pacing outside her door.[2] In this chapter I illustrate and challenge the increasing pathologisation of the listening experience, through a reading of Beckett's teleplay *Eh Joe*, and three of his later works for theatre *Not I*, *Footfalls* and *Ohio Impromptu*. The performative nature of both drama and medicine, indeed the theatre in both, is a space in which to consider power and its ever-shifting position from one subject, or system, to another. As this thesis has shown so far, Beckett's work can draw out the questions and challenges raised within the clinical encounter: between patients and clinicians, between medical institutions and healthcare professionals, and between voice-hearers and their voices.

In *The Birth of the Clinic*, Foucault questions at what point both seeing and saying (and therefore listening) are separated from one another, and argues for the reinstatement of the 'spatialization and verbalization of the pathological,' to achieve that 'loquacious gaze with which the doctor observes'.[3] Beckett's work stages the difficulties of the 'loquacious gaze', by articulating the patient and clinicians' troubled experiences both on stage and screen, and so captures the spatiality of listening and seeing within a clinical space. The 'loquacious gaze', in the clinical encounter, functions in the same way as Frank and Charon's shared term, 'witness'.[4] Achieving the 'loquacious gaze' enables, and is itself, a process of witnessing and recognition.

The four pieces of drama used in this chapter are examined chronologically for the purposes of clarity. In the introduction to this thesis, I argued that it was Beckett's formal concerns that guide its structure. While this remains the case, the chronology of

[1] Whitelaw, p. 118.
[2] Beckett, *Complete Dramatic Works*, p. 378.
[3] Foucault, *Birth of the Clinic*, p. xii.
[4] Frank, *Wounded Storyteller*, p. 142.

Beckett's works, and the impact of chronology upon his form warrant explication. I am not arguing for a reading of Beckett's work determined by its chronology, rather, by working in such a way, I am better placed to illustrate thematic connections between Beckett's drama and its treatment of the voice in a more coherent order. I begin with Beckett's teleplay *Eh Joe* and subsequently focus my reading on three of his later works for theatre, primarily because this period represents the distillation of Beckett's theatrical form. It has been noted by scholars that Beckett's work becomes increasingly abstracted throughout his career, concluding in the almost complete denial or disposal of the 'category of the character' on stage.[5] Following Beckett's involvement in radio drama, Marek Kedzierski writes that Beckett's stage evolved (or devolved) into a 'womb where an image born of the matrix of the mind is made visible and audible.'[6] Figures are encased in a theatrical womb in which they can listen in on the world outside. I want to use these dramatic pieces to explore the voice, which cannot be easily located precisely because it has not been audibly articulated. For the clinician attempting to understand the voice of the patient from the outside, Beckett's work offers a model for the problems and uncertainty of what we hear and see, of both the inside and the outside. As I argued in Chapter Three, listening requires an act of imagination. In this chapter, I claim that the tension between voices (both 'real' and hallucinatory) in the clinical context and the clinician's privileged position in the clinical encounter is staged through Beckett's conflicting and contradictory voice(s). Marco Bernini, one of the researchers working on the Wellcome Trust interdisciplinary project on auditory-verbal hallucinations 'Hearing the Voice' at Durham University writes that, 'the qualities of Beckett's voices (alien, autonomous, without recognisable source, and having aggressive of commanding contents) resonate with and sometimes even match the phenomenology of auditory verbal hallucinations.[7] Soothing, tormenting, insistent, these voices drag and conduct his characters through their stories. Who these stories belong to is often called into question: whether it is the unseen woman's voice overheard by Joe in *Eh Joe,* or the narrative voice read by Reader in *Ohio Impromptu*, these stories unsettle the agency of the narrator and the narrated subjects. Each play offers a slight formal variation of the one that precedes it. In *Eh Joe* a male character hears an unseen female voice. In *Not I*, a disembodied female mouth speaks to a

[5] Marek Kedzierski, 'Beckett and the (Un)Changing Image of the Mind', *Samuel Beckett Today / Aujourd'hui*, The Savage Eye / L'oeil Fauve: New Essays on Samuel Beckett's Television Plays, 4 (1995), 149–60 (p. 152).
[6] Ibid., p. 151.
[7] Marco Bernini, 'Samuel Beckett's Articulation of Unceasing Inner Speech', *Hearing The Voice*, 2014 <https://hearingthevoice.org/2014/08/21/samuel-becketts-articulation-of-unceasing-inner-speech-by-marco-bernini/> [accessed 7 September 2020].

genderless, silent figure. In *Footfalls*, a woman speaks with her unseen mother offstage. Finally, in *Ohio Impromptu*, two identical men sit together, one reading to the other. These adaptations of the voices and their listeners are where Beckett's work can be read to examine the interiority and identity of the voice through a variety of interpersonal exchanges.

This chapter is concerned with the experiences of those who hear voices, and the impact that those voices have, as well as the impact the clinic has on the subject who attempts to describe and narrate her experience, within a clinical context. Fernyhough writes: 'we are the cacophony of our mental voices. We listen to them as well as uttering them; they construct us through their incessant chatter.'[8] These voices are interior, but they also occupy a space that is separated from the subject. Sound, like all forms of communication, relies on transference from one space to another and from one subject to another. For Fernyhough, inner voices have an agency that constructs at the same time as being constructed. The passage of language through articulation evokes a porous body, whose liminality is defined by what is listened-in on, as well as that which is sounded-out. Just as Butler's language is a means by which to elicit a subject, language is also inherently 'injurious', as the power lies with that very language which is itself creating. Butler posits, 'if we are formed in language, then that formative power precedes and conditions any decision we might make about it, insulting us from the start, as it were, by its prior power.'[9] The problem of power is prevalent throughout this chapter, and so I ask of each play: who is it that is being listened to, and who or what is it that governs what is said? It is by uncovering the difficulties in asking such seemingly simple questions that we move closer toward mapping the relationships and power dynamics between language and those who use it on a medical stage: between clinicians and their patients and between the clinician and the clinic.

Beckett's work is a useful apparatus with which to examine the subjective experiences of disturbance in the clinical encounter. As I outlined in my introduction to this thesis, Heron's 'Beckett on the Wards' workshop is one such example of the practical application of Beckett's works, as a means of thinking through the issues surrounding communication within the clinic. Heron worked with healthcare professionals including doctors, psychiatrists, nurses and psychologists in hospital settings, and through the workshops introduced participants to *Not I* and explored the embodied nature of compassion. Heron and colleagues write: 'Beckett's depiction of

[8] Fernyhough, *The Voices Within*, p. 97.
[9] Judith Butler, *Excitable Speech*, p. 2.

disordered experience offered a stimulating challenge to the categories and narratives used in medicine'.[10] 'Beckett on the Wards' was based on research conducted as part of the 'Beckett and Brain Science' project, particularly the 2012 workshop at the University of Warwick. Recreating the conditions of *Not I* exposed literary and theatre scholars (in partnership with clinicians) to the performative nature of medicine, using the relationship between Mouth and Auditor as a means of exploring compassion. Compassion in this sense was drawn from its etymological root to 'suffer together'.[11] A collaborative suffering unsettles the power imbalances within the clinical consultation. This mutual embodiment troubles the notion of the self-contained and healthy body, as the body of the clinician also becomes a site for power struggles between her role as carer and mutual sufferer.

In the first section of this chapter, 'Free Agents', I read the inner voices staged in *Eh Joe* and *Not I* as independent agents, separated out from those subjects who hear and generate them. Beckett's work illustrates both the verbal and non-verbal acts of voicing. In *Not I*, the protagonist Mouth is embodied verbal production. She is quite literally a mouth that mouths with affective articulations that are felt as a 'steady stream'. With 'her lips moving! […] the cheeks … the jaws … the whole face […] the tongue in the mouth …', what becomes even more important than the words she produces is the method of production and how this is experienced, as the words are produced.[12]

Exposing the phenomenological characteristics of voice-hearing, Alderson-Day's research has shown that the experiences of voice-hearing are both verbal and non-verbal, not only heard, but also often felt, and that this experience changes over time.[13] Such a durational relationship between the subject and her voices is paralleled in the changing relationship the subject has with her body, and her perception of her life and speech, over time. Thus, while voicing may remain insistent, its embodiment alters and adopts new meanings. This change will be similarly explored through the physical manifestation of Mouth in *Not I*, both on stage and in the later television production. For Joe, voices are also distinct and insistent and by depicting the experience of voice-hearing using the televisual form, Beckett presents voices within a specific stylistic framework. Displaying characteristics associated with specific sub-types of Auditory

[10] Elizabeth Barry, 'Beckett and Brain Science', *Warwick* (n.d.) <https://warwick.ac.uk/fac/arts/english/research/currentprojects/beckettandthebrain/> [accessed 3 October 2014].
[11] Jonathan Heron et al., 'Beckett on the Wards: Medical Humanities Pedagogy and 'Compassionate Care'', *Medical Humanities*, 42.1 (2016), 63–64 (p. 63).
[12] Beckett, *Complete Dramatic Works*, p. 379.
[13] Ben Alderson-Day, 'The Silent Companions', *The Psychologist BPS* (2016), <http://thepsychologist.bps.org.uk/volume-29/april/silent-companions> [accessed 29 April 2016].

Verbal Hallucinations (AVHs), Joe and Mouth illustrate a subjective non-clinical experience of voice-hearing.

Today, the Hearing Voices Movement (HVM), which campaigns for 'expert-by-experience' based approaches to psychiatric care and therapies, adopts a similarly non-clinical view of the voice-hearer. Explored in the second section of this chapter, 'Pathologised Voices', the HVM provides an alternative approach to communicating experiences of hearing voices, which despite its opposition to traditional psychiatric practice, could be adopted within the clinical encounter, so as to improve doctor-patient communication. By acknowledging the importance of the heard voice, which cannot be ignored, the HVM offers a subject-centred support model that focuses on the individual, non-pathologised experiences of the voice-hearer.

In section three of this chapter, 'Whose Voice?', I use *Not I* to raise further questions concerning the problem of the voice and its agency, and I examine the performativity of the voice that produces language whose source can never be assumed, and creates sounds that are always elsewhere or belong to someone else. It is in these terms that I argue that voicing in *Not I* offers a model for the clinical encounter, as the patient's narrative no longer belongs to her, as it is reformed into the language of the clinic. Mouth's words may appear alien, but she is nevertheless forced to connect the sounds she produces with her ability to produce them. Moreover, that *Not I* was originally written for the stage draws attention to the performativity of speech and voicing. As Whitelaw described her own performance as Mouth, the actor had to become a conduit for the language being breathed through her.[14] Connor writes: '[i]n speaking, we listen intently to our own speaking voice, in a complicated feedback loop, or duet of utterance and response; we eavesdrop on our own speech, but do not, as it were, hear ourselves listening.'[15] Speaking is reliant upon a listener whether that listener is separate to the speaker or not. One may not hear herself listening, but nevertheless, the exchange between utterance and listening is vital in order for speaking to function. This duet is ultimately dialogic. Fernyhough has conducted research that exposes the dialogic nature of inner speech as a functional mode of voice-hearing that is necessary for successful cognitive processing. In section four, 'Self-talk', I argue that *Footfalls* performs a form of dialogic inner speech through storytelling, which brings its protagonist, May, into being. For May, who is bound in her cyclical pacing to tell and retell the story of herself, her narratives operate as a dialogic call and response. In

[14] Whitelaw., p. 120.
[15] Connor, *Dumbstruck: A Cultural History of Ventriloquism*, (Oxford: Oxford University Press, 2000), p. 8.

Frank's work on postmodern narrative reclamation, the story is seen as an emancipatory act for the patient, offering the patient greater autonomy. Frank captures not only the conflicts between those creating and abiding by medical narratives, but also the roles that both the ill subject and the clinician adopt. The reclamation of narrative is not to be mistaken for a denial of one's status as patient, rather, Frank says:

> [W]hen I am ill, I want to become a patient. It is dangerous to avoid doctors, but it is equally dangerous to allow them to hog centre stage in the drama of illness. The danger of avoiding doctors is immediate and physical, but if we allow them to dominate the drama, they will script it to include only disease.[16]

May's story, like that of the patient, is one which attempts to emancipate its teller, while crucially acknowledging the need for a context in which to tell this story and, most importantly for the purposes of this chapter, have it heard. May's storytelling and story-listening is performative. For the patient, storytelling is a necessary component of the clinical encounter, both in terms of reaching a diagnosis and as an attempt to be therapeutic.

In the final section of this chapter, 'Controlling Voices', the theatre is read as a model for clinical space in which the language available to those on stage belongs to someone else. I read the stage in *Ohio Impromptu* as a clinic that creates and governs the conditions for language and voicing. Just as the patient is required to dictate her experience in a language, which is not her own, in an unfamiliar setting, so the theatre and those involved, including the audience, are required to engage with and submit to a performative spectacle. Here it is the institution — both theatre and clinic — which come under scrutiny, to question who or what guides interactions within these systems, how they speak to each other and who listens within them.

Free Agents

Mark Hayward et al.'s research of the various approaches to understanding and treating AVHs concludes that, where 'voice-hearing results from a misattribution of inner speech, previous literature has suggested that voices are associated with unconscious subvocalisations in some patients.'[17] In both *Eh Joe* and *Not I*, the voices that are heard and felt by Joe and Voice, and Mouth and Auditor, are agentic. Voice's agency extends

[16] Frank, *Wounded Storyteller*, p. 53.
[17] Mark Hayward et al., 'What have we learnt from behavioural coping intervention for voices?', in *Psychological Approaches to Understanding and Treating Auditory Hallucinations: From Theory to Therapy*, ed. by Mark Hayward, Clara Strauss, and Simon McCarthy-Jones (Hove: Routledge, 2015), pp. 27-45 (p. 36).

beyond Joe, who hears her as both coming from the inside and the outside. Mouth similarly hears her voice as a separate presence, while simultaneously feeling it 'buzzing' inside her skull. Language and speech often seem difficult to control or contain, and so the voices heard in these plays become increasingly difficult to overpower. While the presiding theme of Beckett's late plays might be the rejection by the listener of the voices heard, there is an opportunity to equate the experience of being called to listen in, in both *Eh Joe* and *Not I*, with contemporary patient-led movements such as the HVM, which argues that voice-hearers should listen to their voices in order to determine their origins, and help manage them more effectively. In this context, then, the voice is not an enemy that must be silenced, but rather one we should listen in on. The protagonists of *Eh Joe* and *Not I* illustrate the isolation felt by many voice-hearers who are bound in a psychiatric narrative where their voices dominate and represent a more powerful 'other' that needs to be eliminated. The voice-hearer struggles with her voice which can often be threatening and persecutory. But there is also a struggle for power between the voice-hearer and her clinician as she tries to communicate the experience of the voice to one who cannot hear it and furthermore one who wishes to help put an end to it. It seems, then, that the voice needs to be understood and listened to not simply so that it can be eradicated, but rather so that what it represents can be better understood and managed for the person who hears it.

The term voice-hearer, used to define one who experiences unusual auditory phenomena, remains relatively new and is described by Woods as, 'an identity more commonly articulated and authorised *outside* and *in opposition* to psychiatry [italics in original].'[18] The term voice-hearer was coined in 1987, following the case of Patsy Hague, whose relationship with her clinician strikingly inverted 'the conventional relationship between the patient and psychiatrists […]', passing power to the voice-hearer for the first time.[19] A patient of Marius Romme's, Patsy Hague became the founder of what is now known globally as the HVM. Having read Julian Jayne's work on hearing voices, Hague argued with her psychiatrist, insisting that her voices were real and legitimate. Her retaliation against the pathologisation of voice-hearing, as purely a symptom of schizophrenia, helped to found a new approach to discussing it. Hague wanted to scrutinise the reasons for the voices she heard and examine their

[18] Angela Woods, 'The Voice-Hearer', *Journal of Mental Health*, 22.3 (2013), 263–70 (p. 265).
[19] Ibid.

content.[20] This context is important to understand, as it ultimately gave rise to a new wave of de-pathologised encounters with voice-hearers.

Throughout this chapter, both voice-hearing and AVHs are used as terms of reference. These terms are not interchangeable, but I am guided by the literature used in employing both terminologies. While voice-hearers experience AVHs, I am aware that 'hallucination' is a problematic word, as Woods writes that, 'many people who hear voices regard the term auditory hallucination as stigmatising because it implies that their experiences are not real.'[21] In the case of the voice-hearer Eleanor Longden, also cited by Woods, her recovery story involved 'a transition from 'schizophrenic' to 'voice-hearer,' from a clinical language of biological disease, deficit and dysfunction, to a 'normal' language open to the discussion of emotions, personal history and experience.'[22] It is significant that Longden and Hague wanted to recover from the pathologisation of their identity and not simply the voices themselves. Their stories of recovery were recoveries from this pathologisation, which subsequently enabled them to manage their voices more effectively. Frank writes that in seeking support from the medical community, the patient, or sufferer, enacts a '*narrative surrender* […] The ill person not only agrees to follow physical regimes that are prescribed; she also agrees, tacitly but with no less implication, to tell her story in medical terms.'[23] The HVM is precisely a rejection of such surrender and instead, it embraces a '*postmodern* experience of illness [which] begins when ill people recognize that more is involved in their experiences than the medical story can tell [italics in original].'[24] The HVM works to reclaim the voice-hearer's autonomy, and by doing so, asserts the expertise of the voice-hearer as the expert-by-experience.

