Hold Me in a Circle of Tender Listening

Listening-*with* an oral history archive of women's psychiatric experience to create a multi-channel sound work

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Abstract

This practice research explores five women's recordings from the Mental Health Testimony Archive (British Library and Mental Health Media 1999/2000), an archive of fifty oral history testimonies recorded in 1999 and 2000.[1] Working solely with the audio from these testimonies, I have developed methods for listening *-with* survivors of psychiatry in order to create a polyvocal, multichannel sound installation that enables encounters *-with* women who have been systematically silenced.

I started this project from a position of lived experience and have used my embodied entanglement to engage the affective and haunted registers of women's testimonial recordings. Working with sound, in all of its ephemerality and permeability, this research brings women out of their archival isolation and into dialogue with each other. Through practices of listening-*with* and compositioning I have engaged with the spoken and the unspoken, the non-narrativizable and paralinguistic qualities of voice, both human and non-human, such as the sounds of a constantly moving tongue, a fax machine beeping and a page being turned, in order to activate and stage an archive, creating new assemblages of listening. The research traverses a number of disciplines including voice and sound studies, listening and oral history. It engages with transgenerational haunting, demonstrating how twentieth century psychiatry continues to haunt the present, including current psychiatric practices—

[1] The Mental Health Testimony Archive is available to view in the British Library, catalogue number C905.

affecting bodies and crossing spatial and temporal borders, through diasporic voices and media technologies. It asserts that psychiatry, which considers itself a listening profession, has often failed to listen, and asks questions about recovery narratives and oral history as projects for capturing life stories.

Completing this research at time when both the mental health of the UK population and mental health services are deemed by many to be in crisis (MIND 2023; Mahasep 2023) the work makes an important contribution to conversations about psychiatry's past, present and future. It shows how testimony never represents simply a record of the past, but rather deepens the historical present in ways that can be felt. The research develops new, embodied methods for listening-*with*, not in order to assimilate or 'know' the other, but in ways that accept uncertainty, being-*with*, side-by-side, listening and relating in ways that can be transformative. In the end, I hope that audiences of this work, will take the opportunity to reflect on women's experiences of psychiatry in ways that might lead them to consider how things could be different.

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I am very grateful to Carole, Kathleen, Annemarie, Ann and Pauline and to all the women interviewed for the Mental Health Testimony Archive (MHTA), for their rich and generous testimonies and to the British Library for granting me permission to work with the MHTA. Thanks also to everyone at Certitude who listened to the work with such interest and to those at the Big Anxiety Festival 2019 who supported the first installation of *Hold me in a circle of tender listening*.

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Finally, deepest thanks to my Mum, who has been a source of love and encouragement through it all.

Madness stands as a spectre for all women, a warning of their possible fate if they stray from their expected path.

—Jane M. Ussher (2011)

When we tell a story we exercise control, but in such a way as to leave a gap, an opening. It is a version but never a final one. And perhaps we hope that the silences will be heard by someone else, and the story can continue, can be retold.

—Jeanette Winterson (2012: 3)

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A note on images

Over the years I have created various archives of photographs, films and images that relate loosely to the themes in this work. Until now, I hadn't done anything with most of this material, but as I was coming to the end of this writing I decided to revisit it, and, ended up selecting a number of images to include here, which I have placed at intervals throughout the writing. Most of the images I include remain untitled and below I discuss where they come from and how I created them.

Images of Grenadier Guards and other amateur 8mm film footage

Several years before I started this PhD, I spent a day researching the Screen Southeast's Amateur Film Archive, sitting in a tiny, windowless room, surrounded by hundreds of VHS cassettes containing films originally shot on 16mm and 8mm film. One of the first videos I picked up contained films from the 1970s of the Trooping of the Colour. There was something quite magical about these blurry images of Grenadier Guards marching in formation outside Buckingham Palace that took me back to the stories told about my grandfather, a Grenadier Guard during World War II, as well as childhood memories of visits to London. I found several films that day which evoked images from my childhood and unspoken family histories, including a black and white film from the 1960s of a barn dance with men and women dancing in outfits suggesting the American 'wild west' and

a film of the Farnborough Air Show (a feature of my childhood summers, taking place, as it did, just a couple of miles from where I grew up).

The archive granted me digital copies of five 8mm films from their extensive collection, which I layered and montaged into a series of short films. These films ended up sitting on a hard-drive in my desk drawer for several years, until 2016, when I revisited and ended up taking hundreds of screenshots of them, a selection of which I have interspersed throughout this thesis. I have left all of these images unlabelled, partly because they were difficult to caption in any meaningful way, but, also because I wanted the reader to make up their own minds about what they were seeing and felt that leaving them untitled might allow for a more affective encounter.

Images from the Brookwood Hospital Archive

In the early days of this research I spent a day sifting through boxes of photographs and papers from the Brookwood Hospital archive at Surrey History Centre. I wasn't sure what I was looking for but the items that most interested me were photographs from an open day/carnival in the 1970s taken by hospital staff, letters written and illustrated by the Superintendent in the early years of the hospital opening and an album of photographs of the buildings and staff taken in the late nineteenth century.

The centre didn't have any scanning facilities, so, in order to make copies of these photographs and letters, I had to place the originals under a perspex sheet, as instructed by the archive staff, and photograph them from above. Many of the resulting images ended up capturing the archive's strip lighting as it reflected in the perspex and were, to my mind, unusable. However, when I looked at them again, several years later, I saw them in a new light - not as poorly executed digital copies but rather as ghostly images that capture something ineffable about the

hospital and its' many past lives. The images I took of photographs from the Brookwood Hospital open day/carnival in the 1970s were particularly difficult to title and for this reason they have been left unlabelled.

Photographs from The Maudsley 2003 and 2015

The photographs of hospital interiors and exteriors were taken by me when I was an inpatient at the Maudsley Hospital in south London. In 2003, a friend brought in my camera and I began documenting the ward early in the morning, using black and white film. In 2015 I used my mobile phone to take images of myself and the ward environment when no one was around. These images are unlabelled either because they are self-explanatory, or, because, like the images described above, I felt they were best left for readers to decipher for themselves.

Practice

Hold me in a circle of tender listening (47’ 07") Listen here

The practice that sits with this thesis was created as a multichannel, 8 speaker installation and had its first installation at the Big Anxiety Festival in 2019.

Below is a list of sound clips that have been interspersed throughout the text. Most of these were created early in the research process whilst making HMCTL and are in stereo.

(All of the sound work is ideally listened to through good quality headphones.)

List of sound clips

Breath tracks. . . . . §1.12, p. 45

Kathleen Tardive Dyskinesia. . . . . §3.2.1, p. 100

Ann page turn. . . . . §3.2.2, p. 104

Page turn repeating. . . . . §3.2.2, p. 108

So heavily sedated. . . . . §3.2.3, p. 108

Tilly Tin Drawers. . . . . §3.3.1, p. 121

Anne’s Fault. . . . . §3.3.1, p. 123

Mummy says she’s not in. . . . . §3.3.2, p. 127

My mistake. . . . . §3.4.2, p. 133

Fax machine. . . . . §3.5.2, p. 138

Oakwood Banstead. . . . . §3.5.3, p. 147

Rainhill. . . . . §3.5.3, p. 147

GET-UP. . . . . §3.6, p. 150

What you need is sex. . . . . §3.7, p. 155

I've got a little room for you. . . . . §3.7, p. 155

Kenaxis sound experiments

Mother. . . . . §4, p. 165

Diagnosis. . . . . §4, p. 165

Broadmoor. . . . . §4, p. 166

All voices. . . . . §4, p. 166

A beginning: conversations with my mother

Fig. 0.1: Photograph of the author's mother taken in 1959.

One late March evening in 1976, my mum drove into a police station calling for help. My brother and I were in the back of the car in our pyjamas. Mum was taken

away and we didn't see her again for several weeks. What happened in those few weeks, when I was 5, and the lasting effects, we will never fully know, but it set in motion a cycle of events that would repeat across the decades and that continue to resonate.

Over thirty years later my mum and I made a short film together while she was in hospital and then some sort of halfway house. The film was a document of the weekends we spent together over several months—a performative record of conversations filmed in places that had memories for us. We took turns holding the camera, an attempt to address some of the power dynamics inherent in the filmmaker/subject relationship. Mum was remarkably open, telling the camera things she had never told anyone before, and so 'it' became our witness, offering us both space to think and speak about things that had, until then, remained silent. I'm not sure at what point it happened, but somewhere in the making, that film came to be more about my mother's experience of going 'mad' than her experience of psychiatric 'treatment' and my own mad experiences were completely ignored.

Almost a year after the film was finished we attended a student film awards ceremony together. Neither of us knew which scene would be shown, and when my mother's face appeared in close-up on the cinema screen, as I was heard asking from behind the camera 'how many times have you been in hospital?' I was completely unprepared for her visceral and shocked response. She reeled backwards in the seat beside me, and, before I could do anything, gathered up her coat and bag and left the theatre.

Reflecting on this event I began to feel that I had created a form of representational violence and that by breaking her silence to the camera my mother had become 'assigned to the role of patient … hysteric […] outside the bounds of normality' (Talukdar 2004: 233). Foucault, in *The History of Sexuality, vol. 1*, describes the

confession as a 'ritual that unfolds within a power relationship', that demands 'the presence of a partner … who requires the confession, prescribes and appreciates it and intervenes in order to judge, punish, forgive, console and reconcile' (Foucault 2019: 61–2).

This analysis, considered in light of my mother's distress at being exposed to an unknown audience, suggests that, far from challenging power structures, my line of questioning and my mother's confessional speaking in the film had served to position her as 'other' while conferring on me some misplaced authority as the 'voice of reason'. For months I struggled with an overwhelming sense of guilt because, by placing my mum at the centre of the story, I had disavowed my own struggles with 'so-called mental illness' (Filer 2019: 8).[2] Whilst there are many tender moments in that film, where the loving closeness of our mother/daughter relationship is apparent, the deep complexity of my position as filmmaker/daughter/survivor with my own experience of psychiatry, was never explored, and in eschewing my own experience, I inadvertently set my mother apart and placed her at a distance, rather than sitting *with* her, side-by-side. It was this painful realisation that, ultimately, led me to undertake the painstaking and lengthy research required for this work, and that has, in the end, led to a transformation in my own understanding, not only of what it is to be a survivor of psychiatry but, also, of the importance of affective research methodologies developed from lived experience.

I set out on this project with the desire to rethink my own position to survivorship, and to explore what it means to listen to survivors when locating myself *within*

[2] As Filer so eloquently explores in his book 'The Heartland: Finding and losing Schizophrenia', the language of mental illness, from seemingly innocuous words like 'patient' and 'treatment' to the terminology of 'mental health' / 'illness' is fraught with difficulty. In this writing I therefore follow Filer's lead in writing about 'so-called mental illness' and avoiding, where possible, the terminology of different diagnoses except where I am quoting from the archive or other writers, or in some other way using other people's words. When I do use the terminology of different diagnoses it will be enclosed in quotation marks, as a way of indicating that these words have a complicated history and multiple meanings.

the conversation, as a survivor. In so doing, I challenge the ways in which we listen to women survivors, by bringing conversations between women to another stage, and, while my voice is not actually audible in the sound work, I am always present through my listening and in this writing. I listen, compose and write from a position of 'with-in-ness' and vulnerability, recognising the multiple, complex perspectives that come from working 'within' and I place myself firmly on the page as a survivor with an embodied understanding of living through distress that sometimes manifests as 'so-called mental illness' (Filer 2019). It has not been an easy task, and over the long, fragmented course of this work, researching-*with* an archive of women's mental health testimonies, I have experienced feelings of deep sadness and stuckness from which I thought I might never escape. In the writing that follows I acknowledge these feelings, not as the result of a disaster in the making, but as part of the conditions for making a work that stages ghosts; what Lisa Blackman calls an 'embodied hauntology'—a form of 'methodological sensitivity' that can only come from being deeply, inextricably implicated and acutely attuned to ephemeral moments, submerged stories and forces that 'register affectively' (Blackman 2015: 25–27).

1. Encounters in the archive and concepts for working -*with* women's voices

In the following chapter I describe the Mental Health Testimony Archive, my early encounters within it and offer a brief account of the practice element of this PhD *Hold me in a circle of tender listening* (from now on abbreviated to HMCTL). I also summarise the main concepts explored in this thesis, including listening-*with* and compositioning and offer an explanation for the -*with* that has permeated my thinking, writing, listening and creating.

1.1 The Mental Health Testimony Archive (MHTA)

I first came across the MHTA in the pages of Gail Hornstein's (2009) book 'Agnes's Jacket: A Psychologist's search for the meanings of madness' (Hornstein 2009). In it, Hornstein, recounts her encounters with the archive and face-to-face meetings with some of those interviewed. The MHTA comprises fifty video-taped testimonies, copyright of the British Library. A collaboration between Mental Health Media and the British Library, funded by the Department for Health, the project's primary aim was to capture the stories of men and women across the UK who experienced psychiatry in the second half of the twentieth century, to increase understanding and challenge attitudes to mental health.