Returning to research conducted into the various forms of AVHs, it appears that there are some clear commonalities in the causes and outcomes of voice-hearing. Citing Chadwick and Birchwood's 1994 research, Clara Strauss claims:

> Distress in response to hearing voices was a consequence of beliefs about voices. In particular, beliefs about voice omnipotence (the perceived power of the voice); voice identity and intent (malevolent or benevolent

[20] The International Hearing Voices Network, 'Patsy Hague: Inspiration', *Intervoice,* 2016 <http://www.intervoiceonline.org/about-intervoice/patsy-hague-inspiration> (para. 6-8).
[21] Angela Woods et al, 'Experiences of Hearing Voices: Analysis of a Novel Phenomenological Survey', *The Lancet,* 2 (2015), 323–31 (p. 324).
[22] Woods, 'The Voice-Hearer', p. 266.
[23] Frank, *Wounded Storyteller*, p. 6.
[24] Ibid.

> intentions) were posited as key factors that might determine voice-related distress.[25]

The distress that many voice-hearers experience is caused, in part, by their belief that the voice they hear is all-powerful, both in terms of its agency and intent. The feeling that they have no control over the voices they hear, elicits a number of negative reactions in voice-hearers: namely a lack of hope and a loss of any sense of security, either caused by a fear of their voices, or by social and emotional isolation. Moreover, the stigmatisation of mental illness means that often voice-hearers remain silent about their voices and do not seek help. This only helps to further isolate them and leads to greater financial and domestic insecurity. It has been reported that friendships and supportive familial relationships play a vital role in the rehabilitation of many people who hear voices, and thus, it is clear that one of the key methods of 'rehabilitation' is for the voice-hearer to maintain interactions with the outside world, while continuing to acknowledge the existence of the voices.[26] According to Romme et al., voices must be accepted, if they are to no longer have such a negative effect on the voice-hearer.[27]

The distress experienced by Joe and Mouth as voice-hearers is felt to such an extent that the voices they hear take them over, and yet at the same time, both characters try to resist listening in. Joe attempts to overcome the voice with his fixed stare, and his face: 'practically motionless throughout, eyes unblinking during paragraphs, impassive in so far as it reflects mounting tension of *listening* [italics in original]'.[28] In contrast, Mouth's insistent: 'No!' aims to stop the voice short.[29] Neither Mouth nor Joe recognise themselves as listeners. This is in stark contrast to many of Beckett's other characters, many of whom are defined by their role as a listener. For example, Listener in *That Time* (1976), Listener in *Ohio Impromptu* and Auditor in *Not I*. Furthermore, Beckett's works are filled with characters whose role is not only to listen, but also to record such as, She in *Rough for Radio I*, the Stenographer in *Rough for Radio II* and Assistant in *Catastrophe*.

Mouth and Joe's relationships with their voices appear to be governed by more than the content of the voice's speech. Their reactions to the voices, I argue, share commonalities with those who hear voices, as they reflect on the nature of the voice,

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[25] Clara Strauss, 'What have we learnt about cognitive appraisals of voice?', in *Psychological Approaches,* ed. by Hayward et al., pp. 46-60 (p. 46).
[26] Simon McCarthy-Jones, 'What have we learnt about the phenomenology of voice-hearing?', in *Psychological Approaches,* ed. by Hayward et al., pp. 5-26 (p. 17).
[27] Marius Romme et al., *Living with Voices: 50 Stories of Recovery* (Hertfordshire: PCCS Book Ltd., 2009), p. 21.
[28] Beckett, *Complete Dramatic Works*, p. 362.
[29] Ibid., p. 377.

and begin to identify and represent them as separate agents to themselves. Philosopher of psychiatry Sam Wilkinson and clinical psychologist Vaughan Bell claim that representing voices as agents (and often specific agents) is the primary reason that voice-hearers often encounter the voices of people that they know, or have known.[30] The term 'agent' is used to mark the agency of those voices heard by voice-hearers. They write that, 'we represent something as an agent when we represent it as having an informational and motivational profile (or perspective).'[31]

AVHs vary based upon the cause of the hallucination, and the subsequent interpretations the voices elicit. In mapping these various hallucinations, Simon McCarthy-Jones endeavours to determine their respective causes and triggers, so as to outline the ways in which these hallucinations present in patients. McCarthy-Jones's description of hypervigilance hallucinations is redolent of the voice that Joe hears in *Eh Joe*. These voices are experienced as though they are placed externally from the voice-hearer and most commonly affect a threatening tone toward the listener. McCarthy-Jones writes, hypervigilance hallucinations are an:

> [E]xaggeration of the normally adaptive perceptual bias humans evolved to detect threat […] The individual becomes hypervigilant for threat stimuli, reducing their threshold for detecting threats in the environment and increasing the chance of auditory 'false-positives', i.e. hearing things that confirm current beliefs around fears of persecution or public exposure of shaming information.[32]

McCarthy-Jones proposes that the majority of AVHs are caused by traumatic events (often in early life), but that in the specific case of hypervigilance hallucinations, patients have commonly been exposed to highly stressful events, including drug use and instances of extreme distress.[33] Hypervigilance hallucinations are often characterised as a threatening voice or verbal sounds, such as laughter.[34] For those experiencing hypervigilance hallucinations, the voices encroach on the listener, as though they were a separate agent. This is not so much a case of listening in, as it is being the victim of an external invasion. While the voice-hearer may experience the voice as though it were located externally, it is important to remember that the voice is always contained within

[30] Sam Wilkinson and Vaughan Bell, 'The Representation of Agents in Auditory Verbal Hallucinations', *Mind & Language*, John Wiley & Sons Ltd., 31.1 (2016), 104–26 (p. 110).
[31] Ibid., p. 111.
[32] McCarthy-Jones, 'What have we learnt about the phenomenology of voice-hearing?', in *Psychological Approaches*, ed. by Hayward et al., pp. 5-26 (p. 12).
[33] McCarthy-Jones, 'What have we learnt about the phenomenology of voice-hearing?', in *Psychological Approaches*, ed. by Hayward et al., pp. 5-26 (p. 14).
[34] Ibid., p. 12.

the subject who hears it. This troubles the voice-hearer's distinction between inside and outside, which merge and fold in upon one another. LaBelle writes that the voice is:

> [S]omething expelled from the mouth, but which *never* leaves me behind — this is both the promise of the voice and its ultimate problematic. The voice does not move away from my body, but rather it carries it forward — the voice *stretches* me; it drags me along, as a body bound to its politics and poetics, its accents and dialects, its grammars, as well as its handicaps. Is not the voice then precisely a sound so full of body, a body under pressure and in search? [italics in original][35]

The voice stretches the subject. The internalised voices that the voice-hearer hears can be thought of in similar terms, as the subject is led by the voice, despite the fact that this voice is located inside. Both the act of listening in and sounding out evoke a spatial context, but locating oneself within this space can be challenging.

As I showed in Chapter Three, being listened to can be emancipatory for some, and unsettling and exposing for others. For the voice-hearer the literal inside and outside of her body is further complicated by the inside/outside nature of the voices that she hears (all of which are of course contained within the mind, even if they are not experienced as such). In Chapter Two I explored Fernyhough and Alderson-Day's use of the Vygotskyan model of inner speech to argue that hearing voices, or constructing voices in one's head is evidence of normative language function. Here, I want to look again at Fernyhough's exploration of Vygotsky's dialogic inner speech, to understand how inner speech can be seen to trouble the distinction between outside and inside. Moreover, I want to suggest that dialogic inner speech also offers an explanation for inner voices, which exemplify non-pathological functioning instead of disorder. Fernyhough writes:

> Instead of struggling to explain what all these alien utterances are doing in a patient's head, a Vygotskian account shows us how our heads are already full of other voices. Taking dialogicality seriously allows the inner speech model to explain how voices are perceived as coming from another person […][36]

There is a conflict associated with this question of inside and outside and to which 'in' and to which 'out' is being referred to. The multitudes of voices experienced are perceived spatially as they are heard through listening in and out and up. Furthermore, the listener may receive these voices as a violent invasion, from the outside. Those voices, which are heard inside but that are perceived as originating from the outside,

[35] LaBelle, p. 5.
[36] Fernyhough, *The Voices Within*, p. 137.

assume external qualities. As Fernyhough says, Vygotsky's model shows that while these voices may be thought of as separate agents, each is ultimately located within the subject's mind.

In *Eh Joe*, however, the voice Joe hears is a separate agent in much the same way that McCarthy-Jones describes hypervigilance hallucinations. This voice pointedly mocks Joe's belief (or wish) that the voices he hears come from within his head. Voice says:

> You know that penny farthing hell you call your mind….That's where you think this is coming from, don't you?…That's where you heard your father….Isn't that what you told me?… Started in on you one June night and went on for years….On and off….Behind the eyes….That's how you were able to throttle him in the end….Mental thuggee you called it…. One of your happiest fancies….Mental thuggee….Otherwise he'd be plaguing you yet….Then your mother when her hour came.[37]

Voice is one of many voices that Joe has had to contend with throughout his life. Beginning with his father, then his mother and now Voice (his jilted lover), Joe is '[t]hrottling the dead in his head.'[38] It is only through a physicalized thought process that Joe manages to overcome the voice of his father using his 'mental thuggee'. So, as voices are heard they are also embodied. The play begins with Joe urgently searching his room: '[o]pening door, looking out, closing door, locking door, drawing hanging before door […] looking under bed,' for the source of the voice that he can hear.[39] Any relief Joe experiences at failing to find the physical source of the voice does not last long before he is pulled into the 'resumption of intentness', as Voice sighs her first 'Joe…'.[40] Despite Voice's constant questioning, she leaves no room for Joe to respond. She asks: 'Thought of everything?... Forgotten nothing?... You're alright now, eh?'[41] The title of the play alone implies a question, although the punctuation is absent. Each of her questions remains unanswered, but it is also unasked. Voice markedly refuses to listen in and instead her violating speech is spoken out and spoken into Joe.

The presence of the camera in *Eh Joe* does much to strengthen the accusatory and tormenting tone of Voice. As precise in his direction and notation for television as he was for his work on stage, Beckett provided detailed camera movements for his production of *Eh Joe*. Through these instructions Beckett constructs a visual

[37] Beckett, *Complete Dramatic Works*, p. 363.
[38] Ibid.
[39] Beckett, *Complete Dramatic Works*, p. 361.
[40] Ibid., p. 363.
[41] Ibid., p. 362

representation of voicing that distinctly stages and locates it in a physical space, in which voice-hearing can be heard *and* seen. Beckett's camera movements enact the disorientating and bizarre phenomenon of hearing the voice that no one else can hear. Moreover, the camera forces the audience to consider the connections between what is heard and what we see, so that the closer the camera comes toward Joe, the more keenly aware the audience become of their own listening in. It is not clear whether Voice's voice is diegetic or non-diegetic sound. The source of her voice may sit behind the camera that closes in on Joe, but she may also be located somewhere else entirely. Furthermore, it may be that the voice comes from within Joe's own mind, and that the audience is offered privileged access to the voice, which despite remaining invisible becomes another kind of spectacle. Beckett's meticulous descriptions of the camera's movement in *Eh Joe* begin:

> After [the camera's] opening pursuit, between first and final closeup of face, camera has nine slight moves in towards face, say four inches each time. Each move is stopped by voice resuming, never camera move and voice together. This would give position of camera when dolly stopped by first word of text as one yard from maximum closeup of face […][42]

The detail and distinction between the camera (spectacle) and the voice (auditory) is important. The audience witnesses two agents (Joe and Voice) at odds with one another, and as the camera begins to move, it becomes clear that the camera now represents a third agent. Graley Herren explores this complex relationship between Voice, the camera and Joe, arguing that the television medium was specifically chosen for its ability to manipulate and control both the process of representation and the viewer's experience. He writes:

> Mysterious voices, 'magically overheard,' that are not one's own and yet seem to be spoken inside one's head: this is precisely the form inspiration assumed in Beckett's own creative process […] It is also the invasive experience endured by so many of Beckett's author-figures — 'the siege in the room' prompted by the siege in the mind. This form of verbal assault is likewise the experience of the radio listener grappling to assimilate Beckett's radio plays; and it will later be the television viewer's experience when she encounters Voice in *Eh Joe*.[43]

Like his works for radio, Beckett uses television to make the auditor/audience conscious of the act of listening and viewing. There is an invasion on the part of the text, as it

[42] Beckett, *Complete Dramatic Works*, p. 361.
[43] Graley Herren, *Samuel Beckett's Plays on Film and Television* (Basingstoke: Palgrave Macmillan, 2007), p. 32.

encroaches upon the private space of the viewer, and yet the auditor/audience member also penetrates the text by viewing and listening to it. This relationship is demonstrated in *Eh Joe*, as the camera becomes the mediator of the drama perceived by both Joe and the audience. It is important to consider how the conditions in which the piece is perceived alter how it is perceived. Herren writes that just as Joe begins his drama by ensuring that the outside world is shut out, 'Beckett expects the spectator to do the same. Once these hermetically sealed conditions are met, however, the teleplay opens up a complex internal meditation upon personal memory, cultural traditions, and the nature of the television medium itself.'[44] In this sense, the audience is placed in Joe's position at the beginning of the play and yet, as the camera begins to move toward Joe, the viewer now adopts the position of the voice. The viewer's perspective is being consciously mediated and her position troubled. This hermetically sealed space becomes a site of disclosure, as the voice-hearer is revealed and interrogated by the stare of the camera, like that of the 'medical gaze', and a clinical space is created, in which this can take place.

Charon describes her consulting room as full of distractions and interruptions so that 'seeing a patient in clinical practice does not automatically result in attention.'[45] The space, she suggests, is at odds with listening and listening in, as while the consulting room may be private it is nevertheless permeable, influenced by the distractions that bring the outside world into it.[46] The challenge lies in trying to contain this space, as Joe attempts to do at the beginning of the teleplay. Frank discusses hospitals in similar terms, claiming that they 'depend on a myth of privacy. As soon as a curtain is pulled, that space is defined as private, and the patient is expected to answer all questions, no matter how intimate.'[47] The illusion of privacy and the need for attention are central to the clinical consultation, yet they remain constantly under threat. While Joe attempts to create Herren's so-called hermetically sealed conditions, he ultimately fails, as voices enter the space either from outside the room, or from within Joe's own head. The clinical space, just like that of the television set, cannot remain impenetrable, and the camera increases this sense of encroachment from the outside world. It is here that I read the set and the stage as clinical spaces. The camera's movement toward Joe through a single fixed gaze adopts the role of both Voice and

[44] Herren, p. 50.
[45] Rita Charon, 'Narrative Reciprocity', *The Hastings Center Report*, 44.s1 (2014), S21–24 (p. 22).
[46] See the opening of Chapter Three for an example of the permeable consulting room and its effects on the clinical interview.
[47] Frank, *At the Will of the Body: Reflections on Illness* (New York: First Mariner Books, 2002), p. 68.

clinician, culminating 'in a close-up so severe that Joe has his nose rubbed in the camera lens just as Voice metaphorically rubs his nose in his past crimes.'[48]

While Joe's anguish becomes increasingly visible with each movement of the camera, the viewer does not learn anything more about the nature of this distress. She sees it, but does not hear it. The camera's gaze, and therefore the viewer's, like that of the clinical gaze, is fixed so that it actually prevents any opportunity to experience the narrative as anything but a relentless invasion of space without clarity, or hope of cure. Moreover, the viewer becomes complicit in this view of Joe, offering him (the patient) little or no space in which to communicate his experience. The camera's view, like that of the clinician, remains on the outside. Our attempts to peer into the subject are aided by the camera and yet they reveal nothing more than the sight of Joe. Voice stops speaking as soon as the camera moves, and starts once more when the camera has moved closer as Voice and camera collude against Joe. As Voice stops and starts her narrative with the camera, the viewer is made increasingly aware of the camera's 'nine slight moves' toward Joe's face.[49] These movements offer a view of medical attention, intensifying as Voice (the AVH) begins to encroach upon Joe (the patient). It is sound's unique dynamic that enables Beckett to stage this invasion spatially, while aurally depicting what remains unseen. As the camera closes in on Joe, the voice also intensifies in its narrative jeering: '[e]ver know what happened?... She didn't say?... Just the announcement in the *Independent*….'[50]

I argue that the movement of the camera can be read as a clinical view, depicting the increased attention of the medical gaze, in response to the intensification of the voices heard by the voice-hearer. The camera becomes both an antagonist to the voice and its accomplice, giving the patient less and less space in which to articulate her experience of voice-hearing. The audience's view is a privileged but passive one. They are exposed to both sight and sound and the inside and outside of the subject within a single frame. The audience witnesses this torture with no power to correct it and, moreover, with the movement of the camera towards Joe in conjunction with Voice's utterings, it is as though the viewer becomes complicit in this invasion. Joe's silence means the audience cannot hear him or his voice within this experience. Using the television form, Beckett achieves a triangulation of inner sounding with Voice, the voice-hearer (Joe), and the audience, so as to capture the strangeness of the experience of hearing what no one else can hear.

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[48] Herren, p. 50.
[49] Beckett, *Complete Dramatic Works*, p. 361.
[50] Ibid., p. 365.

Eh Joe is the only piece in this chapter in which the heard voice is a different gender to that of the voice-hearer.[51] In his study of the phenomenology of voice-hearing, McCarthy-Jones writes that, 'the identity of voices could commonly be linked to representations of aspects of self and precipitating events, such as a participant hearing the voice of their seven-year-old self in adulthood, when they had been abused aged seven.'[52] The voice Joe hears belongs to a past lover who tells the story of a young woman's suicide that has been brought about by Joe's rejection of her. While this seems to be the story of that young woman ('the green one'), it is not clear to whom the story really belongs.[53] Voice may have faced a similar experience to the 'green one', or she may indeed be 'the green one', who tells her story in the third person. Her goading ('This all new to you Joe?...Eh Joe?') mocks Joe as he listens, and suggests that this is a story that Joe has heard before.[54] Moreover, it is not clear how Voice knows this story. She is another disembodied voice emerging from the depths, and her ghostlike quality links her to the death of 'the green one', while also offering her up as a voice of moral conscience and guilt, so that Voice can be understood as a part of Joe himself. She is both inside and outside: externalised as she passes judgement over Joe, and at the same time emerges from within him as a personification of his guilt.

McCarthy-Jones's case of one voice-hearer, who hears the voice of her seven-year-old traumatised self claims that as a result of this trauma, the voice-hearer is trapped in a temporal loop where the voice she hears is representative of that traumatic time. Similarly, for Joe, Voice recounts the events of a young woman's suicide, which like the seven-year old voice, is temporally fixed to the traumatic event. This may go some way to explaining Voice's gender, as Joe's trauma is specifically related to this moment in time. Herren writes that:

> With his invention of Voice, Beckett takes the sexist cliché that 'A woman should be seen, not heard' and turns it on its ear, providing us a female voice that is heard but not seen and a male image that is seen but not directly heard. The teleplay erodes gender barriers even further by so entangling the identities of masculine Joe and feminine Voice that it is difficult to say where one starts and the other stops. Joe prefers to maintain distinct borders between him and others, but Voice subtly breaches these boundaries.[55]

[51] Other examples include Beckett's later works for television: *Ghost Trio* and to a certain extent *...but the clouds*.
[52] McCarthy-Jones, 'What have we learnt about the phenomenology of voice-hearing?', in *Psychological Approaches*, ed. by Hayward et al., pp. 5-26 (p. 17).
[53] Beckett, *Complete Dramatic Works*, p. 365.
[54] Ibid., p. 366.
[55] Herren, p. 54.

Herren's confusion of clichés is somewhat distracting. It is, after all, children and not women who should be seen and not heard. However, Beckett's entangling of genders and identities is significant, as the voice is the only medium through which the breeching of boundaries takes place. Where the camera would seem to only emphasise the impenetrability of the body through seeing, it is the voice that draws attention to the liminality of the body, which both emanates voices and is penetrated by them too. Voice is externalised, in the sense that she remains an unseen presence, and yet located within Joe's mind, she invokes this psychical contradiction between what is seen and what is heard. How Voice is perceived and where Voice is created takes place in a series of internal and external spaces. While *Eh Joe* is consumed by the act of voicing, we never actually see anyone speaking, as Voice remains dis-embodied.

In *Not I*, the shifting dynamic and balances of power and agency between voice, voice-hearer and viewer are similarly played out. In contrast to *Eh Joe* however, the voice in *Not I* is a furious, embodied stream of language, which pours from the site of speech: the mouth. Here, I want to draw comparisons between Mouth's voice and another specific subtype of auditory verbal hallucination, referred to by McCarthy-Jones as de-afferentation AVHs. McCarthy-Jones, et al. have identified a series of AVH subtypes in an endeavour to develop a phenomenological approach to categorising and treating AVHs.[56] De-afferentation hallucinations are commonly associated with patients who have been isolated for extended periods of time. McCarthy-Jones writes that this subtype of hallucination was identified based upon phenomenological examinations of the experience of voice hearing and that 'neurologically [they can] be conceived of as resulting from de-afferentation of the auditory cortex and other language perception areas'.[57] De-afferentation, then, is the interruption of 'sensory information' within the body.[58] The destruction of these connections is experienced as 'continuous (rather than episodic)' hallucinations, the content of which is often musical. While Mouth does not experience musical hallucinations, the buzzing that she hears is continuous and unbroken and is phenomenologically similar to tinnitus, which is another characteristic that McCarthy Jones claims is shared with those who have de-afferentation hallucinations. These hallucinations are not only the product of extended periods of isolation, they are also isolating, and it is in this regard that the voice (and the buzzing)

[56] Simon McCarthy-Jones et al., 'Better Than Mermaids and Stray Dogs? Subtyping Auditory Verbal Hallucinations and its Implications for Research and Practice', *Schizophrenia Bulletin*, 40.4 (2014), S275–78 (S. 275).
[57] McCarthy-Jones, 'What have we learnt about the phenomenology of voice-hearing?', in *Psychological Approaches*, ed. by Hayward et al., pp. 5-26, (pp. 13-14).
[58] *Mosby's Dictionary Of Medicine, Nursing and Health Professions*, ed. by Tamara Myers, 8th edn (Missouri: Mosby Elsevier, 2009), p. 53.

in *Not I* can be illustrative of the continuous voice that seizes control of Mouth. Moreover, as the subject experiences de-afferentation hallucinations as a continuous stream in isolation, Mouth can also be used to explore the agency of the voice-hearer within the clinical (and we might also say public) contexts in which she is required to acknowledge the existence of these voices. Here, I want to examine how the experiences of voice-hearers are listened to.

In the original productions of *Not I*, Auditor is '*enveloped from head to foot in a loose black djellaba […] standing on invisible podium about 4 feet high*' above the stage and conducts, or is conducted, by Mouth's speech throughout the play.[59] Auditor (whose sex is indeterminate), remains silent and motionless but for four 'gestures of helpless compassion'.[60] A spectral version of Beckett's quintessential pseudocouple, Auditor's beckoning toward Mouth seems to be an attempt to bring the two characters, or pieces of a single character, back together through their gestural dialogue.[61] In contrast to silent Auditor, disembodied Mouth is all language. Mouth's monologue is hers, but throughout the play she refuses to acknowledge that she is telling her own story. As she intermittently pauses between outbursts, Mouth exclaims: 'what? .. who? ..? .. no! .. she!'[62]

As the name would suggest, Auditor is a listener, but their presence also mediates Mouth's monologue. Linda Ben-Zvi writs that:

> The figure [Auditor] fulfils several roles: intermediary between the audience and Mouth, offering mute compassion for the tale heard; traditional choral device calling attention to the play as play; raped cleric who can gesture but not alter; analyst who can listen but not heal.[63]

Mouth's logorrhoea pushes her words into the theatre from the mouth of a woman whose body has been left behind, and both Auditor and audience receive this monologue in similarly incoherent ways. According to Ben-Zvi, Auditor and audience adopt similar, if not identical, roles in their spectatorship. Auditor's role, and subsequent removal from the 1975 BBC television production, was, Ben-Zvi writes, a

[59] Beckett, *Complete Dramatic Works*, p. 376.
[60] Ibid., p. 375.
[61] Ackerley and Gontarski write, 'pairs of characters pervade SB's terrain like animals in search of an ark. Some wander deserted byways in pursuit of a saviour; others go nowhere, doomed to existence in claustrophobic rooms or ashbins. Whatever their predicament, the men and women who make up SB's teetering twosomes are tied to each other […] halves of a single personality' (2006, 463-64).
[62] Beckett, *Complete Dramatic Works*, p. 377.
[63] Linda Ben-Zvi's observation of the intermediary role of Auditor is important for my purposes as I consider the role of the audience as Auditor. That neither the audience nor Auditor can comprehend, or heal Mouth, becomes a focus when placing Beckett's work in a clinical context in which the obligation is to see, hear, understand and cure. (Ben-Zvi 1990, 244).

rare example of Beckett allowing 'work written for one medium to be transposed into another'.[64] The conditions of the play were changed so that the new piece with Whitelaw became a 'specially made-for television version of the play', which ultimately transformed not only the way that the play is viewed, but also, the role that the audience plays within the performance. The television production intensifies and isolates the viewing experience, as with *Eh Joe*. Ben-Zvi writes that 'television offers the mechanical reproduction of the event, […] a new mechanical Auditor', so that like the camera in *Eh Joe*, action is mediated through a single, and in this instance, static shot.[65] This throws the audience into its own role as Auditor: silent and powerless. Ann Wilson argues that:

> [T]he role of the audience is as fully written as that of the Auditor. In fact, the roles of the Auditor and audience are similar, for although our response is not physical, like the Auditor's, it is '*a gesture of helpless compassion*.' In the video of the play produced by the BBC, the Auditor is not seen, nevertheless, he remains in the drama, never appearing before the camera's eye precisely because he, like the audience, is the eye of *Not I*.[66]

As the image on screen becomes increasingly difficult to comprehend, the viewer becomes more of a listener.

Ben-Zvi writes that in transposing *Not I* for television the Mouth is transformed from an imperceptible 'speck' to a cavernous 'gaping maw'.[67] This is similar to the expression on Joe's face in *Eh Joe,* which despite coming closer into view, still denies the audience any understanding of Joe's psychical state. When watching the television production of *Not I,* the audience is a passive auditor, as little can be perceived from what is presented on screen. Yet, due to the sheer size of the mouth on screen the viewer becomes more acutely aware of Mouth's physicality. The spectacle of the mouth on screen both invites the viewer to look and pushes her away in incomprehension. In 1975, when *Not I* was first broadcast, home television sets had convex screens. Fifield writes that the curve of the screen:

> [T]hrusts the image into one's living room, holding the gaze with its own ocular curve. Indeed, the play's titular pun thus gains an additional twist in its second format, for now the play makes the television's dilated

[64] Linda Ben-Zvi, 'Not I: Through the Tube Starkly', in *Women in Beckett: Performance and Critical Perspectives*, ed. by Linda Ben-Zvi, (Illinois: University of Chicago Press, 1990), pp. 243-48 (p. 245)
[65] Ibid., p. 244.
[66] Ann Wilson, ''Her Lips Moving' *The Castrated Voice of* Not I', in *Women in Beckett*, ed. by Ben-Zvi, pp. 190-227 (p. 190).
[67] Ben-Zvi, 'Not I: Through the Tube Starkly', in *Women in Beckett*, ed. by Ben-Zvi, pp. 243-48 (p. 246).

> image return our stare: our gaze is held by that mesmeric tube whose detractors have bestowed the nickname the 'devil's eye'.[68]

The audience watch the salivating sight on screen, and the mouth stares back. Yet neither the viewer nor Mouth can fully see, nor can they be seen by one another. This seeing and unseeing — holding and rejecting the gaze — illustrates that the difficulty that Mouth and the auditors (both character or audience) face in communicating with one another extends beyond their inability to speak and hear each other. With one character committed to expression and the other to listening, the role of the audience becomes all the more important in the television play, where Auditor has been removed. In later theatre productions of *Not I* Auditor was also removed, leaving Mouth alone on stage and intensifying the spectacle further as there was nowhere else for the audience to look. Without the mediating force of Auditor on stage the audience are then not only asked to listen in further, but also made more responsible for receiving Mouth's monologue.

The audience's response to Mouth's stream, like Auditor's, is helpless silence, but this silence does not stop Mouth from talking. Both Mouth and Auditor, or Mouth and the audience, experience this voice. They hear and feel this voice together. This triangulation, like that of Voice, Joe and viewer in *Eh Joe*, similarly plays out the power struggles between the voice-hearer (Mouth), her voices (Mouth's voice) and the clinician (Auditor and audience) using sight, sound and the spatial interaction between them as a means by which to consider the difficulty of witnessing and understanding.

Frank writes that 'the witness of suffering must be *seen* as a whole body, because embodiment is the essence of witness [italics in original].'[69] Yet while the Auditor and/or the audience are both bodies that witness, neither can easily see what is happening. Both Auditor, who is cloaked and covered, and the audience, who are plunged into darkness, is disembodied by the conditions of the performance. Suffering is a collective experience but it is also one that Mouth readily denies. Speaking about herself in the third person, she insists: 'she was not suffering … imagine! […] unless of course she was… *meant* to be suffering… ha! .. *thought* to be suffering' [italics in original].[70] Mouth's refusal to relinquish third person calls the identity of the sufferer into question, and suggests that whatever suffering might be experienced, it is not necessarily being understood. Is it Auditor's movements which urge Mouth's narrative

[68] Peter Fifield, 'Gaping Mouths and Bulging Bodies: Beckett and Francis Bacon', *Journal of Beckett Studies*, 18.1-2 (2009), 57–71 (p. 64).
[69] Frank, *Wounded Storyteller*, p. 142.
[70] Beckett, *Complete Dramatic Works*, p. 377.

on, or is it Mouth's repeated: 'what?.. who?.. no?.. she!' that cause Auditor to helplessly raise his/her arms?[71] Auditor's movements are an attempt at compassion, but they are also evidence that something has not been understood. It seems that Auditor and Mouth fail to communicate with one another precisely because they form two parts of a single fragmented body. Separated off from one another there may be some attempt, at least on the part of Auditor, to come together again, trying as they do to overcome the inevitable divide of their embodiment. While the audience may not be trying to re-form or join with Mouth in the same way as Auditor, they are undoubtedly forced to engage with her. As Mouth calls, laughs and screams out into the auditorium, Mouth creates a dialogue with her listening audience, anticipating questions and arguing with an imagined agent.

As an isolated 'body', Mouth's imagined listeners (Auditor and the audience) are illustrative of the invented agents that Wilkinson and Bell explore:

> Putting the emphasis on agent representation, rather than on general capacities of social cognition, we could say that social isolation leads to a bias in the cognitive system toward detecting agents amid non-agentive environment. [....] In other words, you have the experience of someone talking to you because you have represented an agent.[72]

In this section, *Eh Joe* and *Not I* have provided a model for patient case studies, to read Beckett's characters as voice-hearers who experience various forms of AVHs. I do not wish to stop my reading here, as to stop at diagnosis would fall short of the opportunities opened up by Beckett's work in formulating and reformulating the clinical encounter as experienced by the voice-hearer. For Joe, voices remain tormented and unacknowledged, while for Mouth language is alien and disconnected. It is the role of an auditor, then, to understand the experience of voice-hearing in the voice-hearer. The challenge lies in drawing the voice-hearer's narrative out, and listening to it, when confronted with the biomedical discourses that dominate clinical psychiatry.

Pathologised Voices

Many scholars have read *Not I* as a representation of a fractured and schizophrenic self on stage. Weller has analysed the play's 'schizoid voice' and Barry describes its schizophrenic 'aural 'buzzing''.[73] In this section I examine the characteristics of the play, which have led to such conclusions. Woods writes that schizophrenia has been

[71] Beckett, *Complete Dramatic Works*, p. 377.
[72] Wilkinson and Bell, p.119.
[73] Shane Weller, ''Some Experience of the Schizoid Voice': Samuel Beckett and the Language of Derangement', *Forum for Modern Language Studies*, 45.1 (2008), 32-50 (p. 38) and Elizabeth Barry, 'All in My Head : Beckett, Schizophrenia and the Self.', *Journal of Medical Humanities*, 37.2 (2016), 183–92 (p. 188).

treated as the 'sublime object' of psychiatry.[74] Schizophrenia is sublime, Woods writes, because the condition cannot be fully understood as there is no one 'perfect' case of schizophrenia that encompasses all elements of the diagnosis. Schizophrenia is always more or less than the diagnostic criteria that are used in order to identify it. In this sense, Woods claims, schizophrenia is constructed and narrativised as 'opaque, bizarre, and resistant to analysis,' becoming the 'limit point' of psychiatry as there is always something out of reach.[75] The out-of-reach nature of schizophrenia is born, in part, from the fact that one of its primary symptoms (voice-hearing) cannot be perceived by anyone else, but the sufferer. While the clinician can interview the patient and discuss the experience of the voice-hearing, the encounter requires an act of imagination, similar to the imaginative acts I described through radio listening, in Chapter Three. Yet, while schizophrenia may have acquired this mythic status within psychiatry, psychiatrists themselves can often be seen to be at their most comfortable and productive when diagnosing and devising treatment plans for pathologised voice-hearing.[76]

The current *Diagnostic and Statistical Manual for Mental Disorders (DSM-5)*, created by the American Psychiatric Association, offers the following description of schizophrenia:

> The characteristic symptoms of schizophrenia involve a range of cognitive, behavioural, and emotional dysfunctions, but no single symptom is pathognomonic of the disorder. The diagnosis involves the recognition of a constellation of signs and symptoms […] as schizophrenia is a heterogeneous clinical syndrome.[77]

In order to diagnose schizophrenia, the clinician analyses and compares myriad symptoms against one another.[78] As is often the case for those suffering with mental health conditions, no two patients will present in the same way. In the case of schizophrenia, however, the 'constellation of signs' is by its very nature incomplete, or

[74] Angela Woods, *The Sublime Object of Psychiatry: Schizophrenia in Clinical and Cultural Theory* (Oxford: Oxford University Press, 2011), p. 15.
[75] Ibid.
[76] Unlike other psychiatric disturbances, schizophrenia can be highly responsive to medication and therefore it is a relatively simple process for the psychiatrist to develop a treatment plan for her patient.
[77] American Psychiatric Association, *American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition*, 5th edn (Arlington, VA: American Psychiatric Association, 2013), p. 100.
[78] It is interesting to note that the DSM-5 uses the word 'constellation' to define the various symptoms associated with schizophrenia. This celestial and somewhat esoteric word implies that there is a degree of unpredictability in the array of symptoms that schizophrenia incorporates, and that these remain open and subject to individual interpretation.

partially hidden from both the sufferer and the clinician.[79] The DSM-5 offers a breakdown of diagnostic criteria, which compartmentalises symptoms, offering a list (Criteria A) in which two or more criteria should be present in the patient to warrant a diagnosis of schizophrenia.[80] These Criteria A include: delusions, hallucinations, disorganised speech, grossly disorganised or catatonic behaviour, and negative symptoms.[81] Within the DSM-5 symptoms are individuated and distinct, which is to say that they are described as symptoms that a patient might present with, but are never described as being part of that patient. Woods questions the dominant clinical diagnostic approach to mental illness by asking, 'can madness be so easily separated from its material incarnation in the mad person? Is madness a silent or an unspeakable experience for the mad as well as their spectators?'[82] For Mouth and Auditor the answer is both yes and no. Taking Auditor (and the audience) as the spectator and listener of Mouth's monologue, it appears that silence is all that can be offered in response to the outside view of madness, and this silence is in itself silencing. Yet Mouth also offers silence in response to the disturbances she experiences, as she refuses to listen out and in to her story. It seems that this inability to listen is driven, at least in part, by the conditions in which she and also the audience are placed. Both Mouth and her auditor(s) are disoriented as they attempt to bear witness to the voices that are produced on stage.