The MHTA interviews were carried out in 1999 and 2000 by volunteers with lived-experience of the mental health system who were trained in oral history research, interviewing and video recording skills. As well as fifty whole-life video testimonies ranging from two to nine hours long, a later part of the project included a website, 'Testimony: Inside stories of mental health care' where excerpts of interviews could be viewed along with all the transcripts. The website also hosted news about various media campaigns, exhibitions, conferences and awareness-raising events. This excerpt from the website (now a web archive) outlines how the project was conceived:

> Testimony originally came about as a response to the changing face of the British mental health care system. As the old asylum based hospitals were replaced with different models of treatment, there was concern that the stories of those who had spent time there would be forgotten. At the end of the 1990s a group of interviewers from a range of backgrounds went across England and Wales to record first hand accounts from individuals who had experienced life in such institutions. Their aim was to create a historical resource coming from an often ignored perspective—instead of relying on opinions of those distanced from the situation, it would give those with direct experience the power to speak for themselves. [...] As former methods of treatment died away, the life-stories of those who had experienced them could be preserved and recognised as a valid part of the UK's shared history.[1]

[1] http://web.archive.org/web/20110902140721/http://www.insidestories.org/archive

1.2 Early encounters in the Mental Health Testimony Archive

> *I was conscious of listening from an early age. Listening out and holding my breath. I listened for signs. A slight change in the tone of her voice and I knew she was going; going away…again. Perhaps this is what has led me, years later, to a place where all I can do is listen, play and re-play women's voices, over and over. Listening for something—a breath, a tone, a quality that I can't quite put my finger on, that I don't understand but that speaks to me—holds my attention—forces me to listen—to hold my breath and hear.*

After weeks of anticipation, emails back and forth with sound archive administrators, I was finally in a listening booth in the British Library. It was a strangely discombobulating experience, sitting in a glass-sided listening booth, in full view of other library users, having the rules of this encounter explained to me in an uncomfortably tight space. A large pair of headphones sat on the desk by a TV screen, some sort of digital box which I shouldn't touch sat under the desk, and, to the right was a bright red round dial telephone, connecting me to a man in a back room who could wind the videotape on, rewind, pause or change it. Through this televisually and telephonically mediated encounter with women from the MHTA I began my research, never so much as setting eyes on the videotapes onto which the mental health testimonies were recorded.

With some trepidation I sat down to watch the first tape, an interview with Virginia (C905/38/01-03).[2] My notebook from this encounter is crammed with pages of word-for-word transcription—women's words that I would read over later to *see* what had been said.[3] It appears I was on a fact-finding mission, something like

[2] As with all of the women from the MHTA that I name in this work, I have used her first name, as she gives it in her recording, rather than a pseudonym.

[3] I wasn't aware at this point that full transcripts of the video tapes were available at http://web.archive.org/web/20110823042219/http://www.insidestories.org/interviews

that of Elena Trivelli (2015) working her way through piles of yellowing patient's case files in the basement of a closed Italian psychiatric hospital, I kept watching, '[…] compulsively collecting sentences and anecdotes […] not knowing what I was looking for, not knowing how I might possibly *use* these data' (2015: 129, my emphasis). Despite there being little in my notes about how it felt to be watching the videos, I recall feeling somewhat disappointed by my initial encounters. Thinking only about how I might use this archive as *material*, I could not hear much beyond the immediate meaning of what was being said.

Sitting in a tiny glass-sided sound booth, visible to the real Historians poring over manuscripts and rare books, I felt self-conscious watching television and wonder how my position within the space might have worked to block affect. I certainly didn't feel great excitement at the prospect ahead of me (hours of testimony spoken by women captured in documentary video close-ups), unlike Gail Hornstein, who reports feelings akin to rapture, writing that 'each evening the guards at the library had to bang on the door of my cubicle to get me to tear myself away' (2009: xviii). I can't help but wonder whether Hornstein's rapturous experience of the archive is attributable to her ability to position herself firmly as an outsider - a Psychologist 'searching for the meanings of madness'. Early in her book she writes that 'plunging into *their* world, I've often felt like one of those anthropologists who manage, even today, to discover a new culture in some isolated locale' (ibid.: xiv, my emphasis). This analogy has an unfortunate ring of the colonial and sets up a very distinct division between the Psychologist researcher and the 'subjects' of her research.

My own experience couldn't have been more different. Far from being at a distance to the women speaking, I was not encountering a new culture or adventuring into unknown terrain. I was (re)experiencing the all too familiar, encountering myself and my mother at every turn, as women spoke about experiences that were too

close to home and recent in my own life. Watching women in close-up I became obsessed with their appearance, the way their mouths moved, their hands shook, the clothes they were were wearing and the way their hair was styled. These women, so like my mother, and in their past or my future, so like me. There was no possibility for me to set 'them' apart, simply 'subjects' of my research. I might as well have been looking in the mirror. Despite this inextricable entanglement, or perhaps because of it, listening to women's testimonial recordings through headphones, many times over, for weeks at a time was difficult, repetitive and laborious and in the early weeks of listening in the British Library sound booths it was incredibly painful. As Brandon LaBelle points out, listening, as a form of attention, is 'hard to maintain—it drifts, it falls, it lags behind, it is strained by what it hears' (2021: 4). I found myself watching and listening so hard that it was exhausting.

After a couple of months, suffering with severe insomnia and various manifestations of distress, I ended up being admitted to a psychiatric ward for three weeks and had to take a long break from work. When I finally ventured back into the archives, almost a year later, I knew I had to approach the recordings differently. I had, by now, discovered the transcripts online so no longer felt the need to listen to (and write down) every word. Instead, I was able to put the headphones on, close my eyes and let the women's words wash over me.

I began to feel my way around the recordings and developed new modes of awareness, becoming attuned to the many registers of the women's voices and to the spaces of the interviews. It became easier to 'simply stay with something... without having to fit it into some tidy box of understanding' (Lipari 2014a: 136). I listened to my own listening; the effects of sounds and voices on my own body, mood and my experience of being in and becoming a part of the archive, an assemblage of listening, in which the archive and my own place in it was constantly adapting. I

began to understand viscerally how listening moves us and sound moves through us in ways that are tactile and haptic; that can be felt. Rather than fighting against sounds and voices, or fitting them into my own listening agenda and so absorbing 'the other into conformity' with myself, I began to listen-*with*, not in order to listen for 'alterity' (Lipari 2014a: 188) but rather in recognition that, 'listening is passing over to the register of the self, it being understood that the "self" is precisely nothing available (substantial or subsistent) to which one can be "present" but precisely the resonance of a return [renvoi]' (Nancy 2007: 12).

I increasingly felt that there was more to these recordings than was immediately accessible in either the transcripts or the video recordings. What that *more* was I didn't yet know but travelling home each day I was haunted by the women's words and voices. Women I thought I had left at the library stayed with me, accompanying me on my journey and lingering long after returning home.

They were Jewish you know, they were Jewish, so…

My mistake again you see, my mistake.

As soon as they put the needle in your arm you were out, as soon as the needle touched your arm you were out.

These insistent voices were burrowing into my unconscious, like so many earworms, except these were not meaningless melodies or jingles that I couldn't shake off, they were challenging, demanding, testimonial voices that refused to remain quiet, or stay in neatly categorised archival order within the British Library. These voices were impossible to contain, and as they circulated I began to feel them as ghosts, escaping the binds of their archival condition.

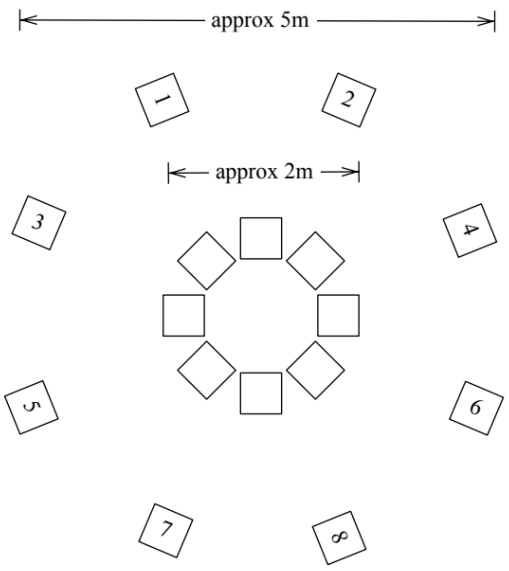


Fig. 1.1: Suggested speaker/audience set up for *Hold me in a circle of tender listening*, with paired speakers listed as 1–8.

1.3 Hold me in a circle of tender listening

The main practice element of this PhD is a multichannel sound work *Hold me in a circle of tender listening* (abbreviated to HMCTL), which is just over 45 minutes long and is designed, in its current iteration, to be listened to from beginning to end. The piece was made using only the audio (.wav) files from five women's MHTA video recordings; a process which involved listening, editing, assembling and spatialising voices and sounds from over 20 hours of recordings. The primary voices heard in HMCTL are those of Ann, Annemarie, Carole, Kathleen and Pauline, who I refer to throughout this work as survivors (of psychiatry). Other voices heard in the piece include those of Judy, who interviewed Carole, Ann and Pauline, and Pauline A. who interviewed Kathleen and Annemarie. Sometimes the voices of the people operating the video camera in the interviews can be heard, as well as voices of people outside the interview room.

HMCTL's first installation, both as a multichannel, octophonic (8 speaker) work and as a stereo piece for headphones, took place at the University of New South Wales Gallery, part of the Big Anxiety Festival, 2019. In order to engage fully with this thesis it is suggested that the reader listens to the spatialised work through headphones before reading any further.

HMCTL is an attempt to create a collective, tender listening space for women I have come to know solely through my encounters with their testimonies. In her work, Art and Madness: Beyond Illness, Anna Harpin argues for an approach to 'madness' and its 'treatment' that is tender. She writes that 'artistic practice is well placed to rethink the nature of the offer of psychiatry along more intimate and tender lines' (2018: 9–10). I take up Anna Harpin's call to work with tenderness, something, that, as the MHTA oral history recordings show, has been missing from the brutalising systems and institutions set up to care for people suffering distress.

As Harpin points out the word tender in noun, verb and adjectival form has multiple meanings, for example, as a verb the meaning of 'to tend' in the Oxford English Dictionary is given as 'to turn one's ear, give auditory attention, listen, hearken' and can be traced to the French word, 'tendre' meaning 'to hold out, offer' and the Latin, 'tendere' meaning 'to stretch, hold forth'. As an adjective 'tender' means 'to become soft or be moved'. Tenderness is a form of openness and vulnerability, which always holds in it the possibility for discomfort and unease; never a 'certain gesture, [...] to be tender or to tender is to make an offer without assurance of its reception' (ibid.: 10).

It is with this tenderness in mind that I have applied a relational and feeling approach to testimonial recordings, as Harpin states 'tenderness is a relation' (ibid.) and, as, I hope my work shows, such a relation does not lay claim to the certainty of knowing or the fixity of identification, but works with fluid and impermanent

states of feeling. Artistic practice, in its many varied forms, is a way to approach 'madness' with tenderness that 'makes plain the urgency of fleshy listening: of listening that extends beyond the ears and is dispersed throughout the body in acts of radically generous relational exchange' (Harpin 2018: 10). Desiring such a 'radically generous relational exchange' I began to listen-*with* women from the MHTA; women who have experienced multiple layers of isolation over many decades, within the psychiatric institution, in their everyday, often, violent lives, and, in the secondary isolation of the archive itself.

The multi-speaker sound installation is an attempt to create circles of tender listening that work on many levels. While the 'me' in the title of the work is never explicitly heard, I am always present through my listening and staging of other women's voices. The 'me' is a way to acknowledge my place among these women, being -*with* them. In the outer circle, each of the 8 speakers amplifies different voices, testimonies, silences and sounds, while the inner circle of seats is an invitation for people to gather in a collective space of listening, breathing, and sounding together -*with* women psychiatric survivors. As a gathering in which long-silenced voices are finally heard, it is hoped that the listening circle might become a place of tenderness and openness, to address the catastrophic loneliness of trauma, and, what women survivors like Jacqui Dillon (Dillon 2011: 144) and Dolly Sen (Sen 2022) experience as the failure of psychiatry to listen (Harpin 2018: 2).

Here I have offered an explanation of my motivation for this research, a description of the archive that I worked with, a brief description of my practice and the place of tenderness in my work. In the sections that follow I highlight the main methods of my research, describing what I mean by listening-*with*, diasporic listening, earwork and compositioning.

1.4 Listening-*with*

> If traumatized [...] or hysterical bodies mark a symptomatic site of what Foucault calls 'subjugated knowledges'—those local, popular, inadequately scientific knowledges 'of the psychiatric patient, of the ill person'—then what kind of study would be able to hear such bodies speak? What methods could make sense of such bodies and the largely unwritten archive of their feelings? How to excavate the 'memory of hostile encounters,' the 'historical knowledge of struggles,' buried at the scene of a subjugated knowing? (Orr 2006: 1)

I am Listening. Your words, voice, sighs, gurgles and bodily noises enter my ears through headphones, finding their way into my body, memory and thinking. I hear you even when I am not listening—your phrases and verbal idiosyncrasies sound in me. You have never been here but you are here. Not simply a woman on a tape, a recording from an archive, or an audio file in my computer. You're becoming part of me. I feel you—your voices, sounds and silences change me. Each time I hear you anew. No breath is ever the same, your tones and registers move me differently on every listening. How to create a method out of this ever-changing perception? I read your words in transcripts, alike each time, but there is no stability here, I cannot conjure your voice the same twice.