Since its first performance, in 1972 at The Forum Theatre, New York, *Not I* has been performed in complete darkness. Light bulbs are removed from emergency exit lights. No light exists on stage save that of the single beam focused on Mouth (and Auditor, if present). In this environment, the audience cannot orientate themselves in the dark.[83] With the audience figuratively disembodied they become the passive recipients of Mouth's chaotic narrative and so this voice, separate but also imposing, is experienced in much the same way as Woods's depiction of madness: as embodied,

[79] These signs are either inaccessible to the patient because the symptoms are described in an unfamiliar biomedical language, or they remain inaccessible to the clinician who is unable to share the experience of AVHs with her patient. To attempt to understand the experience an act of imagination is required on the part of the clinician. Listening in the clinical encounter, as I argued in Chapter Three relies heavily upon the imaginative acts and capabilities of the clinician.

[80] While the DSM-5 remains the dominant source for diagnosis and recommended treatment for mental health disorders, this dossier has and continues to change. Furthermore the influences upon the text, such as interventions by pharmaceutical companies, also affect the way that conditions are framed. The DSM-5 is a historically situated text. Martyn D Pickersgill writes 'I view diagnostic categories as being constituted, in part, through professional, patient and political claims-making and debate […] diagnostic texts, like the DSM come to shape, and be shaped by, a wide range of social actors and institutions' (2013, 521). I wish to highlight these issues, so as to ensure that the DSM-5 is not seen to be offering objective descriptions of conditions, but rather as a politically charged and divisive text. As Pickersgill goes on to say, much of the backlash against the DSM has been driven by concerns that it has encouraged the 'medicalisation of normality' and furthermore, has tended to 'reframe (and perhaps 'create') pathologies amenable to pharmaceutical intervention, which some find disquieting' (2013, 522).

[81] American Psychiatric Association, p. 99

[82] Woods, *The Sublime Object of Psychiatry*, pp. 24-25.

[83] Recent performances of *Not I* have been introduced with a warning from the theatre that audience members will be unable to leave the auditorium during the performance. The audience is quite literally trapped within the theatre.

affective and integrated. It is the staging of *Not I* that strips each figure, including the audience member, of her agency, as Mouth's voice takes control. Writing about Beckett's *The Unnamable*, Chris Ackerley writes that the mystery of the voice 'consists of where the voice is located,' making the reader question whether it is 'without or within'.[84] Throughout Beckett's works, Ackerley writes, 'the origin of voice would remain unresolved, part of the enigma and paradox of being, of the mystery of creativity, yet its very insolubility provided the impetus for articulating the epistemological quandary […].'[85] That the origins of one's articulations are seemingly inexplicable by no means removes the 'obligation' to express them, and such is the case for those patients who endeavour to understand the source and the role of the voices that they hear.[86] It is the choice to uncover the meaning of voices that brings better management and understanding, and yet voice-hearers often lack a space in which to listen in and share these voices with others. Mouth's resistance to sharing her voice (even with herself), and her absolute refusal to listen in to her monologue, does little to stem the flow of utterance. LaBelle writes that:

> Self-talk is thus prone to censorship […] Yet self-talk is precisely a speech that *must* come out: this voice reaches out, it spills from my lips; it needs to be heard even if addressing only myself: it falls from my mouth to be caught by my ear. In such self-hearing, I speak to myself as if I am two. I feel myself as *another* [italics in original].[87]

LaBelle's description of self-talk, just like the voices experienced by the voice-hearer and Mouth's story, is embroiled in a narrative of self-censorship which forces itself out of the subject at the same time that the subject tries to contain it. The body has its own way of speaking out, which as it hears itself is experienced as two voices.

In response to what Woods describes as psychiatry's obfuscation of voice-hearing, there has been a growing patient-led movement to advocate for the value of voice-hearing. Where psychiatric models have sought to eradicate symptoms with medication, and as in the case of the DSM-5, have defined voice-hearing as symptomatic of a larger network of pathological symptoms, which constitute schizophrenia, the HVM works collectively to encourage voice-hearers to listen to the voices they hear. Peer-led networks, such as the HVM, acknowledge the multitude of voices at play within the single subject and encourage patients to listen into them and share them with others.

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[84] Chris Ackerley, 'The Uncertainty of the Self: Samuel Beckett and the Location of the Voice', *Samuel Beckett Today / Aujourd'hui*, 14.After Beckett / D'après Beckett (2004), pp. 39-40 (p. 40).
[85] Ibid.
[86] Beckett, *Proust*, p. 103.
[87] LaBelle, pp. 93-94.

The politicised voice-hearer now asserts a new kind of autonomy and agency as 'expert by experience'.[88] She does so, Woods writes, to 'establish robust networks of self-help while also challenging the authority, ideology and practices of 'experience by profession.''[89]

The HVM illustrates a great number of possibilities for increasing one's understanding of the experience of voice-hearing, primarily in a clinical context, but also in a social and political environment, in which voice-hearing and voice-hearers are credited as experts in their own conditions.[90] In this model, voices-hearers and their voices are no longer viewed as bizarre. Instead, the HVM 'takes the position that the voice is commonly a misunderstood messenger or speaking metaphorically, and is actually helpful to the voice-hearer if correctly understood.'[91] There is an opportunity to appreciate the voices as informative, offering a new way of experiencing the world and one's own representation of emotional states, however distressing the causes may be.[92] The HVM by no means offers a solution to the clinical challenges of understanding voice-hearing and schizophrenia, rather it provides a model whereby voice-hearers are deemed experts in their own condition and their families can be seen to possess a special insight into the experience of such conditions in a social context. Such an interconnected approach should not be overlooked as it gives space to those at the centre of their condition to help explain and understand their own experiences.

Beginning with the work of Patsy Hague in founding the HVM, this position aims at redressing the pathologisation of voice-hearing to assert that 'voice-hearing is not a meaning-less symptom of an underlying illness or disease, but a key part of a person's identity.'[93] It is this identity, the HVM emphasises, which must be listened to. McCarthy-Jones points to some of the difficulties that are associated with listening and understanding the experience of hearing voices, when he says of the clinical encounter that:

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[88] McCarthy-Jones, 'What have we learnt about the phenomenology of voice-hearing?', in *Psychological Approaches*, ed. by Hayward et al., pp. 5-26, (p. 17).
[89] Woods, 'The Voice-Hearer', p. 265.
[90] I do not use the term experts here in the same way as the medicalised description, which Carel references (Carel, 2016). This is not a label that the medical profession gives to the voice-hearer. Moreover, the voice-hearer's status as 'expert by experience' (Woods, 2013) does not conform to a standard or level of expertise that is determined by the clinic. Identifying oneself as a voice-hearer and an expert within the HVM is crucially different, in that it attempts to produce a different model of expertise entirely, and one that sits outside of, if not in direct opposition to, clinical categorisation.
[91] McCarthy-Jones, 'What have we learnt about the phenomenology of voice-hearing?', in *Psychological Approaches*, ed. by Hayward et al., pp. 5-26 (p. 17).
[92] Parallels can be drawn between medieval perceptions of voices and the views of the HVM. Voices heard by medieval Christian mystics, such as Joan of Arc and Margery Kempe, were believed to offer positive insights and enlightenment to the listener. Woods writes that, 'sharing stories is a ritual feature of both local voice-hearer groups and larger international congresses; the exchange of narratives functioning variously as a form of testimony, healing, empowerment and the forging of individual group identity' (Woods 2013, 267).
[93] Woods, 'The Voice-Hearer', p. 264.

> [R]esearch should 'give' people diagnosed with psychosis a 'turn to speak', i.e., that research should take a ('big P') phenomenological approach, involving in-depth questioning of people about their subjective experiences, with questions that suspend or 'bracket' presuppositions about the phenomena under investigation, including its normality or abnormality, and its causes.[94]

Such approaches to voice-hearers' experiences often lead to two issues, which must be considered within the clinical encounter. First, voice-hearers should not be expected to wait for an opportunity to speak, and secondly, by making patients wait, the researcher or clinician's questioning is given precedence over the voice-hearer's narrative. Butler's work attempts to derail the assumptions that the sovereign (the powerful and fully constituted) subject is the only one that can/should have control over the speech act. She writes:

> Untethering the speech act from the sovereign subject founds an alternative notion of agency and, ultimately, of responsibility, one that more fully acknowledges the way in which the subject is constituted in language, how what it creates is also what it derives from elsewhere. Whereas some critics mistake the critique of sovereignty for the demolition of agency, I propose that agency begins where sovereignty wanes. The one who acts (who is not the same as the sovereign subject) acts precisely to the extent that he or she is constituted as an actor and, hence, operating within a linguistic field of enabling constraints from the outset.[95]

The challenge here is not only the difficulty a patient or voice-hearer has in giving voice to her experience in a clinical context, but also the narratives with and *through* which this experience is framed. It is the sovereign subject (in my reading, the clinician) who must acknowledge how she and her patient are constituted in the language that is available to them both. The clinical encounter offers a language to describe the patient's experience that ultimately does not belong to the patient. Thus, even if clinicians offer the time and opportunity for the voice-hearer to speak she still faces difficulty in describing her experience on her own terms. Romme, et al. argue that it is for this reason that we see such marked successes through voice-hearer groups where voice-hearers can share their stories with one another.[96]

Within psychiatry, hearing voices is classified as evidence of mental ill health. Woods writes:

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[94] McCarthy-Jones, 'What have we learnt about the phenomenology of voice-hearing?', in *Psychological Approaches,* ed. by Hayward et al., pp. 5-26 (p. 6).
[95] Butler, *Excitable Speech*, pp. 15-16.
[96] Romme et al, p. 4.

> If, dwelling within the psychiatric system 'the schizophrenic' was never entitled to a story, especially not a recovery story, 'the voice-hearer,' by contrast, comes into being in the explicitly narrative environments […] Voice-hearing is thus a narrative mode of being, one that is performative, personally and socially meaningful, polysemic and open to change.[97]

The HVM, thus gives voice to the experiences of those who hear voices, not simply as a mode of therapy to eradicate voices, but as a means of understanding the voices heard: who they belong to, what characteristics they adopt and how the voice-hearer relates to them.

So far I have read *Not I* as a representation of the experiences of voice-hearing for both the clinician and patient. Voice-hearing is characterised by its relation to schizophrenia and as such, those who experience AVH are often required to engage with clinical and psychiatric institutions of care. *Not I* presents a character whose identity has been all but overlooked by those around her, and as she refuses to acknowledge that her narrative is her own, while recounting experiences which are imbued with a sense of self-denial, Mouth can help us to think about and better understand the voice-hearer who struggles against her voices in a clinical context. Moreover, as an illustration of these tensions Mouth can also be seen to illustrate the potential damage of current psychiatric models in contrast to those peer-led movements such as the HVM, which seek to listen in to the voice so that it might be more effectively understood and managed.

Whose Voice?

My investigation into voice-hearing in Beckett's theatre has been driven primarily by the understanding that the voice is located within a space, both on stage and screen, in which the inside and outside nature of voicing becomes confused. I want to examine the troubling question of the origin of the voice in the theatre and the clinic and, moreover, read the theatre-as-clinic. In this section I argue that the experience of performing Beckett's most notoriously gruelling work renders the performer patient-like.

The patient's voice in the clinic can be difficult to determine, not only because of her position as a patient, but also because her encounters with the clinic are guided by clinical discourses and agendas. Moreover, the clinician also faces challenges as she is led by the decisions and policies of the institute. The theatre is subject to similar

[97] Woods, 'The Voice-Hearer', p. 267.

systemic expectations, and Beckett's performers perform the challenge of voice ownership in ways that can be used in dramatic and clinical contexts.

Connor writes:

> My voice comes from me first of all in a bodily sense. It is produced by means of my vocal apparatus — breath, larynx, teeth, tongue, palate, and lips. It is the voice I hear resonating in my head, amplified and modified by the bones of my skull, at the same time as I see and hear its effects upon the world.[98]

For Connor the voice is unique, because unlike other attributes, which distinguish one person from another, the body *produces* the voice. Connor writes that 'giving voice is the process which simultaneously produces articulate sound, and produces myself, as a self-producing being.'[99] The ability to produce oneself is in many ways the defining characteristic of the voice, and yet, producing that voice or articulating that sound, does not produce a sense of self in itself. For Mouth in *Not I*, this only muddies the already unclear waters of the identity of the subject. I have already shown how *Not I* and *Eh Joe* stage dissociation and fragmentation through narratives that have been separated from those that articulate and experience them. If, according to Connor, my body is a vessel for language and operates as a language-making machine, it seems impossible for the body to be reconciled with language which is not sounded-out, or indeed, language that cannot be formulated at all (for example, people with aphasia), as I explored in Chapter Two. The voice that Connor invokes is brought into being by a combination of visceral embodiment (the palate and lips), and the transient and insubstantial qualities of the automatic and unthinking breath. There is a necessary dialectic between the different factions of embodiment.

In his book, *Dumbstruck: A Cultural History of Ventriloquism*, Connor explores the history of the ventriloquized voice and the confusion of its origins, purposefully cultivated to create mystery and intrigue for the sake of entertainment. *Not I*, as I shall show, also plays with the mystery of voice, through performance, to reveal a language whose source is uncertain. Connor writes that 'to speak is always to hear myself speaking. Learning to speak depends on being able to hear myself in this way. This kind of reflexivity is neither as necessary or [sic] as marked in other senses and bodily operations'.[100] To speak, then, is in some sense to know oneself, and yet we already know this to be a problematic assertion, never more so than in illness. Instead, I want to

[98] Connor, *Dumbstruck*, p. 3.
[99] Ibid.
[100] Connor, *Dumbstruck*, p. 5.

consider speaking as signifying the presence of the body, as opposed to a knowing of the self. Furthermore, for those experiencing language and communication disorders such as aphasia, the ability to speak one's illness becomes increasingly difficult. Similarly, for the voice-hearer the terminology available to discuss one's voices is also at odds with experience. Beyond what is being said, whose voice it is that is being heard, and whose story it is telling, need to be understood. By doing so, one can determine where the voice is coming from, what kind of voice it is, and moreover, the origin of the voice that is being heard.

Mouth's words may not be recognised as her own but she is forced through (and by) her narrative to make some connections between the sounds made and her ability to make them: 'scream … [*Screams.*] … then listen … [*Silence.*] … scream again … [*Screams again.*] … then listen again…'.[101] Moreover, beyond Mouth's duet with her own manner of speaking, the source of her narrative is further confused within the performance itself. Despite her visceral ravings, there is an ethereal quality to Mouth's disembodied suspension above the stage and it appears uncertain as to who it is that powers Mouth. While Mouth's words have taken over her mouth, the audience does not know who controls the words, precisely because she denies ownership of them. Mouth becomes a representation of all that she is *not*. Mouth recounts how:

> gradually she felt … her lips moving … imagine! .. her lips moving! .. as of course till then she had not … and not alone the lips … the cheeks … the jaws … the whole face … all those – […][102]

Yet none of these surrounding body parts are visible to the audience, and the actor performing Mouth remains hidden from view. Mouth focuses the attention of the audience, not only on a mouth but also on the absence of a body. The actor, the motor (and body) behind the mouth is a vessel for the performance. Lisa Dwan has recounted her experience of performing *Not I*, with the torturous process of greasing her face, covering her head in a shroud, strapping her body in and breathing in the curtain's dust in front of her.[103] In many ways, Dwan's body is anything but passive, as she is faced with the panic-inducing entrapment of her role as Mouth, and yet at the same time it is this method that disconnects the actor from herself. Creating an unthinking body, the

[101] Beckett, *Complete Dramatic Works*, p. 378.
[102] Ibid., p. 379.
[103] Lisa Dwan, 'Beckett's Not I: How I Became the Ultimate Motormouth', *The Guardian*, 2013 <http://www.theguardian.com/culture/2013/may/08/beckett-not-i-lisa-dwan> [accessed 6 April 2016].

actor must fulfil Beckett's objective to not act, or to act with 'no colour', as he famously insisted of Whitelaw when performing *Footfalls*.[104] Dwan writes:

> There is not a cell of my body that isn't called to arms while performing, but most challenging of all is to silence one's own internal Not I [sic]. There's no room for reckless thoughts. They disturb the concentration. But like vultures, they hover above his lean lines.[105]

Dwan's own 'Not I' is her own internal soundings out, which are experienced as both internal and alien, and distract her from the here and now of her performance. It is all noise, whereas the performance of *Not I* requires a performer who is almost dummy-like and thus, in some senses, silenced (or perhaps more rightly absent) through performing. Dwan must relinquish all agency so that that the words of the play can be performed. The inner voice is both the power and the distraction behind the performance, and yet the actor is denied the opportunity to listen in on her own performance, as she speaks at the speed of thought, and becomes a container for the voice of another.