This research examines how listening-*with*[4] (as opposed to listening to) and compositioning (-*with*) recordings from an oral history archive of women's 'mental health' testimonies have become forms of creative exploration that enable re-

[4] Deirdre Heddon is the only person I have found who writes specifically about 'listening with', in relation to her experience of working with the late performance artist Adrian Howells, about which she writes: 'Listening in its entangled form is a dialogical listening which stretches a radical openness towards interconnections, 'listening with' (Heddon 2017: 37). I read Heddon's chapter long after I had already formulated my work as a form of listening-*with*.

lational encounters -*with* women survivors of psychiatry.[5] The writing traces my research from the British Library sound booths where I spent many hours watching 23 long form video testimonies, through my 'intra-actions' (Barad 2007)[6] with five women's recordings from the archive, and, latterly, the experience of sharing the work with others. My practice, listening-*with*, puts the MHTA to work, asking questions about oral history as a project that attempts to capture chronological, 'whole' narratives on tape and in transcripts, and offering a critique of the psychiatric institution and its claims to be a listening profession.

In this auto-ethnography of listening-*with* and compositioning I discuss the ways that I have worked with five women's recordings from the Mental Health Testimony Archive (MHTA), and my encounters with voices, sounds and silence. It is autoethnographic in the sense that I am situated (Haraway 1988) a thoroughly entangled researcher who recognises her place in the political context of the work (Russell 1999), researching from a position of lived experience, from which I practice listening in relation -*with* women survivors.

The testimonies, collected and recorded on to video tapes, catalogued (C905) and indexed with a short summary text, sit, most of the time, on a shelf behind closed doors in the British Library, until someone with the right permissions gains access to watch them. The archive in this work is not conceived simply as a collection of tapes in a library waiting to be discovered and mined for material, or a 'thing' from which knowledge can be retrieved, readymade. The archive, as my research sets out to show, is always in process, never a complete or final object, rather it is site of 'knowledge production' (Stoler 2002: 87, 90), activated and produced through my embodied encounters with women who were recorded in 1999/2000.

[5] Throughout this writing I use quotation marks around terminology related to psychiatry, including commonly used terms like 'mental health', 'mental illness', and different psychiatric diagnoses to indicate that they are contested terms, with complicated histories and multiple meanings.

[6] Highlighting listening-*with* as a form of intra-action points to an understanding of bodies, discourse and archive materials as deeply entangled, not existing separately from each other.

These interviews, recorded onto DVC Pro tapes, have been through several processes before they reached me. First they were copied onto VHS tapes, for viewing in the library sound booths, to maintain the integrity of the original DVC Pro recordings. The audio from the five women, selected by me fifteen years later, was digitised by the British Library at my request. These digitised recordings, transferred to me as a collection of audio (wav.) files, then sat waiting on a computer disk, until I exported them into Pro Tools digital audio workstation to begin listening and working with them.

The primary question that this practice research sets out to answer is:

> *How can entangled and embodied practices of listening activate an archive of women's testimonies, engaging its affective registers and creating new assemblages of listening?*

Listening-*with* is a practice that encompasses multiple modes of sensing. In this writing I develop links between listening-*with* and work on transgenerational trauma and haunting, particularly through the work of Grace Cho (2008), whose theory of 'diasporic vision' acts as a departure point for a discussion of listening-*with* as a form of diasporic listening which allows for the transmission of trauma. Cho's diasporic theory is not isolated to seeing, rather it operates as a form of synaesthetic perception that is distributed across the social and cultural field. My reading of her work allows me to understand diasporic-listening (rather than vision) as a form of critical listening, similar in some ways to Harpin's (2018) conception of 'fleshy listening', whereby the whole body is immersed through multiple mediated and distributed channels both human and non-human, material and immaterial, in a form of entanglement which 'challenges the limits of our perception' (Cho 2008: 164), allowing us to engage with trauma, silences, stories and submerged narratives.

Cho is interested in 'the ways in which *listening to the voice* allows us to *see* trauma, how seeing and speaking are mutually important parts in an assemblage' (Cho 2008: 166, emphasis in original). The starting point for her research was listening to the 'hallucinogenic' voices of her Korean mother, whose experience of the Korean war and migration to the US as a GI bride left her deeply traumatised. Her work does not approach trauma at the level of the individual though, or through the lens of pathology, but rather examines how trauma is social, becoming dispersed across generations of Korean diaspora, through multiple, 'diasporic' routes, that include media technologies, like speakers and recording devices, and the cultural productions of the diaspora, e.g. plays, films, works of fiction and non-fiction.

Like Cho, my work is indebted to my mother, whose experience of the psychiatric institution at a time when she was asking for help, was abusive and deeply traumatic. It is not based on 'hallucinogenic' voices of the type that Cho describes but instead asks how listening-*with* voices from a testimonial archive allows us to encounter a diaspora of women psychiatric survivors, in the understanding that trauma is impossible to locate in any one place or temporality. My use of the term diaspora/diasporic refers to both a dispersed population and to distributed perception. I refer to women survivors of psychiatry as a diaspora, like Hester Parr et al. (2003), who found that both ex-staff and ex-patients of the Craig Dunain asylum in the Scottish Highlands considered themselves a diaspora, connected by the experience of living and working in an institution that indelibly shaped their lives.

Beyond using 'diaspora' to describe Koreans who migrated to the USA and those born there as second generation Koreans, Cho uses the concept 'diasporic vision' to refer to the perception of transgenerational trauma that is distributed across a population in memories and silences and through cultural productions and

technologies. She describes her concept of 'diasporic vision' using the example of a film about the sinking of a ship the *Ukishima Maru* that was carrying Korean exiles of war from Japan, back home to Korea, when it exploded, killing almost everyone on board. In her account she writes that

> a diasporic machinic vision is perhaps the only means by which haunted histories can be 'seen' through a distribution of the senses that at once resides in the film images of the *Ukishima Maru* exploding, in the eyes of the viewers of the film, in the silences of those who remember the incident but never speak about it, in the grief of survivors, in the bodies of those absorbed in their grief, in the skeletal remains found on the ship and in the effects of the disaster itself (Cho 2008: 174).

This description highlights the affective and distributed nature of trauma and shows how seemingly past traumas persist, haunting the present. This haunting destabilises notions of linear time, such that 'what is perceived is not located at any single place and moment in time, and the act by which this perception occurs is not the result of a single or isolated agency but of several working in concert or parallel' (ibid.: 166). My work explores this notion of haunting through diasporic listening-*with*. Unlike Cho, I am not exploring haunting through a specific traumatic event like the Korean war and its aftermath. My work, listening-*with* an archive of mental health testimonies, attempts to bring awareness to the excessive of transgenerational trauma that results from women's experiences of the psychiatric institution—to show how twentieth century psychiatry haunts the present, including current psychiatric practices—affecting bodies and crossing borders, through voices, media technologies, practices of listening, silence and other affective agencies.

Listening-*with*, as a kind of diasporic listening, is about understanding the potential for practices of listening to hear beyond signification or representation, to hear silence, the non-narrativizable and untold or half-remembered histories. Relating memories and experiences to a willing and empathic witness/listener is considered to be an important part of healing from trauma (Frank 1995; Laub 2013). However, I am not listening or compositioning in order to elicit an empathic response, but am more concerned with listening *awry* (Drobnick 2004), in ways that leave room for the unknowable, uncertain and ephemeral, accepting discomfort and unease as part of this process.[7]

In writing about voice I engage with new-materialism as a philosophy that broadens the parameters of voice to include the non-human and points to listening as a mode of attunement, rather than simply a mode of communication. Listening, in this context, is not understood as 'a physiological fact but as an act of engaging with the world' (Voegelin 2010: 2) that has the capacity to create encounters -*with* women whose experiences of the psychiatric institution left them traumatised, isolated and inaccessible.

Listening-*with*, together with practices of what Brandon LaBelle (2021: 54) terms 'compositioning',[8] foreground my encounters -*with* an archive as porous, emergent and relational—where listening and making do not proceed as a series of static

[7] Listening-*with*, particularly when considered alongside tenderness as a way of working, might be thought to equate with empathic listening. However, I am not listening in this work in order to elicit empathy, which risks glossing over differences and 'naturalising emotional connection and rapport as a gendered phenomena' (Chadwick 2021a: 560). Working with tenderness is not necessarily a comfortable experience. It requires a willingness to become open and vulnerable to uncertainty. Working with women survivor's voices I experienced frequent and sustained periods of discomfort and unease. The process of listening was never straightforward and rarely friction-free. However, working with discomfort, and 'staying-with' (Haraway 2016) feelings of unease, as Clare Hemmings points out, allows us to question the status-quo, to understand injustice viscerally and generate feelings of 'affective solidarity' that move us to a place of knowing differently (Hemmings 2012: 149).

[8] Compositioning is a term conceived by Brandon LaBelle in his 2021 book Acoustic Justice. At times in my writing it has a (with) in brackets next to it in order to make a sensible sentence. The brackets denote that the 'with' is not actually required next to the word as 'compositioning' is a technical term for forms of 'acoustic orientation' and positioning that already contains the with within it (in the 'com'). According to the online etymology dictionary 'com-' has the following

encounters with pre-existing bodies and voices, but as dynamic and affective 'intra-actions' (Barad 2007) that inform and co-shape one another. My use of a hyphenated -*with* is in part a reference to Jean Luc Nancy's ethics of being, in which he argues for the irreducible primordiality of being-*with*, in a move away from Levinas's religious framing of alterity as the 'other' against which we come to know ourselves. Nancy (2007) argues that a potent solidarity and sociality occurs in being 'side-by-side' rather than facing the 'other'. He refers to this as 'being-singular-plural' in which he characterizes the 'singular plural' not as the same ('I') or the other ('you'), but the self (soi), as an 'each one' always already in relation, and which is more originary than both 'I' and 'you' (Watkin 2007: 54). In other words, as Deirdre Heddon (2017: 27) surmises in a chapter on the late performance artist Adrian Howells, 'being-singular-plural renders one *with* the other'. The artist and psychoanalyst, Bracha Ettinger's work on trans-subjectivity describes this being-*with* in a different way, emphasizing the maternal/matrixial relation she argues that humans are always already in relation, co-emerging and trans-connected through the 'matrixial experience of being in the womb—growing and co/emerging with/in an other' (Ettinger 2006). As Louise Boscacci writes of Ettinger's work on wit(h)nessing, 'we each first share space and time within the maternal "womb," or matrixial space and time. In this co-poiesis—co-making—the first person is already relational: there is no I without a non-I' (Boscacci 2018: 343).

1.5 Earwork

Listening-*with* is not only a form of diasporic listening, it is also a form of what Cyrus Mody (2005: 176) refers to as 'earwork'. In this work there are moments when I refer to these three terms separately, and other moments where they might be

etymology as a 'word-forming element usually meaning "with", "together", from Latin com' (https://www.etymonline.com, first accessed 13/02/2020).

used interchangeably. Earwork has a slightly different slant to listening-*with* where the emphasis is on entanglement and relationality, and diasporic listening, where the emphasis is on haunting and affect. Throughout this writing earwork refers to the specific ways in which I practiced listening within the *space* of an archive in order to attune to the many layers of institutional life. Earwork, according to Mody (2005) and others studying how sound impacts on people and objects within institutional spaces, is a form of *practiced* listening that comes from being immersed in an environment and becoming attuned to the many sounds of that environment and what those sounds signify and do. Earwork has been used by researchers to describe learned methods of acoustic meaning-making in different aural environments, particularly in organisational settings like offices, laboratories and hospitals.

My earwork has enabled me to become attuned to the environment of the psychiatric institution as it is witnessed within the oral history archive—both of which become sites of production through my intra-action. My listening activates the archive, enlivening experiences that might not otherwise become apparent, and in this sense, as the next section on compositioning shows, my listening stimulates the production of a new archive/s, for example, when my listening brings to consciousness the effects of drugs on women's voices and bodies. Such forms of earwork allow a different sensibility to the acoustic environment of the oral history interview, one that enables me to tune into the many layers of the institution as it works on bodies and spaces in multiple and complex ways. Throughout this work it is not necessary to think of earwork as a separate practice to listening-*with*, it is part of the same, but the emphasis on tuning into institutional space makes it worth mentioning here.