Whitelaw, who would set the bar in her performance as Mouth in 1973 at the Royal Court, believed that, 'if you allow the words to breathe through your body, if you become a conduit, something magical *may* happen [italics in original].'[106] Whitelaw's (or Beckett's) words breathe themselves through the body of the performer instead of being breathed, leaving the performer's body to follow in their wake. Recounting her experience of the performance, Whitelaw writes:

> Before the first night of Not I [sic], on January 16th, 1973 I went through my own sort of mantra. Strapped into the chair, I said to myself: *'Right, let your skin fall off, let your flesh fall off, let the muscles fall off, let the bones fall off, let everything fall off …'* I wanted to be left with nothing but my centre, my core which seemed to be situated somewhere around my gut — the little flame which I needed. And I thought, now keep out of the way, Whitelaw, work with what's left, don't get in the way of that, pilot your own plane, ride the turbulence [italics in original].[107]

Like Dwan, Whitelaw is in danger of getting in the way of her performance. For Whitelaw, however, this obstruction is embodied, whereas Dwan's is a vocal 'Not I'. There is a need to fragment and strip Whitelaw of her embodiment, so as to concentrate on what is at her 'core'. She removes her body so as to erase her sense of 'I', which

[104] Whitelaw, p. 120.
[105] Dwan.
[106] Whitelaw, p. 120.
[107] Ibid., pp. 127-28.

resists the restrictions placed upon it in performance. Moreover, the actor must wait for the performance to happen to her, as she sis stripped of her agency to initiate it.

Beckett constricts his actor to the extreme in *Not I*, breaking the body apart and reducing the theatre to a blank, anti-theatrical space. Yet despite this, the body in *Not I* still has ways of speaking up. From the very beginning, Mouth confounds our perception of what a body should be and how that body should operate. Mouth's voice is her body and her mouth affords what LaBelle describes as an:

> [E]ntry onto the complicated weave of language and power, inscription, iteration, by locating speech as part of a greater assemblage where breath and spit, food and vomit, desire and angst, for instance, all stage their particular events to ultimately surround, interrupt, flavour, and support forms of agency and communion.[108]

LaBelle's description of a mouth as an 'assemblage' evokes Mouth in *Not I*. Mouth has a memory of her own, which is articulated through both her language, and also the processes centred in this mouth. LaBelle sees the voice as a subject. Just as the mouth is a space in which such bodily matter can assemble, it is also part of that matter so that the voice has some agency and some identity of its own.[109] And yet, while the mouth and the voice are bound up in their embodiment and the subject through which they articulate themselves, the voice is also alienated through performance.

By creating a distance or dislocation between the speaker and what is said, be it dramaturgical (as for the actor) or psychological (as for Mouth), the staging of *Not I* makes us question the validity of what is said and the agendas driving what is articulated. This confusion between articulation and expectations can be likened to the troubles of the clinical encounter in which listening is interrupted by the differing, and at times conflicting, agendas of the speaker (the patient) and the listener (the clinician). Indeed, patients as listeners may be inhibited from listening in to themselves in a clinical context, as their body is made curiously absent, on behalf of clinical narratives. Moreover, the actor's performance is reflective of the performance of the patient in illness, and the words spoken are characteristic of an inner scream while simultaneously belonging to someone else. Dwan writes that:

> Only a few of us know what it is to hang in that darkness, terrified and alone till the curtain opens to let in the laser of light that fires the mouth

[108] LaBelle, p. 2.
[109] LaBelle, p. 5.

> and then to speak so fast you can't think and think so fast you can't speak … yet speak she must.[110]

Dwan performs the role of an ill subject, but in performing Beckett's works, she herself is patient-like. Both the character and actor are plunged into the darkness of illness, whose isolation is only interrupted by the misunderstanding bright lights in the theatre. Beckett's works do not only offer representations of illness, they also appear to induce it. The theatre becomes a clinical stage, which reveals the narratives of voice-hearing, while highlighting the limitations of the language available to the voice-hearer to describe her experience. This clinical stage can quite literally play out the relationships between voices and bodies in space, to manipulate that sense of inside and outside within the theatre itself.

In her autobiography, *Billie Whitelaw… Who He?* Whitelaw narrates her experience of *Not I*, alongside her son Matthew's painful experience of meningitis. On her first reading of *Not I*, Whitelaw writes, 'in the outpourings I recognised my own inner scream which I'd been sitting on ever since Matthew's illness began.'[111] For those surrounding the patient, this scream and isolation is felt in ways which are akin to the patient, and yet they look in from the outside, trying to listen in to the experiences of those who are suffering. While it may be true that only a few actors know the feeling of the light on one's mouth, the body's compulsion to speak-up and sound-out, and its demand on the subject to listen in is familiar to those who experience AVHs.

If one of the challenges of the clinical encounter is the uneven distribution of power between interested parties, Beckett's *Not I* demonstrates the patient's urgency and terror in the narrative she puts forward. The rise of the HVM is a reaction to this and thus, Beckett's *Not I* augments the performativity of the self, portraying the body as a conduit for the myriad voices which take precedence over one another in the clinical context. In *Not I* the voices are at once a torturer and a calmative. LaBelle writes:

> [W]e know well how the voice is already an expanded geography pricked by an entire constellation of psychosocial, sexual, and linguistic elements, which would suggest that the mouth equally starts and ends where our relationships take us. In this regard, the mouth is *all through our body* […] Hearing voices within may assist in finding the words, but it may also unsettle the clear delineations that mark us as subjects; the inner voice always threatens to expose the central truth of individuality, as one of fragmentation [italics in original].[112]

[110] Dwan.
[111] Whitelaw, p. 116.
[112] LaBelle, p. 91.

The 'truth of individuality' is one of fragmentation, but I argue that it is also one of dialogue. Identity is not only constructed by voices that come from and through the body, but also voices that connect bodies to one another. What the voice and the mouth expose, is the liminality of the body in overt and inner articulation. The question of how the subject uses this multitude of voices, as a way of understanding the self, is rooted in the function of inner speech and the way we tell stories.

Self-talk

According to Frank, 'stories do not simply describe the self; they are the self's medium of being.'[113] We exist in, and because of, our stories. While the quality of one's existence is open to question for characters such as Mouth, the story she tells is nevertheless a narrative of being. This story is both monologic and dialogic. Monologic in the sense that it is her story performed into a void, and dialogic as she interacts with and responds to the voice she produces. In *Footfalls*, Beckett intertwines the monologues and dialogues of May and her mother. Divided into three separate narratives the first offers a sparse dialogue between May and her mother, taking place on- and offstage. In the second, May's offstage mother tells the story of her daughter's unending pacing in the hall. In the final narrative, May re-enacts a dialogue between a character, which he calls Amy and Amy's unnamed mother. The story May tells appears to mirror the interactions between May and her mother, which were depicted in the first and second parts of the play. May's autobiographical and dialogic monologue illustrates the characteristics of functional and necessary inner auditory dialogue. May uses storytelling as a means to construct the story of herself, through the dialogic characterisation of Amy and her mother. This is not a series of uncontrollable voices, but rather voices that are controlled and brought about by May herself.

What are we doing when we talk to ourselves?[114] To answer this seemingly simple question, others must be asked. Fernyhough and Alderson-Day pose similar questions in their research on the role of inner speech, inner talk and voice-hearing. They have also investigated the ways in which these phenomena are experienced phenomenologically.[115] In this section, I want to determine the distinctions between

[113] Frank, *Wounded Storyteller*, p. 53.
[114] Recent research has shown that many people hear voices. Many people who hear voices have not previously received any kind of psychiatric diagnosis: 17 per cent of individuals questioned on voice-hearing in Woods et al.'s 2015 survey (see Woods et al. 2015, 328).
[115] Both Fernyhough (PI and Co-Director) and Alderson-Day (Co-Investigator) form part of the Hearing The Voice research project, funded by the Strategic Award from the Wellcome and the Wellcome Trust Collaborative Award in Humanities and Social Science. Fernyhough and Woods at Durham University lead the project. See www.hearingthevoice.org.

auditory phenomena and inner talk. Fernyhough and Alderson-Day posit that inner speech is functional, operating as a form of running commentary to one's actions, so as to guide the completion of tasks and moderate one's behaviour.[116] Inner speech aids metacognition, by offering a linguistic way in which to think about our own process of thinking. Alderson-Day and Fernyhough frame this form of processing in linguistic and verbal terms, for fear of making too simplistic or crude a comparison to the broad and non-specific term 'thinking'. Inner-speech provides a more concrete definition for what they define as form of conscious and linguistically grounded thought. Beyond its linguistic basis, Fernyhough likens inner speech to overt speech and talk.[117] The dialogic qualities that are embedded in inner speech are referred to as dialogic thinking, which Fernyhough defines 'as delimiting a class of cognitive processes in which the thinker flexibly makes use of simultaneously held, multiple perspectives on reality.'[118] It is this ability to adopt multiple perspectives on reality that enables our own understanding of ourselves.

Inner speech and dialogic thinking are not only vital to storytelling, they are also integral to the creative process.[119] There is a reciprocal relationship, then, between the understanding of inner speech and the analysis of literary texts. According to Fernyhough, we are all voice-hearers. Through the representation of agents, the subject builds characters with whom to engage in dialogic power relations: the writer and her characters, the clinician and her patients. These voices become a text that is to be read, so that by considering inner speech as a functional process, rather than dysfunctional, as has been explored previously in this chapter, we can begin to understand the ways in which it aids storytelling and the role it plays in the conception of the self. This self is conceived through stories and these stories inevitably shift and change over time, no more so than during illness. Using Frank's reading of storytelling in illness, *Footfalls* can become a lens through which to view the patient and her story. In *Footfalls*, the characters are compelled to tell and listen to stories, as they enact a form of call and response between storyteller and listener: for May and her offstage mother, and for Amy and her mother in the story that May tells.

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[116] Alderson-Day and Fernyhough, p. 931.

[117] Citing the Vygotskian view of inner speech as a development of overt speech, Fernyhough claims that the dialogic or verbal nature of inner speech is necessary and understandable. Fernyhough writes that overt speech is increasingly forced 'underground' as children develop and as it is drawn inward it is semantically transformed. Vygotsky referred to this truncated form of overt speech as 'private speech' (Fernyhough 2015, 46-59). See Chapter Two for further discussion on the cognitive functions of inner speech.

[118] Fernyhough, *The Voices Within*, p. 45.

[119] As I cited in Chapter Two, Fernyhough refers to Beckett's *The Unnamable* as an example of a literary text that has 'the power to elicit inner speech and get us sounding-out its voices' (Fernyhough 2016, 97).

In *Footfalls*, the stories being told belong to the narrators and their listeners at the same time. Similarly, in the clinic stories are told and listened to collectively, so that the story belongs to both. Charon describes this phenomenon within the clinical encounter as narrative reciprocity. Narrative reciprocity, she writes, enables:

> [S]hared decision-making and patient autonomy. It might open the door to mutual acknowledgement of the value of each participant's beliefs and habits. It might appear as a humble realization that no one understands what health is and a concurrent welcoming curiosity about one another's conception of how the body and speech and mind work.[120]

Like Charon's co-constructed narratives that I explored in Chapter Two, 'narrative reciprocity' is difficult to achieve. Storytelling and sharing stories offers no such reassurance and resolution for Beckett's characters. It seems that the primary challenge for Beckett's narrators in *Footfalls* is to remain within their own stories. The stories May tells echo rather than assert. This storytelling is not powerful, nor is it easy for May to hear her story. May, like many of Beckett's other characters (such as Mouth), is unable to listen to her own story and the stories told about her. Her insistence in telling the story of Amy is a way of constructing a version of herself and her mother for the listener. It is a failure to identify with her story and a refusal to listen in.

As I showed with the HVM, therapy is aided by the collective listening in to the experiences of voice-hearers, by other voice-hearers. 'Listening', 'acknowledging' and 'accepting' are words that feature throughout the writings on hearing-voices and various cognitive approaches to therapy. The recovery approach is a process 'of turning points' as Romme puts it.[121] It is storytelling, the telling of one's *own* story, that functions as an instrument of healing, and in each instance the storytelling operates as a means of asserting agency beyond performing the role of patient. Frank writes that in seeking medical care, patients have been forced to undergo a '*narrative surrender* [italics in original]', so that their story no longer belongs to them, but rather is framed in medical narratives and charts, which become the 'official story of their illness.'[122] The HVM is a direct retaliation against an 'official' medicalised narrative and is an attempt by the voice-hearing community to reclaim and construct its own narratives. Within the clinical context, the 'official' story of a patient's illness no longer belongs to her, and it also remains static, so that it is unable to reflect the changes in the patient's experience of that illness. The story becomes a fixed lens through which to view that patient.

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[120] Charon, 'Narrative Reciprocity', p. 22.
[121] Romme et al, p. 9.
[122] Frank, *Wounded Storyteller*, pp. 6, 5.

Stories, then, become increasingly restrictive as their repetition renders them meaningless and much the same might be said for the stories that May relates in *Footfalls*. Indeed, repetition in *Footfalls* dissolves the characters rather than asserting them. *Footfalls* is the story of women: May, and her elderly mother. It is also the story of another unseen mother and her daughter Amy, both of whom are narrated by May, who remains the only character on stage. May is a fading figure from the very beginning. Set on a dimly lit stage, whose light continues to recede, May's story similarly diminishes over time.

Beckett's influence for *Footfalls* can be traced to his attending a lecture, delivered by Carl Jung at the Tavistock Clinic in 1935. In the lecture, Jung recounted the story of a young female patient who he claimed he was unable to help, because 'she was not actually living'.[123] Maddy Rooney in *All That Fall* recollects a similar experience of a lecture in which a patient is described: 'the trouble with her was she had never really been born!'[124] Furthermore, in *Footfalls*, May's mother (the voice offstage) makes reference to May's own beginnings in the second part of the play: '[w]here is she it may be asked. [*Pause*.] Why, in the old home, the same where she — [*Pause*.] The same where she began. [*Pause*.] Where it began [*Pause*.] It all began. [*Pause*.] But this, this, when did this begin?'[125] Indeed Beckett's use of 'it' and 'this', suggest a life that has never really begun, and thus can never really have been lived. S.E. Gontarski writes that 'the character we see on stage and whose footfalls we hear — at least, according to Beckett, during the mother's monologue in the second part — does not exist.'[126] Characters are spoken of but they are not there; a theme that continues throughout *Footfalls*. Gontarski's question of whether or not May and her mother are real, is, in many ways, irrelevant to my reading of *Footfalls*. What is important is that storytelling continues to take place as an attempt to bring subjects into being, and the theatre is contingent on the staging of dialogue. The subject is absolutely reliant upon her inner dialogue and her ability to tell stories as a means of asserting agency. It is, then, the clinical encounter that threatens one's ability to do so.

Problematic beginnings abound in Beckett's work, as we have seen with Mouth who has been born too soon, brought 'out… into this world… this world… tiny little thing… before its time'.[127] Others have been born in the wrong place, or even have

[123] S.E. Gontarski, *The Intent of Undoing in Samuel Beckett's Dramatic Texts* (Bloomington: Indiana University Press, 1985), p.162.
[124] Beckett, *Complete Dramatic Works*, p. 196.
[125] Ibid., p. 401.
[126] Gontarski, p. 162.
[127] Beckett, *Complete Dramatic Works*, p. 376.