1.6 Compositioning

Compositioning is a term I borrow from Brandon LaBelle's (2021) work on acoustic justice. It relates to the ways acoustic practices work at 'orientation'—the ways one reckons with the social, spatial and temporal order to find 'a manner of living' (LaBelle 2021: 24). Similar to some definitions of assemblage (Featherstone 2011) but with the 'acoustic' at its heart, compositioning is about:

> how orientation is constructed or fought for through an acoustic performativity; a vibrational commoning [...] which do[es] not so much orchestrate the field of audibility, or compose from a distance, but rather contend[s] with the overlapping temporalities and spatialities, as well as frequencies and oscillations that emplace us, that stick to us, or become sticky and therefore malleable, and that we seek to make meaningful. Compositioning is an embedded process that grabs what it can and that arranges it along the way (LaBelle 2021: 54).

The relationality, with-ness, affectivity and situatedness implied by this definition is at the heart of my praxis. LaBelle chooses the terminology of compositioning, rather than simply using the word composing, to highlight with-ness and positioning, to reorient listeners to the ways in which acoustic practices can create communities, particularly among those who are less audible. Compositioning is a way of sounding the richness and fullness of voices that are alive.

Listening-*with* and compositioning are practices of care, ways of tending and attending, being-*with* women survivors who have experienced a desperate lack of care. I composition -*with* women who have previously been isolated, labelled and categorised (both in psychiatric terms and within an archive), to create opportunities for encounter in spaces where our voices have not previously been heard, or have only been heard in ways proscribed by institutions. Rather than

understanding women through the lens of identity, my work becomes a way to explore the social and collective trauma of the psychiatric institution.

This work draws on and contributes to knowledge and practices across a broad field of cultural studies, particularly in relation to trauma and haunting. Below I outline in brief what I mean by haunting and how I refer to it throughout this writing.

1.7 Silence, shame and haunting—listening-*with* ghosts

She sits in a high chair, feet off the ground, hands gnarled and bent with arthritis, head bowed, hiding her pain behind a veil of thin greasy hair. My great grandmother, hanging there, unwashed, waiting to die.

> The day room…it was a very large room, very high ceilings, quite a lot of windows, none of them curtained, bare lino again and down part of the room, in the middle, there was a row of, of old ladies in what were called geriatric chairs. They were chairs with fronts on that these old ladies couldn't get out of …the nurses used to tie the trays onto the chairs so the ladies couldn't get out of the chairs […] under some of the chairs there's puddles of urine which obviously the smell that goes with it and there's just this big, very big room. (Pauline 2000)

Like every family mine has its share of secrets, lies and half remembered stories about those who are no longer alive; gaps where shame and silence reside. Throughout this work I have placed images and half-remembered moments from my family history, alongside the words of women from the MHTA in order to animate the ghosts of an uncertain history—an experiment with auto-ethnographic forms, shaped by my entanglement with multiple bodies and unconscious experi-

ences. For 'if … studying ghosts allows us to rethink a society's relationship to its dead, particularly to those who are subject to some kind of injustice, the ghost and its haunting effects act as a mode of memory and avenue for ethical engagement in the present' (Cho 2008: 29).

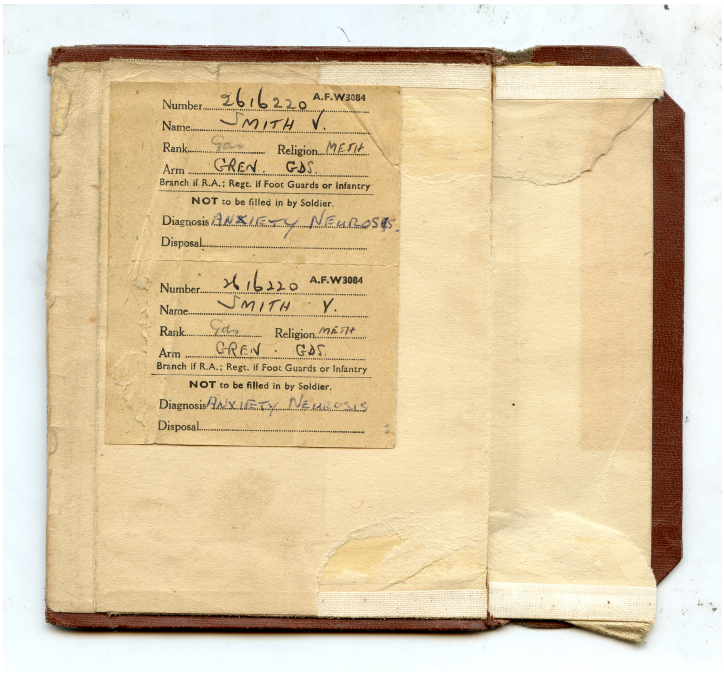


Fig. 1.2: Scan from the author's grandfather's Soldier's Service Book

These ghosts are not simply my family's or my own. As Nicholas Rand writes in his notes to Abraham and Torok's 1994 book, studying transgenerational haunting 'enables us to understand how the falsification, ignorance, or disregard of the past—whether institutionalised by a totalitarian state … or practised by parents or grandparents—is the breeding ground of the phantomatic return of shameful secrets' (Abraham and Torok 1994: 169). Ghosts might be handed down in a story told to cover up some family shame, like the story of my grandad's flat feet. So often was it repeated that as a child I made up a rhyme about it:

Grandad's got flat fe-et, he had to leave the army

Grandad's got flat fe-et, he had to leave the army

The real reason for his army discharge only came to light when I was clearing out his council house after his death in 2000 and I discovered his Army service book. Quizzing my mum later she finally told me the terrible effects of the London Blitz on her father, a Grenadier Guard at Buckingham Palace throughout the war. Such secrets, 'forgotten' or erased histories become hauntings working their way down generations. This idea of traumatic memory as a memory that is not one's own, has been rehearsed in different configurations across trauma and memory studies. Marianne Hirsch's work on 'postmemory' refers to memory that has skipped a generation as a result of the trauma of the Holocaust and draws on Cathy Caruth's conception of 'trauma, [that] does not simply serve as a record of the past but precisely registers the force of an experience not fully owned' (1996: 151). In this reading, the trauma of the original event is a gap, a silence or absence within the generation that experienced it but then passes onto the next generation, to be re-experienced, not as the original event but in ways that may or may not be understood as the trauma of another, or, as in the case of postmemory, the previous generation's trauma.

> *How many times have you been in hospital?*
>
> *Can't you remember?*
>
> *Try to remember.*
>
> *What happened to me?*

What secret is at stake when one truly listens? (Nancy 2007: 5)

The silences that haunt the oral history archive take many forms. They might exist in the gap of a question never asked or one story told in place of another and they are rarely characterised by actual silence. Silence is just as likely to manifest as a great deal of speaking or in the fleshy sounds of a tongue and mouth that fill the spaces between speaking; a woman saying 'my mouth's gone dry' or 'can we take a break?' Silence might sound as a break in the recording when the fax machine

intrudes or in the calm, learned speaking voice of a woman who has 'lost' her west country accent. Silences exist in moments that are alluded to but never narrated; moments of contradiction, or vocalised refusals, of which there are many in the MHTA recordings, for example, when Carole announces (in relation to a very brief mention of sexual abuse that she suffered as a child) 'that's all I am going to say on the matter'. In Annemarie's recordings there is no mention of domestic abuse in her marriage but an article in The Observer (7th April 2002) about the MHTA that I read some months into my listening contains details of the violence she suffered at the hands of her military policeman husband during her seven year marriage. What I hear when I recall Annemarie talking about her marriage is 'He was 21, I was 16. He was 21…'. However, despite there being no mention of domestic abuse in her interview, reading that article seemed only to confirm what I already knew.

In any unconscious haunted by trauma, there is a constant tension between speaking and not speaking. In families, silences can become established, working their way through generations. Silences of the sort attached to those who committed 'loved ones' to asylums, behind high walls, in bucolic settings, far from prying eyes and gossiping mouths. Out of sight, out of mind. Such secrets transmit down generations, carrying feelings of shame that stretch across generational lines long after the original source of the secret can be identified, 'wreaking psychic havoc for its inheritors' (Cho 2008: 183). According to Abraham & Torok 'shared or complementary phantoms find a way of being established as social practices along the lines of staged words' in ways that are productive (1994: 176). By sounding these phantoms I wish to release them, in order that they might find others like them, create 'new kinships' and set in motion the 'unpredictable effect[s] of multiplication' (Cho 2008: 185).

In this way, my practice attempts to illuminate how the unspoken trauma of psychiatrised women takes on a life of its own and travels through bodies, through generations, across space and time. It takes a hauntological approach to listening-*with* that recognises how trauma persists. If, as Avery Gordon argues, haunting occurs as a result of 'endings that are not over' (2008: 13), experiences that have, for decades, been erased from public record or silenced but continue to create psychic and material affects, then in order to attend to the trauma of the MHTA I must find alternative methods for noticing, including embodied modes of attunement that arise from my deep entanglement with the archive and the women who speak within it.

These relational entanglements can be taken as a strategy, a way of thinking, a mode of creating and an ethic within the work—a modality through which I can listen and respond -*with* disparate voices. Voices and sounds mediated through multiple layers of technology, that can record, store, relay, edit and process, enabling the perception of evanescent feelings while keeping in view the institutions that have tried and failed to contain them. Haunting in this context becomes a mode

of encounter that captures elusive and ephemeral forms of feeling and social consciousness, shines a light on structures of institutional power, and understands the actions of the researcher as vital elements in the process.

Listening always 'invokes corporeality …envelops listeners, and …resounds within the body' (Drobnick 2004: 10) and the longer I listened-*with* these women the more I felt their many voices working on me, producing new understandings and, at times, undesirable effects. Spectres seem to surface in spontaneous moments of 'fleshy listening' (Harpin 2018: 10), in which women's anguish, pain, loneliness and loss is felt. In this context, voice becomes a medium of 'affective and existential contact' (Leimbacher 2017: 298) producing disturbances, impinging on bodies and psyches, including my own, in unpredictable, unsettling, ways.

Over many months of intense listening-*with* these women's voices I began to suffer numerous somatic and psychic effects. I was plagued by the return of childhood nightmares, wondering endless corridors interminably searching for my mother. Fearing sleep, I suffered months of chronic insomnia which got so bad I ended up on a psychiatric ward for three weeks. I also began to experience what I can only describe as night visitations—a small, blonde toddler would appear at the side of my bed, facing me with outstretched arms, so real I felt I could reach out and hold him, but on waking he was no longer there. The searing pain of my waking grief remains vivid even now (these visions began just a few months after my own losses to miscarriage, whilst working with recordings of women who had all experienced child loss in some way).[9] In these vivid 'dreams' my own experience seemed to be merging with Ann's, whose MHTA recordings I was working closely

[9] It is only in retrospect, many months after completing work on HMCTL that I have come to reflect on the enormity of child loss within the MHTA recordings. It is surely no coincidence that when selecting five out of twenty-three women's recordings in the British Library every one of them had experienced child loss: Through lost custody; adoption; the death of a child; pregnancies 'lost' or never conceived as a result of drug side-effects or on the advice of psychiatrists. Such losses often remain silent and unacknowledged.

with at the time. Ann, who was already an unmarried, single mum and 'on a lot of medication', felt she had no choice but to give her second son, a 'beautiful golden baby', up for adoption. Could it be that the child I was 'seeing' at the side of my bed was from her past?

As painful and unwelcome as these experiences were I look on them now as alternative forms of knowledge, that enabled me to relate compassionately with the women I was encountering through my listening and that show how 'we are involved in the world *with* others in an inextricable tangle" (Merleau-Ponty, 1962: 454 in Shotter 2013: 133, my emphasis). My focus here is always on what listening *does*. Sound artist Hildegard Westerkamp writes that listening is 'inherently disruptive' and requires a 'preparedness to meet the unpredictable and unplanned, to welcome the unwelcome' (2019: 46). Listening requires commitment and through this work I have come to understand viscerally how listening can challenge normative assumptions, is uncomfortable and potentially transformative. As I became more deeply implicated in the lives of these women I felt my body becoming increasingly open to the experiences of others, a kind of bodily vulnerability that engenders questions of relationality and ontology, of what it is to *be* in the world, together.

Bracha Ettinger (2006) refers to this merging and sense of oneness as the 'matrixial borderspace'—where borders are spaces of betweenness rather than lines that separate. Her psychoanalytical take on subjectivity moves away from Lacan and Freud's theories of castration, in which subjectivity is created by the cut from the maternal and is based on a logic of castration, lack and the desire of a return. Ettinger instead understands the subject as always bound to the 'feminine' or matrixial—in a generative relationship with the 'mOther', which highlights forms of 'withness' in which subjectivity is not defined by the perpetual agony of loss of the 'petite objet a' where the 'womb is denied' as in Lacan, but rather through

a shareability and trans-subjectivity, conditioned by 'the impossibility of not-sharing' (Ettinger 2006: 75). Ettinger's work is particularly pertinent to processes of creativity in which subjectivity emerges through encounter. Through my praxis, my own psychic and somatic responses to listening-*with*, difficult as they are to explain in the rational terms of much academic research, are forms of jointedness—of 'knowing-*with* and knowing-*through* the audible' (Rice and Feld 2021: 1) and inaudible, and of experiencing through being-*with*.

1.8 Ineffable methods: know-how or no-how?

Erin Manning warns us that method 'works as the safeguard against the ineffable' (2016: 32), for if something is not categorisable it cannot be accounted for and is in danger of being set aside as insignificant. Manning argues that there are serious consequences for research if we ignore its unconscious, unknowable aspects—as knowledge becomes relegated to the sphere of 'conscious knowledge' leading to the backgrounding of embodied knowledge, whereby any 'uneasiness that destabilizes thinking' is expunged (ibid.). Erin Manning's writing has crossovers with Suely Rolnik's writing in relation to art as a mode of production that 'puts the world to work and reconfigures the landscape' (Rolnik 2011: 24). Like, Manning, Rolnik brings subjectivity into close relation with artistic practice arguing that transformation can only occur when we become vulnerable to other possibilities.

> Whatever the means of expression, we think/create because something in our everyday lives forces us to invent new possibilities, in order to incorporate into the current map of meaning the sensible mutation that is seeking passage in our day-to-day experience. (ibid.)

Sarat Maharaj argues that thinking *through* art making is a process that is distinct from 'circuits of know-how that run on clearly spelled out methodological

steel-tracks. It is rather the unpredictable surge and ebb of potentialities and propensities—the flux of *no-how*' (Maharaj 2009: 3). 'No-how' opens up ways of working that are 'seething' with a 'para-discursive charge'—with 'pathic and phatic force'—a range that is embodied, somatic, non-verbal and performative (ibid.: 4). Maharaj is referring specifically to visual arts, however, I believe that listening-*with* and compositioning can be considered forms of 'no-how', attending to the unspoken as a way of working that is 'impromptu in the course of the art practice-research effort' (ibid.: 2). As Salome Voegelin puts it 'a preference towards the unknown and the incomplete is not a formal conceit, a stylistic fancy, but a serious response to the failings of a complete and reasonable world' (Voegelin 2019: 7). This proclivity for what might be considered 'anti-method' aligns with the ethos of mad studies research, an emerging area of study which embraces epistemic uncertainty as a deliberate tactic, allowing for unusual and unpredictable ways of working. As Hester Parr points out, when engaging with subjects that animate the asylum as a site of exploration, the researcher should be prepared to reorient her 'research methodologies to [...] messiness' (Parr 1998: 350).

Taking up this call to work with the unknown and unpredictable has had a direct bearing on the way I found myself working, in ways that were not based on replicability or preordained procedures but rather relying on my bodily and unconscious responses to archival sounds and stories to tease out and composition -*with* strands of entangled histories. Listening can be repetitive, scrolling back and forth along a timeline, stopping and starting, listening and re-listening, peeling away words and sounds, isolating noises, phrases and juxtaposing different elements of the recordings, listening-*with* breaths, bodies, rooms and voices. Encompassed in the concept of 'no-how' is the idea that creative research, like listening, is inherently unstable, emerging in slightly different ways each time. These are practices that can never be exactly replicated, as Julian Henriques points out, even 'repetition,

like the Heraclitean river, is never the same twice' (2010: 77). Listening-*with* often seems to be going over the same old ground, but each and every listening is slightly different, always creating something new.

Throughout my thinking, practice and writing I have listened-*with* submerged narratives, silences and displaced actors to create forms of 'mediated perception' (Blackman 2015: 25). Such displaced actors include children whose voices sound out at unexpected moments in the testimony, brought into the future, in the voice-body of a child. Or the moment a woman cries out a painful 'mother' as she conjures breathless familial bodies into the present, releasing a spirit, calling forth the ghosted remains of long dead relatives. Even a fax machine intruding in a moment of speaking can be heard as a ghostly agent in the assemblage. These voices, stories, events, and experiences cannot be contained in the archive or elsewhere; they will always be in transit, on their way to somewhere else. Not a 'thing' waiting to be discovered, but instead a 'state of affairs' (Dovey, 2010:16 in Trivelli 2015: 123) that requires the researcher to become attuned and activate the felt memories and stories of survivors. In my work the MHTA recordings become a kind of 'enchanted' material, to use Jane Bennett's terminology (2001), that has the potential to be alluring, uncanny and disturbing. As I listen-*with* voices and testimonies I am called into dangerous places, sites of the dead, forgotten and buried, witnessing close-up the effects of trauma on bodies, including my own. These spectral encounters, or embodied hauntings, as I am reminded by Karen Barad 'are not mere recollections or reverberations of what was' they are 'an integral part of existing material conditions' (2017: 74) and allowing for the entry of the ghost calls attention to their inaudibility and exclusion.

1.9 Some words on affect

Like much research on haunting as a mode for encountering trauma, this writing utilises the term 'affect'. I do not have space here to delve into the many 'swerves and knottings' (Gregg and Seigworth 2010: 5) of affect's various theoretical origins or expand on criticisms of their different strands.[10] Instead, I turn to the queer feminist writing of Ann Cvetkovich, who uses terms like feelings, affect and emotion 'more like keywords, points of departure for discussion rather than definition' (2012: 5). This equivalence offers a degree of 'ambiguity between feelings as embodied sensations and feelings as psychic or cognitive experiences[...]' and maintains 'a conception of mind and body as integrated' (ibid.: 4), where the body is not contained or a *thing*, but is porous and permeable, defined by its ability to affect and be affected (Gregg and Seigworth 2010) or to be moved and to move.

To write-*with* feelings resonates with feminist work from lived experience and a politics 'suffused with feelings, passions and emotions' (Gorton 2007: 333) that recognises the critical links between affect and gendered, classed, sexualised, racialised and other institutional relations of power. The movement towards affect/feelings/emotion has been part of a broader shift away from textual/linguistic deconstructionism that 'parallels a shift in emphasis from epistemological questions' to the ontological and 'questions as to the nature of (pre-discursive) realities' (Greco & Stenner, 2008:10 in Pedwell and Whitehead 2012: 117). According to Patricia Clough, theories of affect allow us 'to grasp the changes that constitute the social and to explore them as changes in ourselves, circulating through our bodies, our subjectivities...' (2007: 3). These understandings of affect connect with feminist demands to bring theoretical attention back to the body, and, significantly for my work can be brought into dialogue with critiques of psychiatry

[10] Gregg & Seigworth, 2010 (p.6-8) outline 8 main orientations and approaches to affect's theorization that sometimes overlap.

that examine the social, cultural, material, immaterial and historical dimensions of psychiatric diagnoses, the pharmaceutical industry and other psy-institutions and their manifold effects on women's bodies (Chesler 1972, Showalter 1987, Ussher 1992, Orr 2006, Millet 1991, Trivelli 2014) and that recognise how psychiatry has been profoundly gender-biased, such that the 'very constitution of sanity and "mental illness" in late 20th-century society was anchored in the bedrock of male normativity' (LeFrançois et al. 2013: 6).

To research the affective realms of an archive requires methodologies that 'are sensitive to human and nonhuman agencies, entanglements, and thresholds' (Blackman 2015: 26), that take account of experiential realities that have been systematically silenced, as well as the conditions of the archive and psychiatry's techniques of power. I am, therefore, not interested in creating sound or theorising sound for its own sake, in aestheticising archives or in an empirical project, thematising, analysing, deconstructing oral history narratives. Instead, this work aims to create encounters -*with* a diaspora of women whom I refuse to understand through the lens of clinically constructed diagnoses that silence trauma, but recognise as women who co-emerge through creative *compositioning*, with ever-mutable subjectivities.

Knudsen and Stage (2015) argue that research questions about affect become eminently more answerable if they are concretely related to particular bodies (for example, the researchers own body) in discrete social contexts (the speech, sound, and voices from recordings/transcripts of five women's witness testimonies in an oral history archive of psychiatric survivors). However, that is not to say that my research turns only on how my own body is affected by listening-*with* and compositioning (-*with*) an archive of testimonial recordings, I am much more interested in how new, or, previously unaccounted for knowledge, arises as a result of my intervention, listening-*with* the material and immaterial aspects of the archive.

Throughout this writing I, therefore, pay close attention to the *act* of listening and towards the listener, who, as Farinati and Firth (2017) point out, is an 'actant' whose listening offers a salient force. The researcher here can never be an outsider listening-in, but instead animates the archive in ways that intensify the present moment, stretching and contracting temporal and spatial parameters.

1.10 Why listening/sound?

HMCTL was made solely with sound from the Mental Health Testimony Archive. It does not contain any external field recordings or compositions and the sound that it works with is largely unprocessed, meaning that it has not been fundamentally altered from the original audio found in the video recordings. Although the texts (transcripts) of the archive are important elements in this work which I quote at length, it was through aural encounters, listening-*with* the archive, rather than viewing the transcripts, that this research developed.

That is not to say that I hadn't considered working with visual media. I spent a significant amount of time viewing the testimony videos in the MHTA and

working with other still images, including from the Brookwood Hospital archives and my own photographic archive.[11] In the Brookwood Hospital archives I took numerous photographs of archived images which I later decided not to use.[12] Additionally, I carried out research in the Screen Southeast amateur film archive, comprising hundreds of 16 and 8mm amateur films. I edited five of these films and later overlaid some of these edited films. Several years later I returned to these short overlaid films and captured stills from hundreds of the film frames. I do not discuss the work I did with these films or images in any detail here, however, in bringing together this thesis I have returned to all of these still images and curated a collection of untitled photographs which I have inserted throughout this writing. By placing sound clips from HMCTL alongside still images and other moments of experimentation in the thesis I create a 'collage' (Orr 2006: 29), which disrupts the familiar linearity of the thesis format.

An important reason for my focus on sound from MHTA is that when faced with the video images of speaking/gesturing women I felt strangely distant to them. They were 'there' and I was 'here' watching. The documentary style video portraits brought to mind psychiatry's history of photographic portraiture, used to classify and objectify women 'patients'.[13] As Irina Leimbach points out in relation to film 'documentary [...] has little time for the sonorous voice that enriches and complicates our experience of another without being reducible to meaning' (Leimbacher 2017: 297). When I closed my eyes to listen I felt my emotions

[11] This archive includes photographs taken in the Maudsley hospital during two inpatient stays, shot on black and white 35mm film in 2003, and, mobile phone images taken in 2015.

[12] The images were shot through perspex sheets, a requirement of the archive, so my own image, the strip lights above my head and camera appeared reflected in many of my photographs of these archived pictures, ruining (as I saw it then) the original images.

[13] Photographic imagery featured prominently in the work of male psychiatrist's such as Charcot, who used his now infamous photographs of women from Salpêtrière asylum to illustrate Hysteria. Other less well-known men like Dr Hugh Welch Diamond in the UK believed that photography provided objective permanent records of different types of madness and aided in the management of women (in Showalter, 1987). I am not interested in trying to subvert the patriarchal, clinical gaze by using different visual modalities.

stir. Sound and, more specifically, 'acousmatic' voice (Chion 1999) which has no external image, became a way for me to bridge this perceived distance. Hearing without seeing seemed to open something in me that I couldn't access when I was looking.

Sound is permeable, neither here nor there, it seeps, contaminates and spills over, is affected by bodies and the spaces it fills and, likewise, affects the way bodies behave. Speech originates from within and, in being heard, is taken within. This sense of with-in-ness made sound the perfect form for a work seeking to create encounters-*with* that might challenge psychiatry's classificatory systems, and enable listening that questions supposed divisions between madness and sanity. In its ability to cross thresholds sound also challenges ideas of archives as containers of pre-ordained knowledge.

Numerous sound artists and theorists since the 1950's have theorised what sound is and what sound does. For Brandon LaBelle 'sound is intrinsically and unignorably relational: it emanates, propagates, communicates, vibrates and agitates' (2010: ix). However, the practice being discussed here is not work that 'harnesses, describes, analyzes, performs and interrogates the conditions of *sound*' as LaBelle defines sound art (ibid.: ix, my emphasis). In this writing I am much more interested in interrogating the conditions of listening that animate the many layers of the psychiatric and archival institutions in which I find myself. HMCTL does not, therefore, ask to be conceived as sound art, but rather as a work of listening, which sits with Erin Manning's view of art as 'a *way* of learning' (2016: 46–7). Manning asks what artistic practice can become when the goal is not an object but, instead, becomes a catalyst—a movement towards new ways of being. In thinking with Manning's ideas, my work is not so much about the production of objects but is rather about forms of practice 'that map[s] the way toward a certain attunement [...] still on its way' (ibid.: 47).

1.11 Staging women's words: longing to speak

Practice research challenges traditional forms of academic knowledge creation, offering new modes of questioning, producing and researching the haunting and affective registers of an oral history archive. I composition with text as well as sound so that writing becomes another form of practice, a way for me to create a feeling account of my experiences of listening-*with* and compositioning, placing my body on the written page, as an 'I' that is multiple. The writing is auto-ethnographic, in the sense that I recognise my place in the wider political context of women's psychiatric experience (Russell 1999) and as I document my experiences of listening-*with* and compositioning, I stage women's words, sounds and silences; traumas 'too deeply embodied for an I to speak them' (Clough 2000: 20). Whilst I remain invisible and inaudible, my body is entangled—listening, writing, feeling, thinking, creating -*with* women, unavoidably and deeply implicated.