'never really been born'.[128] To tell, or to be told a story, is itself a beginning, and that call for a beginning initiates a story. Frank claims that illness is a call for stories and that within the telling of the story: 'self-story is told both to others and to one's self; each telling is enfolded within the other. The act of telling is a dual reaffirmation. Relationships with others are reaffirmed, and the self is reaffirmed.'[129] In this sense, storytelling is a process of liberation and affirmation, and yet no such restorative opportunities seem available to May. Instead, storytelling imprisons May as she continues 'revolving it all', her footsteps enacting a call and response to one another culminating in a 'wheel' that begins the whole sequence once again.[130]

Footfalls consists of echoes that form the basis for the structure of the play, and Katharine Worth writes that the play is, 'so artful that we are never able to know for certain who is listening to whom and in what dimension of reality. Hearing is presented as a conscious need for which special preparation has to be made.'[131] This is again a question of not only what we listen to, but also how we listen to it and in what spaces it is sounded out. The way that we listen to patient-stories is similarly guided by the context in which they are heard and the clinical story is one that can inhibit patient agency. *Footfalls* makes the audience aware of the importance of listening most notably in part two, as May's mother relates the story of how May insists on hearing as well as watching her footfalls. Seeing, it seems, is not enough and she must become more than a visual spectacle. May's mother narrates:

> May: I mean, Mother, that I must hear the feet, however faint they fall. The mother: The motion alone is not enough? May: No, Mother, the motion alone is not enough, I must hear the feet, however faint they fall.[132]

This imagined or recounted dialogue between May and her Mother is only performed in so far as it is heard. Traditional notions of dialogue are rejected throughout Beckett's later dramas. Catharina Wulf claims that Beckett's televisual works are bound to an 'aesthetics of reduction and condensation', which looks back to his famous 1937

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[128] Matthew Feldman writes: 'Of course, such uterine tropes abound across Beckett's texts, from Belaqua's pleasantly purgatorial 'wombtomb' in *Dream of Fair to Middling Women* and Jung's 'never properly been born' in the Appendix to *Watt*, to Mrs Rooney's 'The trouble with her was she had never really been born!' in *All That Fall*. Beckett's first entry from [Otto] Rank also has fascinating resonances with the desire for company and the darkened, embryonic condition of the narrator in *Company*' (2006, 107).
[129] Frank, *Wounded Storyteller*, p. 56.
[130] Beckett, *Complete Dramatic Works*, pp. 400-01.
[131] Katharine Worth, 'Beckett's Auditors: *Not I* and *Ohio Impromptu*', in *Beckett at 80/Beckett in Context*, ed. by Enoch Brater (Oxford: Oxford University Press, 1986), pp. 168-92 (p. 184).
[132] Beckett, *Complete Dramatic Works*, p. 401.

German Letter to Axel Kaun.[133] These aesthetics most certainly extend beyond Beckett's work for the television. Furthermore, in *Footfalls*, he creates a stage on which to play out his distilled dialogue between subjects. The gradual removal of colour from the stage and performance, as well as the narrowing of sensory experience, strips Beckett's characters of any agency within their various barren environs.[134] So while Fernyhough believes that 'central to our ability to engage in dialogue is our use of language to describe the world for ourselves as agents — that is, to represent our intentional relations to (our perspective on) reality', Beckett's work precisely problematizes this assumption.[135] He uses the very aspects of dialogic inner talk and the patterns of storytelling to do so, so that the process of storytelling as a dialogue is, instead, shown as a struggle for power between the voices that have been created. If the role of inner speech and self-talk, is to regulate and to internalise that which need no longer operate externally, what *Footfalls* shows is that May's mind and the story of May and her mother cannot be contained. While we might try to draw speech inwards to give it order, we cannot take it all in ourselves and instead the story takes over.

The process of storytelling in *Footfalls* both creates and undoes its characters. The environment in which the characters are staged persistently tries to undo May, Amy and both their mothers, and the stories themselves do little to support any concrete sense of identity. Yet May's commitment to storytelling in the face of a fading voice is palpable. Regardless of the efficacy of the narrative being told, inner speech enacts the very agency, which Frank claims is lost in the medical narrative. Whether the narrative is meaningful or not, it is nevertheless a sound that is articulated in the context of other sounds, which as Mladen Dolar writes, 'appears to be endowed in itself with the will to 'say something,' with an inner intentionality.'[136]

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[133] Catharina Wulf and Alan English, 'Introduction', *Samuel Beckett Today / Aujourd'hui*, The Savage Eye / L'oeil Fauve: New Essays on Samuel Beckett's Television Plays, 4 (1995), 1–14, (p. 2).

[134] While the structure of my thesis is largely determined by Beckett's formal choices, it is important to note that changes in Beckett's form can be understood within the context of his work. An increasing movement towards abstraction, as I have claimed, in part fuels the distillation of his form. Abstraction has been a useful critical concept, albeit not one that Beckett himself preferred. Erik Tonning writes, 'Beckett did not think of his work in terms of 'abstraction'. Neither did he take a particular interest in 'abstract' art *per se*' (2007, 13). Yet, as Gontarski claims, from *Play* onwards, Beckett continued towards a pared down and more sparse aesthetic in his later drama (Gontarski 1997, 94). Patterns seem to emerge from *Play* onwards which suggest that Beckett's work becomes increasingly focused upon the fragmentation of bodies and, furthermore, the separation of the body and language while maintaining an emphasis upon the voice which, as Mladen Dolar writes, connects them (2010, 53).

[135] Charles Fernyhough, 'Dialogic Thinking', in *Private Speech, Executive Functioning, and the Verbal Development of Verbal Self-Regulation*, ed. by Adam Winsler, Charles Fernyhough, and Ignacio Monetro (Cambridge: Cambridge University Press, 2009), pp.442-52 (p. 43).

[136] Mladen Dolar, 'The Linguistics of the Voice', in *The Sound Studies Reader*, ed. by Sterne, pp. 539-54 (p. 540).

Controlling Voices

Beckett's characters in his late drama are bound to the voices they hear and create. The connections between those voices, as I have shown, are often tenuous or tempestuous. In the final section of this chapter, I explore how the power dynamics between voices, in *Ohio Impromptu*, are placed in a state of flux from one character and space to the next.

Ohio Impromptu stages the difficulties of listening in as symptomatic of institutional practises. Listening in can be read through *Ohio Impromptu* as a representation of how listening takes place in both the performative space of the clinic and the theatre. Where specific voices may have appeared in dialogue with one another in the other works discussed in this chapter, Beckett's *Ohio Impromptu* introduces tensions, which can be read so as to explore clinical care and the role of the clinician within the institute. Where patient-centred care has become increasingly important in the study of medical humanities and medical ethics, it is imperative to consider the role of the organisation that contains multiples voices and hierarchies that vie for power over one another, in order to determine the influence this has on performance.

'As alike in appearance as possible', Reader and Listener in *Ohio Impromptu* compete for power over one another.[137] Both characters function as allegorical archetypes, defined by what they do: one reads, the other listens. Like Mouth and Auditor, the subject appears to have been split apart. In the case of *Ohio Impromptu*, however, it is the roles that have been split instead of individualised body parts. Indeed, the body here has been doubled. While each character fulfils a different role, they are a reflection of one another, similar to the echoes of characterisation that I explored in *Footfalls*. Heidegger describes our being, in relation to others, as: 'a projection of one's own being toward oneself 'into an other.' The other is a duplicate [dublette] of the self.'[138] Reader and Listener function as dublettes and their separation from one another is vital to their encounter within the play. Here, I want to explore Reader and Listener's coupling as a model for reading the relationship between the patient and clinician, and also between the clinician and the healthcare system more broadly.

It could be assumed that Listener is the one in control, playing the role of clinician within this encounter with Reader. Nancy writes that the listener is forever 'straining toward a possible meaning,' and in so doing, she seeks to define or diagnose.[139] In much

[137] Beckett, *Complete Dramatic Works*, p. 445.
[138] Martin Heidegger, *Being and Time*, trans. by Joan Stanbaugh (Albany: State University of New York Press, 2010), p. 121.
[139] Nancy, p. 6.

the same way as the clinician's method of history-taking guides the narrative of a patient, Listener's repeated knocks on the table appear to direct the path of the story. The knocks on the table are scripted, as they guide the Reader's reading forward, but they are also evidence that Listener is registering what Reader reads. With his head bowed, not looking at Reader, Listener sounds-out his listening in knocks: listening makes a sound. These knocks seem to dictate the significance of the story that Listener hears, but Listener also appears to seek out the meaning of the story through them. As I showed in the opening of Chapter Three, the sound of a doctor's typing in the consultation may be a sign that she is listening to her patient, but it may also be distracting for the patient who is trying to speak to the clinician that is turned away from her and is otherwise engaged. Moreover, the ways in which the story is told and the questions that are asked in the consultation, as I argued in Chapter Three, might close off other opportunities to communicate outside of a medicalised narrative framework. Here, however, I want to explore the limitations that this framework may have on the clinician as well as the patient. History-taking, in its most traditional sense, can be seen as just as prescriptive for the clinician as it is for the patient. Nancy writes:

> When one is listening, one is on the lookout for a subject, something (itself) that identifies *itself* by resonating from self to self, in itself and for itself, hence outside of itself, at once the same as and other than itself, one in the echo of the other, and this echo is the very sound of its sense [italics in original].[140]

The echo from one subject to another is well illustrated through Beckett's use of the double (or Doppelgänger), and through this coupling Beckett complicates the origin of the narrative and the narrative voice. Other examples in Beckett's work include the voices that Listener listens to in *That Time* (1974) and the phantoms, Bam, Bem, Bim and Bom, in *What Where*. With Reader and Listener as the visual and aural echo of each other, the power which seems to have been ascribed to Listener (through his knocks) is easily undone, as Reader tells the story of a powerless, inert auditor: Listener. Reader reads:

> One night as he sat trembling head in hands from head to foot a man appeared to him and said, I have been sent by — and here he named the dear name — to comfort you. […]
> Some time later he appeared again at the same hour with the same volume and this time without preamble […]

[140] Nancy, p. 9.

> Finally he said, I have had word from — and here he named the dear name — that I shall not come again. I saw the dear face and I heard the unspoken words, No need to go to him again, even were it in your power.[141]

To say nothing at first of what is read to Listener, it is important to acknowledge that Reader reads. The written word is a record and as Reader reads from the book, the book and its contents become a character. Moreover, as the story is read from a book, the audience understands that this is a narrative, which has been told previously, as it has been written down. The audience, like Reader and Listener, are witnessing a story revisited.

Ohio Impromptu tells the story of a carer of sorts (perhaps Reader), who has been asked to read to a character, much like Listener. Reader's story reveals that the care offered to Listener is to be taken away, and so while the Listener appears to have lost control over the narrative and its outcomes, Reader is equally powerless in the story he reads. The decision to end these visits has been made by an unknown authority whose only presence is manifest in the book. As in the clinical encounter, the written word becomes the key reference point that is consistently deferred to, and is considered to be the accurate account of what has taken place and what should take place in the future.

The reference to 'the dear name' of a third party in the excerpt above suggests that 'the dear name' is the very character that maintains control over the narrative. '[D]ear name' might be thought of, not so much as a person, but rather as an institution or encounter: an institutional body that has both sent Reader to Listener and has later called an end to these visits. The book offers a pre-scripted account of these meetings as well as a message of their ending — separating Reader from Listener, or carer from patient — and it is the scripting of this encounter which makes listening to it, and the ability to adapt to events, impossible for both Reader and Listener. *Ohio Impromptu*'s staging of the power the environment has over Reader and Listener's relationship offers an analogous view of the clinical institute that determines what kind of care is delivered. Neither Listener nor Reader possesses power, and instead, it is the institution (and the environment in which this institution operates) that has agency.

Within a clinical context, the healthcare system underlies the approach to care offered to patients and this care is affected by aspects such as funding, government policy, law, professional education and training, etc. Care cannot happen in isolation between patient and practitioner, but instead relies upon interactions within a network of

[141] Beckett, *Complete Dramatic Works*, p. 447.

people and systems, so as to operate reciprocally. Care, in this regard, is not only a matter of diagnosis and treatment, but also of interpersonal communication. Reciprocal care, it can be argued is based upon the exchanging of narratives. Charon writes that narrative reciprocity in clinical care offers:

> [A] radical alternative to the framework of unequal power or resources. The ethos of reciprocity frees us from the dilemma of 'for whose good?' […] one conceptualizes all participants as givers and receivers, as each having a fundamental stake in and contribution to the engagement and each having a means of fundamental growth by virtue of the process. A radical reciprocity illuminates and helps one to navigate the deadly shoals of cultural superiority, beholdedness to deep pockets, imperialism in its many guises, the use of others, the 1 percent.[142]

Listener and Reader's relationship denies the reciprocity which might have helped to reconcile the differing agendas of the two. Put another way, Listener and Reader fail to collectively resist the institutional body that has control over them both. The agendas of Reader, Listener and 'the dear name' — and what they deem to be appropriate care — are at odds with one another. Just like healthcare professionals and healthcare systems, they differ in their approach. In real terms, central organisation and funding for patient-led groups and social models of care (such as the HVM) takes place predominantly within the charity sector, which means that while these models enable a certain level of autonomy, it is evident that groups such as this do not necessarily fall within the remit of national or state-led healthcare systems. Ultimately, the integration of social and clinical models of care appears particularly challenging within this institutional framework. Charon writes of her commitment to 'beholdedness' in the clinical encounter: 'to behold and to separate the beholding from the acting', and by pausing she is able to listen to her patients in a way that guides the reciprocal nature of her clinical practice. The challenge appears to be to both resist the compulsion to act and to navigate the constraints of the clinical context upon the clinician.

In order to understand and address the different performances and power imbalances, we need to appreciate the multitude of voices at play within any single clinical encounter and acknowledge their heterogeneous nature. Such heterogeneity is problematic within a single system context, and even more so when we consider the differences between healthcare systems globally. It is important to note that Charon writes from a specifically North American perspective. The performance of medicine in this context is for a paying 'customer' and, as such, the dynamic between doctor and

[142] Charon, 'Narrative Reciprocity', p. 23.

patient is markedly different to that of doctors and patients within the UK's NHS. The clinician is there to serve, and yet the immediate cost associated with her services perhaps offers with it a certain status, which may not be as evident in healthcare systems such as the NHS.[143] In an attempt to address the difficulty of power and the restrictions of many clinical models of care at the level of doctor/patient encounter, Rita Charon and Martha Montello employ a narrative approach to medical ethics, which they believe:

> Recognize[s] that the singular case emerges only in the act of narrating it, and that duties are incurred in the act of hearing it. How the patient tells of illness, how the doctor or ethicist represents it in words, who listens as the intern presents at rounds, what the audience is being moved to feel or think — all these narrative dimensions of health care are of profound and defining importance in ethics and patient care.[144]

Charon and Montello's solution exposes the multiplicity of narrative voices that create the clinical encounter, and, moreover, emphasises the importance of listening to these narratives. The clinician must do her best to attend in the clinical interview.[145] Illness is understood, not only through telling but also representation. As I have shown throughout this thesis, for those with language disorders or those who hear voices, the expression of a narrative is in itself a challenge, to say nothing of the inherent difficulties associated with the clinical 'deficit model of mental-illness'.[146] Moreover, as I argued in Chapter One, it cannot always be assumed that constructing a narrative is easy, even in non-pathological cases and contexts. As Woods writes and as I explored in Chapter Two, while the medical humanities has looked towards narrative medicine as the means by which to foster better communication between doctors and patients, there is a danger in presuming that narrative is the most 'natural' or 'authentic' mode of expression available to the subject.[147] While voice-hearers and those with language disorders might appear to be different because of their diagnosis, they are in fact located in a continuum with all subjects. Exploring the experiences of these subjects and the particular problems they face within clinical encounters is important, crucially because they should be witnessed and attended to, but it also opens up a discussion about care at all levels, and for all subjects. The construction of a narrative is, as I argued in Chapter One, culturally, socially and temporally constituted. Here, my claim is that the notion of

[143] See Chapter One, in which the UK healthcare system context is explored further.
[144] Charon and Montello, 'Introduction', in *Stories Matter*, ed. by Charon and Montello, p. ix.
[145] Charon, 'Narrative Reciprocity', p. 22.
[146] Romme et al, p. i.
[147] Woods, 'Post-Narrative: An Appeal', p. 402.

a normative and stable subject cannot be realised, nor can subjectivity and storytelling be examined in isolation.

The narrative dimensions of healthcare, Charon emphasises, must be rendered through the clinician's reflections. However, by doing so, the way that the patient's experience is shared and subsequently retold is fundamentally shaped by the presence of the clinician within the encounter and the choices that the clinician makes when she come to represent the patient's narrative. Charon's writing is not produced in order to diagnose the patient, but rather to reflect upon the patient's narrative and Charon's own interpretation of it. This self-reflexive process takes place in addition to the co-constructed notes the doctor and patient create together that I examined in Chapter Two. Writing plays a vital role for Charon in shaping her impressions of her patients and the clinical encounter, and also offers insight into the impact the encounter has had upon her personally. Recounting a long-standing relationship with a patient and the patient's husband, Charon says that, 'writing functioned as a self-portrait as well as a clinical portrait of the three of us.'[148] It seems then, that writing is both descriptive and prescriptive. The concern is that once the written word has been produced, it remains static and yet has the power to dictate the subsequent actions that are taken within clinical contexts. Patients' notes are not written for the patients to read them.

The relationship between reading, listening and writing in *Ohio Impromptu* is demonstrative of these complexities. In one sense it appears as though Listener is directing the narrative with his knocks, yet these knocks only ever elicit repetitions from Reader. Listener's knocks might thus be read as his attempt at offering a different story to the one that is being told, but if this is the case Reader is unable to offer, or indeed create, an alternative. Within the framework in which Reader and Listener are placed, Reader only has one story to offer. The written narrative binds both the reader and the listener. Listener's knocks can be seen as representative of a patient's struggle for autonomy when trying to navigate the medicalised narrative of his own experience, which is being read back to him. The reader who revisits the written word so as to impart the unseen writer's message, struggles in the same way as Listener, who is trying to decipher the instructions that have been written down. Power lies with the written word alone, which represents the institute. As this documentation may have been created at a particular time within the clinical encounter, or just after it, it now represents both patient and clinician across all time. Poirier addresses the restrictions of the medical narrative, highlighting its failure to represent the chronicity of the patient.

[148] Charon, 'Narrative Reciprocity', p. 22.

While the patient's experience might change, 'the narrative voice that tells the tale at rounds will remain virtually unchanged, implying a continuity and a consensus that may not truly exist.'[149] There is thus an inevitable tension arising between the need for clarity in clinical practice and the problem of patient representation. As the story of the patient is repeated over time, it becomes increasingly irrelevant to the present experience of that patient. Moreover, there is no present for the listener to listen to. Both the clinician and the patient's present are stalled by the consistent recounting of the past.

Beckett's work replicates narratives and characters, not only intertextually but also by repeating sequences within a single work. As with *Eh Joe*, *Not I*, *Footfalls* and also O*hio Impromptu*, the audience bears witness to a story that has already begun and continues to be repeated. Looking beyond the use of repetition as a plot device, theatre productions are also repeated, as I explored in Chapter One through my analysis of *Catastrophe*. The fact that a play is repeated also draws attention to the existence of the work across multiple times and spaces. The false continuity of clinical narrative to which Poirier refers, need not be thought of in terms of the continuity of plot, but rather of form. Beckett's use of repetition within the inherently repetitious theatre evokes the healthcare system in which repetition embeds narratives within a clinical context specifically designed to be repeatable. Each act of storytelling is unique since its players, location, time and interpretations govern it, and the clinical setting would appear to be no different. Viewing the clinic as a repeatable model, however, negates the heterogeneity of the encounters it may be subject to, through the very infrastructure of the clinic. Be it a script, a story read aloud, or a history taken from a patient, both theatre and clinic rely upon the triangulation of reader, listener and writer. *Ohio Impromptu* offers a theatrical space to stage the formal constraints placed upon medicine, where controlling voices are in turn controlled by the institution with which they interact, and the subjects who listen to them.

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In this chapter, I have explored power. The power exchanges and imbalances between subjects and institutions have formed and, in turn, are formed by communities. These communities, like 'the community of speakers' that Butler describes, consist of multiple subjects and their speech and the situations in which they speak cannot be 'defined easily by their spatial and temporal boundaries.'[150] To speak is to sound-out, but, as I

[149] Poirier, 'Voice in the Medical Narrative', in *Stories Matter,* ed. by Charon and Montello, pp. 41-58 (p. 51).
[150] Butler, *Excitable Speech*, p. 4.

have shown, sounding out also requires listening in, acted out so as to embed the narratives and cross-cultural and temporal contexts out of which the narrative is born. For the listeners and speakers in Beckett's late drama a community has been created, even if it is not experienced as one. Each listener and each speaker invokes a community, which informs both their listening (or refusal to listen) and their speaking.

I began this chapter by claiming that listening is both an aural and spatial act. I conclude here with the qualification that the spatiality and aurality of listening has the ability to cross boundaries between subjects, between institutions and between communities. This context (or community) is imperative to the process of listening. In the four plays I have explored here, beginning with the teleplay *Eh Joe* and concluding with *Ohio Impromptu*, I cover an almost twenty-year period in Beckett's career, illustrating how the dynamics created between listeners, speakers and readers continued to offer Beckett an opportunity to stage listening as a consistently problematic process.[151] My exploration of listening within the clinical context has proven to be similarly complex, especially for those subjects who experience unusual auditory phenomena, such as hearing-voices. These voices, at once invasive and overlooked, encroach on the listener precisely because they are rejected.

The rejection of voices and the refusal on the part of voice-hearers and clinicians to listen in appears to be born from a clinical context that overlooks the complexity of the clinical encounter, so as to diagnose and endeavour to cure. This process unfolds as a form of Butlerian 'injurious speech'. The injurious speech act is elicited by a context, which gives rise to it at the same time as maintaining and reinforcing that context. For the patient, the voice-hearer, the clinician and the healthcare system, what is listened to has already been constructed before it is uttered. As Butler says of hate speech: 'The speaker who utters the racial slur is thus citing that slur, making linguistic community with a history of speakers.'[152] These communities take place and interact across time, drawing on the tropes of past speech acts, and embedding them further through repetition. It is here where Beckett's works can be used to examine the problems of power in the clinic. As I said at the close of the final section of this chapter, it is the repeatability and, moreover, the construction of the clinical encounter and theatrical

[151] As I have already noted, the trajectory of Beckett's writing moves toward abstraction, and yet as Enoch Brater writes, the reduction of the stage and the fragmentation of the body, heightens the intensity of the spectacle (1987, 18). Moreover, referring to *Not I*, Brater claims that '[i]n the theatre, Beckett makes us desperately conscious of the agonizing limitations of seeing, hearing and speaking. Yet before *Not I* such constraints never seemed so theatrically enticing' (Brater 1987, 35). With a move toward abstraction, Beckett is thus able to intensify the theatricality of his work and alert the audience to the limitations of those elements that are vital to the success of theatre and the conditions on which it depends.

[152] Butler, *Excitable Speech*, p. 52.

performance as repeatable models which, while transcending both temporal and spatial boundaries, do not account for the heterogeneity of contexts and subjects faced, be they audience members or patients. The collectivisation of voice-hearers into a pathologised group is precisely what I hope to turn away from, so as to attend to what is seen and most importantly heard.

Beckett's work takes place on both the inside and the outside of the subject. Just as Whitelaw recalls in the quotation used to open this chapter, 'the audience had to be sucked into this rioting, rambling hole' of the performance.[153] The inside and the outside of this hole, and what is pushed out of it into the audience (and into the clinic) may in fact need to be considered from the inside, so as to locate the site at which speech is formed. By doing so, the differences between what is said and what is intended can be reconciled. As Butler writes, 'The disjuncture between utterance and meaning is the condition of possibility for revising the performative, of the performative as the repetition of its prior instance, a repetition that is at once a reformulation.'[154] It is through such reformulations that the opportunity arises to reconfigure the clinical and theatrical space into which we must listen.

[153] Whitelaw, p. 118.
[154] Butler, *Excitable Speech*, p. 87.

Conclusion

> The communication of bodies involves a communication of recognition that transcends the verbal. Bodies commune in touch, in tone, in facial expression and gestural attitude, and in breath. Communication is less a matter of content than of *alignment*: when bodies sense themselves in alignment with others, words make sense in the context of that alignment. When alignment is lacking, even the best semantic content risks misinterpretation or will be unsatisfactory as a message [italics in original].[1]

I began this thesis by claiming that I would examine speaking, listening and power. In closing, I want to return to how these central themes are enacted through a medicalised reading of Samuel Beckett's writing. The epigraph to my conclusion is taken from Frank's seminal work, *The Wounded Storyteller*, a text I have drawn on extensively throughout this thesis to explore the patient experience that is spoken, heard, performed, and compiled within the clinical encounter. Communication is embodied — it 'transcends the verbal' — and my thesis has endeavoured to illustrate the difficulties in aligning bodies in space, across time, and within the institutions in which the ill body finds itself.

'There's the record, closed and final. That's what we're going on,' barks a vexed Morvan in *Rough for Theatre II*, '[t]he client is here and nowhere else.'[2] My thesis has sought out the means by which clinical records and narratives of patient experience are created, and called into question the 'here' where the patient is located, neither of which is 'closed' nor 'final'. Where clinical discourse attempts to fix the patient within a particular location — either in documentation, recordings or time — the identity of patients and the encounters clinicians have with them are far less certain than medicalised approaches to narratives would suggest. The location of the patient cannot be fixed, rather, it is tethered to specific spaces and temporalities. Patient experiences change and patient narratives are consistently mediated through these changes. Through Beckett's writing, I argue, we can achieve a greater understanding of where the patient is made manifest and how this characterisation operates across multiple locations and temporalities.

Within this thesis, Beckett's works have functioned as a form of medical writing. While Beckett's own 'long-standing curiosity about medical matters' offered an entry point, it has been my intention to apply a Beckettian lens to the challenges of the clinic

[1] Frank, *Wounded Storyteller*, pp. 49-50.
[2] Beckett, *Complete Dramatic Works*, p. 246.

in the contemporary moment.[3] I have used Beckett's works as a means by which to answer the challenges of clinical communication in ways not currently addressed by the clinic today. Narrative and listening are central themes within the clinical encounter, and they have been treated as challenges only when the subject's seemingly fluid and able body has been disrupted by illness. I argue that narrative and listening are troubled to begin with. I have studied narrative and listening pathologies in order to reveal that the sense of a normative subject cannot and does not exist.

The first half of this thesis established how narratives are constructed within, and according to, the clinical encounter. Becoming a patient is performative. By entering the clinical space, the subject is given the role of patient and in so doing her identity becomes flattened as she performs a role and adapts her behaviour, language and narratives to suit clinical discourse. 'Narrative,' Charon writes 'by its nature is disruptive', but it can also be harmful when it does not account for the subjective experience of the individual.[4] While narratives may disrupt, they also have the power to fix the individual in a narrative form, which does not reflect the changes in her state and experience. Moreover, within the clinic, narrative is a pathologising force, which reinforces the binary between health and illness and renders the subject passive in her patienthood. Beckett's work troubles this binary by revealing that non-pathological functioning is similarly incomplete and that telling one's story is always difficult.

In the second half of this thesis, I turned to listening and pursued an alternative form of clinical practice that explored Beckett's use of audio technology, to bend an ear towards embodied listening practises that listened more to the sounds the body makes than the content of its expression. Finally, in Chapter Four I argued that clinical discourse on the negative and damaging effects of voice-hearing (as a symptom of pathological mental illness) is so pervasive that it has led to patients rejecting symptoms, which would be managed better if they were properly listened to. Rejecting one's experience of illness leads not only to the patient's isolation, but also to an erasure of patient subjectivity.

My objective, then, has been to answer two central questions: how do we narrate illness and how do we listen to illness? In pursuit of the answers, I have drawn upon works now firmly placed within the medical humanities canon: from Foucault and Sontag, to Frank and Charon. Yet, I have also sought to entangle with them the works of contemporary developmental psychologists such as Alderson-Day and Fernyhough, the

[3] Knowlson, p. 668.
[4] Charon, *Narrative Medicine*, p. 219.

anthropologist Bartra, scholars of psychoanalysis such as Frosh and Brennan, the narratologist Meretoja, philosophers Carel, Heidegger and Nancy, as well as critical and cultural theorists such as Deleuze and Butler. These scholars have enabled me to reflect on and entangle what might at first appear to be two rather simple questions.

Entanglement counters the well understood integrative models of inter-disciplinary study, not only because it insists upon forming new methodologies as opposed to overlaying one existing method onto another, but also because it challenges the scholar to enter into entanglement, so as to discover new questions which may not have been known from the outset. By adopting this approach, this thesis has gone some way to answering the questions of how we narrate and how we listen to illness. It has also raised new questions: how can clinical practice accommodate the liminal body? Furthermore, in what ways do existing healthcare models need to account for the chronic lack of time in consultations, and how can Beckett's work be put to further practical use in medical education and patient advocacy contexts? These are vital and continuing questions that the thesis has only begun to articulate.

Sounding Out – How Do We Narrate Illness?

I have challenged the received notion that it is the symptoms of an illness that are the central disruption to the healthy body. Where it is understood that it is the patient's illness that causes her distress, I argue instead that being forced to engage with the clinic can be just as damaging. Being ill does not simply alter the way the patient experiences her body, it also dramatically affects how that body is shared and communicated with others. In order for communication to be effective, the clinic expects patients to submit to the lexical, narratological and organisational codes of the medical institute.

This thesis builds upon the existing conversations within the medical humanities by challenging first wave approaches to narrative within the field. I have offered answers to and methods whereby the issues raised by an anti-narrative position in the medical humanities can be addressed. I do not advocate casting narrative aside, but rather, reconfiguring our ideas on the forms that a narrative should take in order to be effective in clinical settings. Moreover, I have sought to challenge received binary notions of health and illness by arguing that disorder and in particular disordered language, is endured by all. I have devoted my attention to two specific conditions: AVHs (associated with schizophrenia) and aphasia. While I opened Chapter One with an examination of quest narratives — looking at cancer stories in particular — I have

subsequently focussed on aphasia and AVHs because, unlike the cancer narrative, these conditions/symptoms have not yet been integrated into theoretical works on the narrative-based medicine and resist traditional modes of narrativisation.

In Chapter Two I charted the history of aphasiology to understand how language is used, created and interrupted through neurological damage. Debates during aphasiology's infancy raised important concerns about how to represent the heterogeneity of the condition and furthermore outlined the key divide between practitioners who created visual representations of the brain based upon localisation theories and those neurologists, like Hughlings Jackson, whose understanding of the condition was guided specifically by interactions with patients. It was through his patients that Hughlings Jackson determined that the aphasic subject was not without language, but rather was unable to build language into propositional statements. Language was still available to the subject, but was, seemingly incomplete. Interrupted speech and language may be evidence of disorder, but I argue that all subjects present characteristics that are shared with the aphasic, and that it is the clinic that defines the subject as pathological and disordered.

I define traditional modes of narrativisation as stories told by one subject and listened to by another. These stories have a clear beginning, a concrete present (middle) and an anticipated future (end). In the clinic, narrative fulfils a diagnostic purpose, and yet, the diagnosis is not the end of the story, it is one instance among many that form the spectrum of temporalities experienced and occupied by the ill subject. And if the story does not end at diagnosis, neither does it begin a new story. The experience of illness is multi-chronic. Where narrative is seen as a recuperative tool through which to convey experiences of illness it actually becomes a barrier to it. Beckett's characters have been pathologised by many scholars, showing evidence of illness from mental health to aphasia to dementia and much more, but through my analysis of *The Unnamable* it is the 'normal' functioning body which faces challenges similar to the pathological one. Language always relies on someone or something else in order to happen and the language accessible to the narrator is already shaped by the codes and agendas of other characters. Butler writes that '[l]anguage sustains the body not by bringing it into being or feeding it in a literal way; rather, it is by being interpellated within the terms of language that a certain social existence of the body first becomes possible.'[5] The body can thus only exist within language, and yet the problem remains as to how this language is constructed, and what this language enables or inhibits.

[5] Judith Butler, *Excitable Speech*, p. 5.

Indeed, for the subject who becomes a patient upon entering the clinical space, her language performs her patienthood, as it has been colonized by the clinic.[6] Charon writes that:

> Narrative makes its own paths, breaks its own constraints, undercuts its own partners. As it does in dreams or in Beckett, narrative anywhere can make new out of old, creating chaos out of linearity while, subversively, exposing underlying fresh connections among the seemingly unrelated. Not only through its ordering impulses but also through its *disordering* ones, narrative can help one see newly for the first time something concealed, something overlaid, something buried in code [italics in original].[7]

If narrative has both ordering and disordering impulses, I have challenged our understanding of what ordered and disordered mean to the clinic and Beckett, and determine that this dichotomy is productive to the study of both. From the very beginning of Beckett's literary career it was failure that interested him most, and his own experiences of illness and psychosomatic symptoms guided both his creative output and scholarly pursuits. Writing and learning were born from a disordered mind and body. Yet writing and research seems to have failed Beckett; it did not uncover what Charon sees as concealed, overlaid and buried in code. Narrative did not provide clarity.

To return to Beckett's 1937 letter to Axel Kaun, the veil of language, behind which sits either 'those things (or the nothingness)', was never torn apart.[8] Instead, his search for a cure for his symptoms seemed only to harden the veil. The things and nothingness which seep out from the veil are not language which offers a new narrative, but rather *more* narrative. Written so early on in Beckett's career, this letter is now read as a manifesto of sorts, or rather the articulation of the hitherto frustrated and confused approach to his writing. While Beckett remains confused and frustrated in this letter, insisting to Kaun that 'an answer is requested', Beckett seems, at least, to have a plan:

> [I]t can only be a matter of somehow inventing a method of verbally demonstrating this scornful attitude vis-a-vis the word. In this dissonance of instrument and usage perhaps one will already be able to sense a whispering of the end-music or of the silence underlying all.[9]

[6] Hurwitz and Bates, 'The Roots and Ramifications of Narrative Medicine', in *Edinburgh Companion to the Critical Medical Humanities*, ed. by Whitehead and Woods, pp. 559-76 (p. 568).
[7] Charon, *Narrative Medicine*, p. 219.
[8] *The Letters of Samuel Beckett Volume I*, ed. by Fehsenfeld and Overbeck, p.518.
[9] Ibid., p.519.

This thesis has explored Beckett's misleading scorn toward language. Language falls short of representing experience and the state of things, not only because language itself is faulty, but also because the contexts in which language is used affects and inhibits successful articulation. Traditional conceptions of language and narrative need to be cast aside, but there is a constant questioning of how this should be done, and if it were to be successful, what would be left for him to work with? It is clear that whatever is to be found behind the veil of language cannot be so easily decoded and read in the ways that Charon suggests.