In staging voices from five women's recorded testimonies, bringing words, voices, breaths, sounds and spaces to this stage, I draw on the recordings, transcripts and oral testimonies of five women from the MHTA along with my own fragmented memories to conjure an *uncertain* 'history that longs to be spoken' (Cho 2008: 170). If as Abraham & Torok state 'phantomogenic words' are 'staged words' (1994, in (ibid.: 167)) then to 'stage a word [...] constitutes an attempt at exorcism, an attempt, that is, to relieve the unconscious by placing the effects of the phantom in the social realm' (Abraham and Torok 1994: 176). I deliberately disclose 'the places where feeling and lived experience collide with academic training and critique' (Cvetkovich 2012: 80), writing in different registers (the academic, personal and performative), experimenting with inscription as forms of making and performing.

This practice is ultimately about finding ways to bring the polyvocal, lived experiences of psychiatrised women into sharing spaces of encounter, not only through the sound work but also in the thesis, and as a result most of the long quotations and all of the sound clips in this work are survivor voices. In this writing I show how, through processes of co-enaction, my embodied responses become active elements in the research in ways that acknowledge trauma as productive and generative. These multiplicitous encounters -*with* women open up space for transformative, trans-subjective experience, in which being-*with* is experienced through the tone of a voice, a word or phrase that is repeated, the sounds of a woman's mouth moving, a fax machine, page turn, or, women breathing together.

In the prologue to her book Panic Diaries, Jackie Orr asks 'in a society of unspeakable madness, how does a mad woman tell a history of what has come to be called a "mental disorder"? And, immersed in a merciless language of non-madness, how will we ever hear her?' (Orr 2006: 1). I hope that my listening-*with*, compositioning and writing-*with*, rooted within feminist traditions concerned with performative, auto-ethnographic modes of researching through the body, bearing the traces of trauma, and desiring justice for those long-silenced, provide ways to 'hear her' and connect with the experiences of women who have suffered 'the deep-seated, intangible, psychical complications' of 'living within a ruling episteme that privileges that which they can never be' (Ann Anlin Cheng, 2001:7 in Cho 2008: 162).

1.12 Breathing-*with*

The sonic flesh has no dermis, no skin, but inhabits the possibility of the world with its own formless possibility. It is organs without a body, without social boundaries, etiquette, and merges into the volume of the world with its own capacity to be…(Voegelin 2019: 119).

You are breathing into me. You are not here and I am not there but we are together. I experience your breathing as penetrating witness to your presence. Your breath moves me. My chest expands, lungs fill, and then deflate as your breath escapes me. You-I breathe. We *breathe in time together, breathing-with-one-another. Breathe-with-in, breathe-with-out, breathe-with-in, breathe-with-out.*

Kathleen sits in the corner of a dingy office with a large printer/photocopier on the office table behind her, a rubber plant to one side, against the wall. She is seated in a small swivel chair with arms and is wearing a dark dusky pink coloured top, slightly too big around the neck and revealing at the top of her left shoulder the scalloped edge of a pale pink vest. She speaks slowly and deliberately, staring off to one side, perhaps looking out of an unseen window, sometimes upwards, at times making eye contact with the interviewer and smiling or chuckling. She has been filmed facing the off-screen interviewer at a diagonal angle, the camera framed in close up on her head and shoulders. She lifts her left hand up to her neck, looks down as she speaks or looks up to the ceiling or at the interviewer in a quizzical way. Sometimes she asks a question, or leans forward towards the interviewer. She lifts her right hand to wipe her nose with a wrinkled tissue, revealing two brass bangles on her wrist and a silver ring, like a large wedding band on her middle finger. She smiles and laughs as she talks, but even when she is silent, pausing to remember or reflect for a moment, looking down, her mouth is restless and I find myself fixated by the movements of her mouth, tongue and cheeks, as her tongue wipes across and behind her bottom lip, moving back and forth, making clicking, licking, clucking sounds; she swallows, pulls her bottom lip in over her teeth and her cheeks puff slightly.

As I watch this clip again I am reminded of the intense difficulty of listening in the archive; caught between trying to capture every word spoken and being engrossed

in the video images—the appearance, facial features, gestures and movements of the women in front of me—struggling at the immensity of the task ahead. At home, with five newly acquired audio recordings[14] and after many weeks of listening and feeling stuck, the boredom, restlessness and pain of listening to these dense spoken narratives for clues about what I might do with them leads me to start taking words out. Working with five women's voices, using Pro-Tools, a digital audio workstation (DAW) that forces me into a certain temporal linearity, I find myself longing to hear less. Longing for silence or voices that seem to convey more than they say (Dolar 2006). I can't think for all this speaking, I can't listen anymore, these voices are too real and the stories they tell too difficult.

I decide to strip back the words being spoken to give the track breath, or life, which has somehow got lost in all this listening.[15] I need to revive the voices and myself as listener, with some 'vital energy' (Järviö 2015: 28) for after long days listening I feel listless, despondent and stuck. A sharp pain has developed in my left side and I'm struggling to get enough air into my lungs. I have to remove the headphones and walk away from the computer just to catch my breath. Perhaps this is just a 'momentarily immobilizing encounter' (Bennett 2001:5 in Trivelli 2015: 129) of the sort Jane Bennett describes in her work on enchantment, a moment of 'feeling [...] disrupted or torn out of one's default sensory-psychic-intellectual disposition' (ibid.) and which Elena Trivelli, in her work on Basaglia's Gorizia asylum, describes feeling 'every morning' as she 'descended into the basement' of the asylum at Gorizia, to rifle through piles of yellowing patient's files, untouched for decades (ibid.). But I am not in some haunted place surrounded by old clinical

[14] I selected five out of 23 women's testimonial recordings from the MHTA and paid the British Library to digitise these as audio files (wav.) so that I could upload them into Pro Tools and work with them at home. I had to complete a simple application form to obtain permission from BL to use these five audio recordings in my research. The acquisition of these women's voices is not something that I discuss in detail here, but the decision was fraught with concern on my part about my right to 'use' these oral narratives as sound-material, thus amplifying some voices whilst excluding others.

[15] Here I discuss in detail how I worked with just three of the women's recordings to create breath-tracks (Kathleen, Ann and Carole).

files researching the physical remains of a buried archive in the damp basement of a crumbling asylum. I'm just here, at home, wearing headphones and listening to women speak. But this listening is haptic. It moves me. I find myself 'touched by voice', listening-*with* voices that are acousmatic, separated from their 'original' source, and yet never entirely disembodied—even as recordings, played through headphones, these voices are material and immaterial, they matter, physically and ontologically (Leimbacher 2017: 298).

I start with Ann who speaks in fast-paced densely packed Glasgow-inflected paragraphs, barely taking the time to breathe between sentences. These thick paragraphs of speech become even more apparent when I search through her transcript. Listening to her I find myself holding my breath—I have to consciously remind myself every now and then to breathe—BREATHE. I work for several hours—just cutting her words. I am not accurate, and find that I leave the tail ends of words and beginnings as I cut away the most densely packed sound-waves on her session track. I am unsure whether to leave in her 'mmms' and 'ahhs' and other vocal 'disturbances'. I decide to leave them in. Listening back to the sections I have cut and stuck back together her breath is often hard to find—it slips in and out with the beginnings and ends of words and occasionally in a quiet space between her long, fast-paced passages of speech. So much breath seems to be getting lost, that it seems only in those sections of words not accurately cut away that I am able to decipher her breathing at all. It is almost as if she is afraid to stop speaking, afraid of what silence might mean. She keeps talking hurriedly, sometimes seeming to struggle to catch her own breath and tripping over her words. Perhaps if she stops speaking the enormity of what she is saying will hit her. The childhood poverty, the shameful single parenthood and the child she felt she had to give up: 'I should take these people to court for what they did' she states in the middle of recalling all the drugs she was given and their many side-effects.

With Kathleen removing words is more straightforward—her speech is slow and measured. Her voice is gentle, breathy, slightly gravelly and very low. She leaves long pauses between her sentences, perhaps something to do with being a smoker or it could simply be that she is drifting off into a world of memory as she formulates an answer. Is this the first time someone has asked about Long Grove? Or about the patients she met in Holloway Sanatorium? I am mesmerised by her slow delivery and sometimes drift into daydreaming, forgetting that I need to cut her speech not listen to it 'I'm a dreamer, I'm a dreamer…' One problem with her recording is that the audio settings on the video camera seem to have been set so low that I struggle at times to hear her breath—perhaps I need to normalize the sound? Such a strange technical term when considered in the light of these recordings. I decide not to normalize the breath track to bring the volume up, concerned it will have the effect of flattening her voice.

Other noises become more apparent in Kathleen's recording as I strip away her speech—the clicks, clucks and lip smacks that mesmerised me whilst watching her speak on the monitor in the British Library. Playing back what I have cut together, I remember that such tics are a common symptom of Tardive Dyskinesia (TD),[16] a side effect of antipsychotic medication, particularly associated with Chlorpromazine, also known as Largactil. As I listen to these noisy movements—the assemblage of mouth, lips, tongue, teeth, saliva starts to take on a life of its own—a manifestation of the intra-action of medication and mouth which I discuss in detail later.

[16] Tardive Dyskinesia (TD) is a condition that can appear in some patients on long-term psychoactive drug therapy or may appear after drug therapy has been discontinued. The syndrome is characterised by rhythmic movements of the tongue, face, mouth or jaw (e.g., puffing of cheeks, protrusion of tongue, chewing and puckering of mouth). Sometimes these may be accompanied by involuntary movements of the extremities. TD can appear in all age groups, although prevalence appears highest among older patients, particularly elderly women. The symptoms are persistent and in many patients appear to be irreversible. http://www.rxlist.com/thorazine-side-effects-drug-center.htm

> *Listening to Carole for several hours today extracting the words from her testimony and stitching together her breath I am struck by the enormity of this task. What does it mean to remove words? Is this an ethical encounter? These oral history interviews, with their endless questions and answers, reveal only history told in chronological order. I know there is* more *than I find in these words.*

Doubts paralyse me. Not only am I trying to edit Carole's words, I am removing her speech altogether. The feeling of guilt attached to deliberately stripping these testimonies of their apparent meaning is real. As I sit for long hours extracting words and sentences I can feel the tension this guilty feeling imparts on my body. Is this some sort of transference? The somatic affects of too much listening? My shoulders ache and I have developed a pain in my left side. In the end I do create a 'breath-track' for Carole and the results, on listening back, are revealing. Underneath the calm, controlled delivery of speech that seems well-rehearsed (near the end of her testimony she reveals that has previously been involved in the making of a documentary about women convicted of arson) is the breathing of a woman who sounds panicked.

As I listen repeatedly to her sharp intakes and quick out breaths I find my whole body responding in powerful ways over which I have no control. I am breathing-*with*, my body is tuning into her breath in ways that suggest 'breathing coordinates bodies-in-time' (Lande 2007: 100). This breathing-*with* confuses temporality, creating the feeling of her being here -*with* me, right now. Carole and I breath-*with* each other, even though she is not here and our *actual* bodies are physically separated by years. This listening-*with* seemingly immaterial breathy sounds creates material changes; a 'sharing of the other's flux of experiences in inner time …living through a vivid present in common' that might be understood as constituting 'the mutual tuning-in relationship, the experience of the "we"' (Shutz, 1964:173 in ibid.: 100-1). A 'matrixial borderspace' which we co-habit that exposes

how our subjective bodily boundaries are permeable and 'have already always been transgressed' (Ettinger 2011: 4).

Each breathy encounter becomes a corporeal being-*with*, every in- and ex-hale challenges what I think I know about skin and the borders of my own body, unsettling any presupposed distinction between inside and outside and disturbing my understanding of distance and proximity. These are more than proximal encounters of the type described by Adriana Cavarero when she writes that 'nothing more than the act of breathing is able to testify to the proximity of human beings *to* one another (Cavarero 2005: 31, my emphasis), for this suggests two prior bodies entirely separate, bounded and contained in their own skin, touchable only from a distance. This listening/breathing 'in time' moves me, my skin and ear drums resonate with the sound of *her* breath, and my brain/lungs are activated to breathe-*with*. We are becoming -*with*—a resonant, relational encounter in which bodies co-emerge through sounding, breathy forms of co-enaction—breathing-*with*.

This breathing-*with* might be considered a form of 'enactive witnessing'—usually defined as a form of analytic practice that allows for 'memory in its varied forms, without attempting to symbolize or make personally understandable the experience [...] of trauma' (Reis n.d., 1 in Clough 2009: 153). According to Clough enactive witnessing 'proposes to engage trauma and its characterization as being resistant to symbolization and to a linguistically oriented narration of memory, not in the domain of epistemology, [...] but rather in the domain of ontology or performativity in relation to bodily affect' (ibid.: 153). Like one practicing a form of enactive witnessing, this bodily listening-*with*, attuning to the breathing of Carole, Kathleen, Ann, Pauline and Annemarie brings attention to the desperate isolation of the traumatized person, whose experience of solitude seems impenetrable, even as they seek a witness. Listening-*with* and breathing-*with* are moments of becoming

and like enactive witnessing can be understood as modalities of somatic, affective experience, that is ephemeral, that exists only in the present.