The goal of narrative-based approaches to medicine has been to get at the things that have been buried in code. Yet the notion that what lies inside or within the subject is encoded suggests that it is knowable, as though it were simply a matter of asking the right set of questions which then gives rise to a narrative that can be retrospectively reordered. Building this narrative into a linear timeline, Charon argues, means it can then be used, understood and shared between the clinician and the patient. Code is too simple a metaphor for what is uncovered. I have read *The Unnamable* as a text, which works in opposition to this view by narrativising the failure of narrative to deliver on the epiphanies it seems to promise. Narrative brings on more narrative, without realisation or insight, but the process of narration itself is vital to the narrator and patient alike. The problem is, this kind of narrative, which has no aim and delivers no results in terms of its content, is not accommodated within the clinical encounter. Time sits at the heart of all these concerns regarding narrative and listening. Time is both lacking and misunderstood. The linearity, or lack thereof within patient narratives is how order and disorder might, in one sense, be defined by the clinic.

By disrupting narrative-based practices within the clinic, I hope to engage clinicians in wider debates about the power distribution within the clinic and also help to productively complicate notions of how a story is created. The ill subject is narrated and narrates in myriad ways. The challenge for the patient and Beckettian subject is that they must both shoulder their role of patienthood, while continually fighting against the representational constraints of the clinic. This thesis has argued that the clinic and the bodies within it are temporally and spatially constituted. In Chapter Two I showed how current anti-narrative scholarship, has argued that clinical encounters are diachronic, but also that 'illness demands instead that we attend to the right now'.[10] Woods is right to incorporate 'now' into the diachronic rendering of illness, but I have argued that the chronicity of 'now' needs further examination. There are many more temporalities at

[10] Woods, 'The Limits of Narrative', p. 75.

play within the clinical encounter and while diachronicity accounts for the before and after within the illness experience, it does not offer a space for further temporalities within both before and after. Moreover, it seems to lose sight of during and all that is encompassed within this. During (or now), I argued, accounts for the experiences of illness inside and outside of the clinic, but it also specifically encapsulates narration as a specific event. Narrative is an act just as much as it is a product of narration, and the ways narration is carried out within the clinic are moulded by the clinical encounter: both at the interpersonal and institutional level. Deleuze's conception of the durational body helped here, as not only is the body constituted across all time, the narration of that body is similarly temporally located and fluid. The harm the clinic inflicts on the patient comes in part from the clinic's carving up of the clinical encounter into independent temporal instances, which freeze the patient story and fail to account for the particular conditions that have brought forth that narrative. As doctors record these narratives, and as they take a history of the patient, they overlook the ever-present present state of the patient and so patient narratives no longer reflect who the patient is now, nor what is being experienced or what has been experienced. What constitutes 'now' for the patient is similarly difficult to locate. I have argued that 'now' is the act of narrating, but like Deleuze, I argue that the body can be understood across all times. Now is informed by what has gone before, what lies ahead and what exists in each moment of the present. These multiple temporalities are entangled.

Beckett's bodies are always here, and yet elsewhere. Often carved up into individual body parts or individual functions, from Mouth and Auditor to the breath and cry in *Breath*, Beckett's disembodied bodies grapple with a means of narrating themselves. Their function is the defining characteristic of their subjectivity, just like the diagnosis and the pathological definitions of the patient that come to define the subject in the clinic. Moreover, in my reading of Beckett's *The Unnamable* through the lens of Disability and Dysfluency Studies, I argue that Beckett's adoption of a dysfluent literary style offers the opportunity to consider all forms of utterance — pathological or otherwise — as dysfluent. Supposedly 'normal' functioning bodies rely on a complex network of substitutions to enable them to operate. Bartra's exocerebrum elucidated the neural shortcomings of the normative subject to help show that all bodies and all language production share characteristics with aphasia, as we try to narrate and function and in the world. The compulsion to pathologise these shortcomings is driven by a

medical gaze that views the subject as a collection of 'signs and symptoms', which are to be read and decoded.[11]

This thesis does not argue for a rejection of the clinic, and I am conscious that while I have drawn upon the work of many who refute biomedical discourse, I want to warn against any reading of the clinic as simply doing more harm than good. Nor do I wish to lay the blame for difficulties in narrating and listening to illness solely at the clinician's door. Both the clinician and the patient suffer from the constraints placed upon their time together and the restrictions that traditional narrative-based medicine practices affect when trying to narrate and listen to experiences of illness. I argue that Beckett's work is so valuable in this reading of the clinic because illness, failure and limitation form the foundations of his literary (and academic) works. Throughout his oeuvre, Beckett's fixation with the body and its decline begins with a body that was never fully formed. It is not a question of watching a body lose its faculties, but rather a body whose shortcomings are present from the very start, that is to say, Beckett draws bodies whose normative function always falls short of the notion of a body in 'harmony and equilibrium.'[12] Narrating decline from this altered viewpoint enables Beckett, and the medical humanities scholar, to question received ideas of what a body can do and how a body tells the story of itself. The notion that narrative might represent an emancipatory tool for the patient and clinician — for the subject at large — is precisely what this thesis attempts to undo, or rather, entangle. Narrative, according to a medicalised approach might attempt to contest established identities, but as Frosh writes, these 'attempts very often result in stronger versions of the same.'[13] Moreover, the body that listens to these narratives listens out (or in) for those identities that are familiar. Narration is foreclosed and the listener listens only for the purposes of reading what is already known.

Listening In – How Do We Listen to Illness?

In order for narrative to function it requires the presence of an interpreter, or a listener. This listener is not a passive receiver of the narrative she hears. Interpretation, like narration is temporally and spatially constituted. Meretoja writes that:

> As interpretations of the world, narrative practices have real-world effects. This is precisely what their (per)formative and productive

[11] Foucault, *Birth of the Clinic*, p. 110.
[12] Canguilhem, p. 40.
[13] Frosh, p. 637.

> character means: they take part in constructing, shaping and transforming human reality.[14]

In the second half of my thesis, I examined the role of the doctor and patient as listeners to illness. Listening is both difficult and misleading, but it is also productive. Listening does not simply involve taking on information. Instead, it produces new interpretations and translations by manipulating and reifying what has been heard. Moreover, what one hears is influenced by what one expects to hear in a given context. Listening is embodied. Where clinical medicine has sought to hear past the body, to edit out the seemingly superfluous elements of a narrative for the purposes of diagnosing disease, the body is an unavoidable presence because of the sounds its makes and feels. In Chapter Three I argued that Beckett's use of radio and audio technologies can function as a translational tool for learning how to listen to the body and the sounds that it produces. Beckett's work for radio alerts the listener to the interpretive acts required of her, as she listens in to the unheard or preconscious sounds that bodies produce. This self-conscious engagement with listening media and the difficulties presented by listening to an absent body offers insights into the challenges that both patients and clinicians face as they try to listen to — and represent — their experiences of illness. The absence of the body is of course a defining characteristic of radio, but with this in mind, Beckett's works in particular bring a greater awareness of the body's sounds over and above its sights. In the clinical context, where sight has taken precedence within medical care, I have used Beckett's works to draw the absent body back into the clinical encounter through sound. In Beckett's radio drama the listener hears bodies that do not know they are being listened to, but the listener too listens with her body. Like touch, listening has the ability to traverse the boundaries of the body. Through it, we can perceive the outside and imagine the inside of the body. Listening requires an act of imagination but it is one that depends upon an embodied engagement between speaker (or sounder) and listener. Something happens to the body as it hears and is listened to. Being heard is both empowering and unsettling and Beckett's use of audio technology stages this unsettled listened-to body through unintentional outbursts. The importance of overhearing is also crucial; listening is invasive, but sounds also come to us. In the clinic, the body is looked at and into. In Beckett's work the body is overheard and by hearing its intentional and unintentional soundings out, it becomes all the more embodied.

[14] Hanna Meretoja, *The Ethics of Storytelling*, p. 47.

Finding connections between challenges of listening and storytelling in the clinic and Beckett's oeuvre has been problematic at times, but the differences between the clinic and Beckett's exposition of storytelling and listening has often proved the most fruitful and productive. While Beckett's works and clinical writing might both acknowledge that listening is a challenge, I recognise that the acts of imagination on which listening is contingent are treated differently in Beckett's radio drama than in clinical consultations. I propose, however, that the value of this study lies in investigating how it is that Beckett's work forces us to listen, and to listen to the difficulty of listening. Listening is not directed towards a single goal. The clinician might begin by listening to diagnose or determine what she is listening to, but the danger is that the body is removed from this encounter and is listened past. The clinician listens so as to access the content of the narrative, without considering its form. Beckett's embodied language, often language and sounds that do not ask to be listened to, offer a vital insight into the potential of listening to non-narrative expressions which the body creates.

Being heard is unsettling, because while the subject tries to moderate the way she communicates information, listening to sounds that the body does not consciously produce and which the body itself cannot hear, makes her vulnerable to interpretations that cannot be controlled. Through my exploration of unusual auditory phenomena in Chapter Four, I have shown the potential for the body to make verbal sounds, which seem to be uncontrollable for the subject who produces them. I argued that listening to illness is not only a challenge for the clinician (the subject we would most commonly associate with listening in the encounter) but also for the patient too (the speaker). Beckett's late drama and his teleplay *Eh Joe* perform the difficulties of listening to one's inner voices. By providing a model for clinical listening, Beckett's *Eh Joe*, *Not I*, and *Footfalls* stage voice-hearing as dialogic. This dialogue troubles the notion of a stable body at the same time as producing a body through language. The voice both belongs to the subject and to someone else. While I raised similar questions in the first half of my thesis, concerning the narrator's uncertainty about the source of his narration in *The Unnamable*, in Chapter Four, I argued that dialogic inner speech makes the producer of the voice its listener too. The primary challenges of listening are thus twofold, first because of its chronicity and second, due to clinical discourse that interrupts or inhibits it.

In Chapter Three — through *Krapp's Last Tape* — I read the eponymous Krapp as a manifestation of what O'Dowd calls the 'heartsink' patient. Defined according to the

effect she has on her clinician(s), the 'heartsink' patient is a homogenising identity, synonymous with difficulty and the failure to get well. Listening chronically brings about 'heartsink' but this by no means stops either the patient from articulating illness, or the clinician from being beholden to listen to it. The dynamic between the voice-hearer and her voices was explored in similar ways. I argued that *Eh Joe* and *Not I* could be read as staged subtypes of AVHs. This pathologised reading is done to explore the experiences of those who hear voices and demonstrate the effects of voice-hearing on the voice-hearer within pathologised models in which the voices are experienced as wholly negative. This relationship is problematic as clinical discourse encourages the voice-hearer to turn away from her voices, reading them as a symptom that must be ignored or eradicated as opposed to listened in on.

Finally, I argued that listening represents another act of voicing, through its ordering and reordering of patient narrative. Using the pseudocouple in *Ohio Impromptu* as a model for doctor-patient interactions, I examined how the delivery of care is governed by more than what is simply said and heard. The systemic constraints of the clinic guide the nature of the largely scripted interactions within the clinical encounter. Listener's listening in *Ohio Impromptu* is guided by the written word, representing the fixed procedures of the clinic. In Winning's words, the clinician is rendered 'docile' in much the same way as the patient who is forced to comply with the procedures, the lexicon and the methods of the clinical institute. The written word might be seen within a narrative medicine framework to offer a way of working-through the doctor patient relationship by means of self-reflection, but once the words have been written they remain static, and do not incorporate developments in the patient's experience and need. The clinic ventriloquizes its participants, calling on doctors and patients alike to perform and regurgitate biomedical discourse. Beckett's late theatre, thus, not only stages the problems of care giving, but also enables us to refigure the 'apparently clear-cut bodily behaviours and locations' of the patient and doctor across 'material space — ward, clinic, surgery, operating theatre' and beyond.'[15]

Future Entanglements

Beckett's writing has played an integral role in the work of many scholars situated within the field of medical humanities.[16] Their work has played a crucial role in

[15] Winning, 'Afterward', in *Edinburgh Companion to the Critical Medical Humanities*, ed. by Whitehead and Woods, pp. 325-35 (p. 329).
[16] Elizabeth Barry, Matthew Broome, Jonathan Heron, Ulrika Maude and Laura Salisbury, all of who have been cited throughout this thesis.

expanding the field and the use of Beckett within it. Their research has also enabled vital work within practice-based medical humanities workshops, such as those carried out as part of the 'Beckett and the Brain' research project within clinical and health management settings. It is through Beckett's works that scholars have come to explore central concerns within medical humanities, including language production and disorder, the body and technology, and psychoanalysis and psychiatric practice.

When I say that these works concern Beckett, they concern portrayals of such conditions and practices within his work, and begin at the site of the work to read those wider themes and subjects associated with the field. They prove Beckett's literary power to elucidate the tensions and representations of the body in innumerable states, which can be placed within medicalised frameworks. This thesis builds upon such work, but takes an alternative approach by making the central concerns of the clinic my starting point. From here, I used Beckett's works as a way of exploring the challenges of narration and listening within the clinic, but I have also used the clinic as a means of reading Beckett's work differently. It is through the formal aspect of the clinic that I have been able to examine Beckett's formal choices more closely. While it is clear that Beckett maintained an interest in the body, in language and the voice throughout his career, it was his formal choices that have dictated my exploration of these thematic concerns. I have entangled narrating and listening, to continue existing conversations within critical medical humanities, but also expound them. Beckett's medicalised life writing offers a model for thinking about the identity of the patient as performative, temporally and spatially constituted and vulnerable to the systemic dominance of the clinic.

My research is part of an on-going entanglement of conversations about communication, narration and listening within the clinic. Beckett's works have the power to give voice (and sound) to the experiences of those subjects who have, hitherto, been overlooked or heard past. Moreover, the seemingly endless adaptation and appropriation of Beckett's works is proof of his continued relevance within current debates concerning disability. The performer and activist Jess Thom (co-founder of 'Touretteshero') has recently adapted Beckett's *Not I* to create an accessible and relaxed performance of a play famous for its difficulty (both for the performer and the audience member). Thom performs Mouth as a neurodiverse character who is disabled by the society in which she lives, not by her neurological condition. Performed alongside a British Sign Language interpreter who translates the piece live and incorporates Thom's tics — which are scattered throughout the play — Thom's performance is both rigorous

in its reading and dramaturgy, while also spontaneous. By co-opting Beckett's work in this way there is not only an opportunity to read Mouth as a disabled character, but also to give the character a role within contemporary activist spaces. There is more work to be done in this regard. In addition, recent formal adaptations to Beckett's work also warrant further study and could, I argue, be used to advance scholarship concerning the affective qualities of Beckett's formal choices, within a medicalised reading of his work. Examples such as Out of Joint's 2015 production of *All That Fall* performed live in the theatre to an auditorium of blindfolded audience members, and the Pan Pan Theatre's 2011 production of the same play, in which the audience listen to a pre-recorded production seated on rocking chairs in a dimly lit room, are evidence of the capacity for Beckett's work to be transposed into alternative forms. These examples remain committed to addressing the core concerns of Beckett's radio drama: listening to bodies and listening together. With continued developments in technology and dramaturgy, new adaptations of Beckett's work are possible. Nicholas Johnson and Néil O'Dwyer's collaboration with V-SENSE at Trinity College Dublin to create 'Virtual Play' has produced a particularly exciting virtual reality staging of Beckett's *Play*. By placing the user in the position of the interrogative light in *Play*, Johnson writes that 'aligning the spotlight with the user's gaze, [gives] them control of the spotlight and the power to explore the narrative on their own grounds.'[17] Beckett's interest in the potential of the analogue technologies with which he worked, has been augmented here to consider the ontological implications of digital technology on the experience of theatre and the staging of the power dynamics within the play. These methodologies could undoubtedly be extended and applied to transdisciplinary scholarship on Beckettian readings of the clinic.

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In the first of his three dialogues with Georges Duthuit, Beckett discusses the works of Tal Coat whose painting he says was accomplished, only in as much as it tended towards the accomplishments of all previous painting. It had, Beckett acknowledged, achieved 'prodigious value', though unfortunately Coat's work, like the Italian painters before him 'never stirred from the field of the possible.'[18] This first of Beckett's dialogues with Duthuit is undoubtedly his most famous, and while his much quoted

[17] Nicholas Johnson and Néil O'Dwyer, 'Virtual Play: Beckettian Experiments in Virtual Reality', *Contemporary Theatre Review*, 28.1 <https://www.contemporarytheatrereview.org/2018/beckettian-experiments-in-virtual-reality/> (para. 6).
[18] Beckett, *Proust*, p. 103.

insistence that one has an 'obligation to express' is the apotheosis of this discussion, it is Beckett's remarks preceding this that I wish to close with. Articulating his desire for art that no longer operates on the 'plane of the feasible', Beckett says:

> I speak of an art turning away from it in disgust, weary of puny exploits, weary of pretending to be able, of being able, of doing a little better the same old thing, of going a little further along a dreary road.[19]

Weary of pretending to be able, but by no means willing to stop his attempts at expressing the inexpressible, this conversation is vital to understanding the inevitable and yet necessary production of failed expressions. This quotation might be read for its futility, but it is Beckett's insistence and his characters' commitment to keep on keeping on, despite all the ailments and interruptions that might prevent them from doing so, which I see as a necessary and enlightening lens through which to read the chronic patient who finds herself entangled within the cacophonous clinical encounter.

[19] Beckett, *Proust*, p. 103.

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