Listening-*with* these speaking voices as 'whole life' stories, as they were conceived in the creation of the oral history archive, encompassed a lot of time feeling blocked—time spanning many weeks and months when I resisted the work and made little progress. My sense of being stuck was, at times, overwhelming; a form of what Cvetkovich (2012) describes in her work on depression, as 'intellectual anxiety', which she argues might come about as a result of academic/capitalist pressures of having to create/write in order to maintain one's place in the academy. She writes that 'the material dimensions of being stuck or at an impasse are important to its more conceptual meanings and suggest the phenomenological and sensory dimensions of depression, which can literally shut down or inhibit movement' (ibid.: 20). She goes on to suggests that one remedy for such depressed feelings might be found in forms of creativity:

> If depression is conceived of as blockage or impasse or being stuck, then its cure might lie in forms of flexibility or creativity more so than in pills or a different genetic structure. [...] Defined in relation to notions of blockage or impasse, creativity can be thought of as a form of movement, movement that manoeuvres the mind inside or around an impasse, even if that movement sometimes seems backward or like a form of retreat. Spatialized in this way, creativity can describe forms of agency that take the form of literal movement and are thus more emotional or sensational or tactile (ibid.: 21).

Understanding depression as 'being stuck', rather than through a biomedical lens, as pathological, it becomes a form of 'hidden knowledge, that is making its bid for freedom' (Cvetkovich, 2012 in Harpin 2018: 11). Removing words from the archival recordings was the creative movement that released me from this terrible impasse, at least temporarily. In the seemingly simple action of creating breathing space on

the Pro Tools timeline, an expanse opened for the sounds and movements of breath, including my own, to emerge. Taking out words and releasing breath created new ways to witness that didn't depend on formulating questions or understanding answers, enabling what Patricia Clough refers to as 'a rethinking of the symbolic mix—culture, language, representation, and narrative—as the *sole* resource of dynamism and change' (2004: 3, my emphasis). It was a vital part of my early work with women's voices and recordings, that opened me up to the ways that bodies are inseparable, allowing me to experience listening differently, not relying on my ears alone, but in ways that were truly synaesthetic.

Breathing-*with* is an experience that can unsettle the structures of the psychiatric institution—uncovering layers of trauma that could never be contained within asylum walls or the lives of individuals held there, enabling the circulation and transmission of traumatic memories in affective ways that would be neglected by focusing solely on spoken or textual narratives. In the action of breathing-*with* my body becomes part of an assemblage of voices, breaths, narratives, symptoms and practices, 'in which silences [...] emerge not as obstacles but as voices of a different type, that speak "when mouths are silent"' (Davoine and Gaudillière 2004: 226). Breathing-with creates new knowledge from the excess of the archive and a recognition of my place as inextricably entangled-*with*. This is not to say that long form narratives and spoken testimonies are not important, but rather that speech as a demand, that is based on an understanding of individuality as encompassed within a 'whole-life' autobiography, narrated linearly from past to present, does not allow for the richness of experience that cannot be put into words, that comes alive always in the present moment. Attempts at creating chronological, linear accounts of autobiographical memory fail to acknowledge the dendritic nature of memory, that memory is made in the moment of remembering, and, a question asked in one moment might be the catalyst for completely different memories at

another point in time. My listening-*with* is an attempt to breathe life into many layers of experience, and removing words and foregrounding breath created the conditions for forms of enactive witnessing that allowed for my own, and other's, unconscious experiences, to become apparent.

Within the composition of HMCTL the breath tracks feature quite minimally. They sound in the first 1'57" of the piece, but are broken up and interspersed with other sounds.[17] The work that these breaths do is, I hope, more than the space given to them, in terms of alerting the listener to the state of bodies throughout the composition, enabling the listener to tune into the most intimate, bodily vocalisations, and draw ears to the sounds of women and institutions that live within the work. But it is not only breath that is at work here. Listening again to the first 1'57" of the composition this is what I hear: An intake of breath with some shuffling sounds, and another sharp intake, Kathleen saying yeah, and background noise from the video camera being set up, snippets of broken breath, clicks, sniffs, sounds of the camera being moved and switched on, an interviewer's voice, the momentary ring of a fax machine, stomach gurgles, distant speaking in the corridor, mmms, uhmms, ahhs, a chair being scraped on the floor, a couple of fragments of speech, 'potential neurotic', laughter, and at 1'57" the distant sound of a hoover in the background. It isn't easy to list all the sounds and each listening creates something slightly different, so this list is not exhaustive and another person's list is likely to be different to mine as their ears pick up other sounds from the jumble. Some sounds are indefinable, neither one thing nor another, sounds that

[17] In an earlier version of HMCTL the first two minutes began with the voices of the people interviewing and recording the oral history testimonies stating the index number for each interview, the interview number and tape number: 'C905 interview 41, tape number 2; C905, interview number 23'. In this way the listener became aware from the outset of listening to an archive being created, constructed and organised in specific ways, numbering testimonies, tapes and the archive as a whole for categorisation, storage and retrieval purposes and that the logic of this archive is outside the hands of those being interviewed. However, after completing most of the sound work I decided to revisit the first few minutes and instead bring breath in from the beginning, foregrounding the im/materiality of women's voices.

have been created in the piling up of breaths, chair scrapes, uhmms and ahhs on the Pro Tools timeline. The ways in which sounds vibrate, coalesce, expand and move into each other, something like 'her' breath mixing with my breath, creates tones and timbres that might not register consciously, that cannot necessarily be individually recognised.

This background 'noise' or what Michael Serres refers to as 'sonic flux' is full of sounds that might not be singularly identified, that fill what Christopher Cox calls 'the auditory unconscious' (Cox 2009: 19). Michael Serres understands noise as the background of information, that grounds our very being, and is never ceasing. In his article on the sonic unconscious, Christopher Cox uses an example of sounds of waves and sea to illustrate how all sound that we perceive as individual, delineated from other sounds exists in a mass of sound that isn't consciously sensed (ibid.: 21). He refers to the philosophy of Gottfried Leibniz and the idea of 'minute perceptions' in which conscious perception is 'grounded in a vast swarm of elements that do not reach conscious thought' but have a 'virtual existence'—that 'determine conscious perception but are not present to it' (ibid.). Leibniz, as Cox notes, believes that memory in a similar way has a 'virtual existence' (ibid.) as our experience always takes place against the background of a vast memory bank, which, mostly, remains unconscious but can be generated in a moment by, for example, by an image, melody or encounter—bringing a tiny piece of experience into the present, momentarily revealing it and providing a glimpse of the entirety.[18]

Such a moment of temporary illumination sounds in the 'sonic flux' of the first 1'57" of HMCTL, at 1'13" when Kathleen speaks the words 'potential neurotic' and laughs before her speaking breaks down into breathy noise. Her voice so low that

[18] This conception of memory works with a view of forgetting as a memory that is simply concealed or silenced until the moment it is triggered and illuminated. Real forgetting, when memory becomes totally inaccessible, is more accurately thought of as erasure. Such catastrophic memory loss might cast a person into a permanent present-state, where the past is unknown and futures become unimaginable.

it is, perhaps, only her words that reveal her to be a woman, for this diagnosis 'neurotic', as Elaine Showalter points out has long been considered a particularly 'female malady' (Showalter 1987). The words 'potential neurotic' offer a critique of the way diagnoses are applied and situate Kathleen's experience at a particular moment in time when neurotic was a common diagnosis for women. The words many latent meanings, against the breathy, unstable noises of the first two minutes allows a listener fleeting access to Kathleen's experience, and the effects of the psychiatric institution.

HMCTL is composed of largely unprocessed sounds[19] and in the first couple of minutes these sounds are arranged in accumulating layers. The breaths and other noises do not crescendo evenly from quiet to loud or contain any particular pattern or repeated tropes and are not rhythmic or musical. The sounds were selected through processes of feeling my way around the women's tracks, cutting and stitching moments together in ways that were instinctual. This assemblage does not

[19] When I refer to unprocessed sounds, I mean sounds that have not been through any special effects processing such as a granular synthesiser that might, for example, alter the dynamics or pitch of the sound. The original sound has been digitised and made into wav. files from the VHS video tapes but has not undergone any processing that fundamentally changes the character of the sound waves.

adhere to conventions of experimental, electronic or musical composition, which tends to highlight the aesthetic qualities of sound or voice through patterning, repetition, rhythm and dynamics.

In the first few minutes of HMCTL, the fragmentation of sound is intended to alert the listener that they are listening-*with* traumatised bodies. The work of listening thus becomes an offer, an opportunity to tune into women's voices, silences, stories and experiences, a way of holding out a tender ear, as an act of compassion and care (Harpin 2018). Brandon LaBelle's work on acoustic justice provides ways to think about how listening is a form of political action. He plays with Ranciere's concept of the 'distribution of the sensible', proposing acoustics as 'the distribution of the heard' as a way to articulate 'economies of attention' and capacities of listening as they are shaped by social, historical, technological and political forces (LaBelle 2021: 14). It is these 'economies of attention' that I explore through my listening, in order to think about how we can listen differently -*with* psychiatrised women, and, to create new conversations about the way women, and others who suffer distress, experience the psychiatric system. It is an important conversation to have, as Helen Spandler and Mick McKeown (2017) point out, it is only when we acknowledge the wrongs of psychiatry, past and present, that we can start a process of healing some of the damage that has been done in the name of psychiatry and begin the long work of creating better modalities of care.

Despite being conceived in an arguably linear form as a composition that is listened to from beginning to end HMCTL is not an attempt to describe *whole* lives, to create a chronological narrative that travels in one direction, or an attempt to explain or create identities. Rather, it seeks to mediate against the chronological demands of oral history, psychiatric case-study, anti-stigma campaigns, Recovery Narratives and other tropes that might appear to offer liberating stories of redemption based on individual 'insight'. HMCTL is full of gaps, submerged and silent voices, as well

as narratives and stories that intersect and weave around each other, that open up the possibility for a collective 'diasporic' telling about the experiences of women in the twentieth century psychiatric institution and beyond.

My compilation of small sounds at the beginning of HMCTL is an attempt to create a sense of anticipation and to introduce the listener to the multiple lives sounding in the work, foregrounding the aliveness and vitality of these women, introducing us to their force. Tuning into the collective aspects of breathing and the 'sonic flux' or background sounds of the archive *in production*, the body is not simply understood as a cultural construct, rather, 'machinically assembled bodies' can become 'compositions of elements, assembled [...] in order to do something, to transform, expand, or contract themselves and other bodies' (Clough 2004: 11). Through breathing-*with* women and attuning to the many sounds of the archive as it is being created, I begin to understand my entanglement in what Cho refers to as 'the assemblaged body'—a social, diasporic body, distributed across spatial and temporal planes as it seeks a place to land. As the breaths and other sounds dissipate at 1'57" the quiet droning of a hoover can be heard in the distance; the sound of the institution making its call.

2. Listening and not listening: psychiatry, recovery narratives and oral history

> *What silenced me finally was coming to understand how absolutely those who locked me up had to believe in the correctitude of what they had done; nothing in the world could let them doubt it. They would never give in, never see crazy as a mixed state, an ambivalent affair, or that crazy was not a crime but rather a point of view and need not be locked up, that locking up is an invasion of every human right, an invasion essentially insane—no, no, no, they stood against all that, they had to. Sanity itself demanded that of them, and sanity is a religion to them, an ideology*
>
> —K. Millett (1991: 86–7)

2.1 Silence and listening in psychiatry

When beliefs become *'securely encrusted around some conviction, justification, identity, cause, or the like, [we deny] the legitimacy of the other'* (Gurevitch, 1988:165 in Lipari 2014a: 98).

The experiences of those held in psychiatric institutions, or treated in the community, are rarely heard, and when they are they tend to tell a very limited story. When psychiatric history is recounted by the medical and cultural institutions

that maintain it, this silence is often perpetuated, as psychiatry is promoted as an institution that has made great progress, vast improvements in diagnosis, medical and psychological interventions and in the treatment and involvement of patients/service users. As Mike Micale and Roy Porter state in their book, Discovering the History of Psychiatry, 'since the mid-twentieth century, something labelled 'the history of psychiatry' has been diversely interpreted by its authors as the unilinear progress of humanitarianism and medical science' (Micale and Porter 1994: 4). In such unilinear accounts, the abuses and injustices of psychiatry often remain unacknowledged or consigned to the past, as the way things *used to be done*. As a result the trauma of the psychiatric institution remains a 'black hole' (Cho 2008: 12) in collective memory, largely untold and unassimilated.

Bridget McWade's analysis of UK mental health policy at the beginning of the twenty first century explains how the problems of psychiatry have been laid at the door of the asylums in which psychiatry was practiced, rather than failed psychiatric practices. A 2001 Department of Health report (written just one year after the MHTA interviews were carried out) asserted that 'for much of the past hundred years, decaying, depressing old hospitals housed far too many people—

often far from their homes—for long periods. Out of hospital, people with mental health problems received little or no help' (Mahoney and Sheehan, Dept. of Health, 2001:3 in McWade 2016: 66). This report effectively removes psychiatric practices from this history of neglect arguing that the problems within psychiatry are to be found in the decaying infrastructure of old asylum buildings and the failure of care in the community. The report goes on to state that the stigma and linking of 'mental illness' 'to danger and social exclusion' is the 'legacy of large institutions'; and a public who have 'misplaced attitudes' (Mahoney and Sheehan, 2001: 3 in ibid.: 66). In this rewriting of psychiatric history there is no acknowledgement that psychiatry, rather than reflecting, more often informs the public's understanding of 'mental health' (ibid.) and little recognition that the practices of psychiatry might themselves be flawed.

More than twenty years on the public debate around 'so-called mental health' (Filer 2019) might seem to have made great strides forward, with many people in the public eye coming out to discuss their problems in podcasts, on Instagram and Twitter, radio and TV programmes. When commentators, politicians and journalists claim that the UK is 'in the grip of a mental health crisis' (Campbell

2021), they flag up issues like the Covid pandemic leading to high demand, NHS underfunding and staff shortages as reasons for poor psychiatric care and services. Whilst these undoubtedly have an impact on people in distress and the help they can access, the actual practices of psychiatry, the ways in which diagnoses are made and treatments effected, are rarely discussed or publicly scrutinised. This is so even when a televised abuse scandal comes to public attention, such as that of the Edenfield Centre where the abuse of patients was exposed by BBC undercover reporter, Alan Haslam, and aired on BBC One's Panorama programme 'Undercover Hospital: Patients at Risk' (28th September 2022).[1] At the same time the Diagnostic Statistical Manual expands with every publication as new diagnoses and disease categories are added to its already biblical proportions, leading to ever higher numbers of people potentially falling within psychiatry's purview.[2] For Brodie Paterson et al (2013) there is a kind of 'collective amnesia' in twenty first century psychiatry—the result of 'the monopolizing of treatment achieved by biopsychiatry, the near demise of social psychiatry and a loss of interest in the concept of the therapeutic community', that has blinded psychiatry to 'the significance of the milieu.' (ibid.: 228).

[1] When certain services are scrutinised, as with the recent Edenfield Centre exposé, that comes 10 years after the Winterbourne home scandal revealed shocking abuse of people with learning difficulties, the focus seems to be on individual cases of abuse more than on the psychiatric system itself. Even when reviews are demanded into systemic abuse, it is the *excessive* use/abuse of the powers that psychiatry has, rather than the powers themselves that are considered problematic. As this quote on the Disability Rights UK website (UK n.d.), from Vicki Nash, Associate Director of Policy, Campaigns and Public Affairs at Mind, the leading mental health charity in the UK confirms, 'the apparently excessive and punitive use of restraint and seclusion for people with mental health problems and autism' is 'shocking and extremely concerning', rather the fact that restraint and seclusion are legal, often-used 'treatments' for people suffering mental anguish and distress.

[2] This quote is from the American Psychiatric Association website, Psychiatry.org: '*The Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, Text Revision (DSM-5-TR)* features the most current text updates based on scientific literature with contributions from more than 200 subject matter experts. The revised version includes a new diagnosis (prolonged grief disorder), clarifying modifications to the criteria sets for more than 70 disorders, addition of *International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM)* symptom codes for suicidal behavior and nonsuicidal self-injury, and updates to descriptive text for most disorders based on extensive review of the literature' (https://www.psychiatry.org/psychiatrists/practice/dsm, accessed 17/10/22)

Lisa Blackman argues that the biomedical model that is the basis of much modern psychiatry operates by instating 'a separation between the biological as an 'autonomous physiological state' (Littlewood, 1996: 15) and the cultural; where the latter can only ever register as a peripheral influence' (Blackman 2007: 1). This separation of body from the social, cultural and environmental fields has led to forms of psychiatric practice that are based almost entirely on a biogenetic view of psychopathology, in which disorders of a biochemical basis are understood to be the at the root of psychiatric problems, whereby one's neurochemistry or genetic makeup is deemed faulty and abnormal. As a result ideas around psychopathology have become 'constituted through a logic of loss and deficit that produces the singular, bounded neurochemical or biogenetic body as its object of study' (ibid.). This understanding of the faulty, individual body has far reaching consequences not only in terms of how psychiatric services are organised, but also in how messages about mental illness are replicated across society, through popular, cultural narratives, including through charities and government-funded anti-stigma campaigns, whereby 'mental illness' is promoted as 'an illness like any other' (Read et al 2006 in ibid.) and drugs are the first, and often, only line of treatment.

Despite the overwhelming dominance of neurobiological explanations of 'mental illness', within psychiatric training manuals and text books, listening is almost always listed as a key epistemological practice. As Mohl and Carr (2015) outline in the summary of their chapter 'Listening to the Patient' (2015):

> The enduring art of psychiatry involves guiding the depressed patient, for example, to tell his or her story of loss in addition to having him or her name, describe, and quantify symptoms of depression. The listener, in hearing the story, experiences the world and the patient from the patient's point of view, helping carry the burden of loss, lightening

> and transforming the load. In hearing the sufferer, the depression itself is lifted and relieved. Listening is healing as well as diagnostic (Mohl and Carr 2015: 4).

This quote illustrates, how, even when presented as 'healing' the way psychiatry listens is primarily diagnostic. The role of a psychiatrist is to guide the 'patient' to tell about their 'symptoms of depression' (or some other diagnosis). Listening in this context is about *finding* the patient, as Mohl argues when he states that 'there is nothing more healing than being found by another' (ibid.: 12). This suggests that the patient is otherwise lost, and requires the 'expert' to solve the mystery of where the patient is; to 'find' them among the ruins of their broken lives. Listening is considered here to be the 'primary tool' of psychiatrists, perhaps the most important aspect of the 'therapeutic' encounter, or as Mohl argues, the very 'art' of psychiatry (ibid.: 1). Psychiatric listening allows the psychiatrist to *see* the patient and observe their suffering. Listening, in this context, paradoxically becomes a kind of visualisation tool, that allows the psychiatrist to locate the patient and *see* the cause of their distress.

This kind of listening also engenders particular modes of confessional speech; as Mohl states, the psychiatrist must guide the patient to 'tell his or her story of loss' (ibid.). In the clinical encounter listening to the patient therefore becomes a goal-oriented exercise, aimed at leading the patient to tell what has happened, as the 'expert' psychiatrist gathers information to create a *picture* of the patient, and, ultimately, make a diagnosis. Through this 'monological' listening and the speech it effects, the diagnostician is able to 'utter the last word about someone' (Frank 2005: 967).

The idea of listening as an open-ended process is anathema to diagnostic listening. The psychiatrist Jonathan Shay reflects on this in his work with Vietnam Veterans arguing that listening in the psychiatric context can become a kind of 'intellectual

sorting, with the professional grabbing [...] words from the air and sticking them into mental bins' (Shay, 2010 in Gilligan and Eddy 2017: 77) a sort of coding and categorising of experience. There is, as Carol Gilligan and Jessica Eddy point out in their article on listening as a path of psychological discovery, a huge difference between listening which is ultimately focused on diagnosing someone according to a set of criteria or against a clinical scale, and asking questions and listening from a place of 'genuine curiosity', or not knowing, which leaves open the possibility of surprise, even of 'having one's view of the world shaken' (2017: 77).

Every woman recorded in the MHTA testifies to the systemic failure of listening within psychiatry (Harpin 2018), a failure that acknowledges that when psychiatrists listen they are listening in order to uncover the 'disorder' within a patient's narrative. While traumatic events and stress are understood to impact on mental health this impact is understood through a biological lens, as, for example, in the diagnosis of post traumatic stress disorder or complex PTSD (Herman-Lewis 1992) which pathologizes survivors by understanding responses to trauma as symptoms of internal 'disorder' (Shaw and Proctor 2005). The kind of listening that Mohl promotes as 'healing' is therefore merely instrumental, filtered through a framework that understands stress and trauma as a cause of biological disorder that can find its correction in biological remedies, as Moncrieff and Read explain in the quote below:

> The idea that biological factors 'cause' depression, even if in conjunction with social circumstances, ...presupposes that there is a mechanical and predictable relationship between biology and human feelings and actions that excludes the possibility of meaning and agency (Moncrieff, 2020). Hence viewing depression as a medical disorder that somehow originates in the brain and responds to brain-based interventions is fundamentally inconsistent with understanding it as a 'normal'

> human emotion, albeit sometimes extreme and disproportionate—that is as a meaningful reaction to depressing events and circumstances (Moncrieff, 2020 in Read and Moncrieff 2022: 1402).

There are some appalling moments recounted in the MHTA that clearly demonstrate institutional failure of listening. One that stands out is Carole's experience of being in the Maudsley hospital throughout the mid-to-late 1970s:

> I'd been asked to talk about my childhood . . . and I'd started to unravel some of the things that had happened to me and to talk about some of the treatment I'd received as a child and I was told one day that there was going to be a case conference about me and I walked into the room and there in the middle of it all was my father . . . The psychiatrist invited me to come in and to confront my father with some of the things that I had been telling them about my childhood and the whole room fell silent and waited for me . . . and I said to my father 'don't you remember when this happened and that happened?' and he said 'no, you're making it up, it never happened' and the psychiatrist said to me in front of the whole room 'It's quite clear to me that you're a compulsive liar, I don't want to hear another word about this fantasy'.

Carole's revelation is startlingly similar to the experience that Jacqui Dillon describes in the book De-Medicalizing Misery (Rapley et al. 2011), about a conversation she had with a psychiatrist, during which she started to speak about her appalling experiences of childhood sexual abuse by her family and others and was told simply that 'these things didn't happen—this is part of your illness [. . .] Jacqui, we have had other people in here reporting similar kinds of incidents but when we have invited their families in, and we all sit and talk about it together, they begin to see that this is a part of their illness' (ibid.: 144).

The artist, writer and activist Dolly Sen (2022) powerfully and painfully recounts her first experience of psychiatry as a desperate fourteen year old whose childhood had been characterised by violence, neglect, rape, poverty and racism.

> I hoped this psychiatrist would listen to my pain and save me from the terror. I was frantic to speak to someone about what was happening inside and outside my head. I wanted someone to stop me from drowning. What I learned from that first session is that psychiatry does not offer a life ring to keep you afloat. It puts a concrete block around your feet to freeze your life in time, to make every forward step impossible. The first thing the psychiatrist said, without even making eye contact, was 'So, whats wrong with you?' It was a devastating thing to hear. 'What was *wrong* with *me*?' (ibid.: 251).

All three women quoted above testify to the silencing of the psychiatric institution that diagnosed and pathologized them, rather than hearing their trauma. As Ussher states: 'labelling us mad silences our voices ... the rantings of the mad woman are irrelevant, her anger impotent' (Ussher 1992: 7). Traumatised women have

for decades endured 'treatments' like electro-shock 'therapy' (ECT) and psycho-pharmaceuticals in a form of institutional gaslighting and violence for which the institution of psychiatry has never been held accountable. Like other women diagnosed with a psychiatric disorder when abuse and trauma was at the root of her distress, Jacqui Dillon writes:

> The clear message that I received from the mental health system was that I was ill. Everything that I said and did was because of my illness. The abuse never happened—even thinking it did was part of my illness [...] Because I was ill I needed to take medication. The fact that I didn't want to take medication was because I was ill. If I wanted to get better I must accept my diagnosis and take medication [...] I didn't know what was best for me. I lacked insight. As mental health professionals they all knew what was best for me, because they were the experts. (Rapley et al. 2011: 144–5).

Shaw and Proctor (2005) point out that since the 1990s the diagnosis of 'borderline personality disorder' has frequently been given to women who have suffered the effects of child sexual abuse and other forms of trauma. Like 'hysteria' as a

diagnosis for women in the nineteenth and early twentieth century (Showalter, 1982) 'borderline personality disorder' is a diagnosis that pathologizes women for their response to oppression and illustrates how psychiatry has failed to view women's distress from a social perspective (Shaw and Proctor 2005). As the Diagnostic and Statistic Manual states, some 75 percent of those diagnosed with 'borderline personality disorder' are women (DSM-IV, 1997: 652 in Shaw and Proctor in ibid.: 487) and many have a history of trauma, with at least 70 percent suffering sexual abuse in childhood (Meichenbaum, 1994 in ibid.). Such a diagnosis creates 'aetiological closure' (ibid.: 487) and is an effective way of silencing women from speaking about the causes of their distress. As Carole states in her testimony:

> Eventually someone decided that my diagnosis was 'borderline personality disorder'…I didn't understand what 'borderline personality disorder' meant, I'd never heard it before. Nobody ever explained it to me. In fairly logical terms I thought disordered personality sounds about right. I mean that kind of fits how I feel but I didn't know what it meant in, in psychiatric or legal terms, I didn't realise what a sentence it was, what a terribly pejorative term it was, had no idea of the ramifications of that.

The diagnosis of 'borderline personality disorder' can be a particularly devastating one, for it confirms a sense that rather than sexual assault or violence being the cause of distress, the disorder is located within the individual who suffered the abuse. It pathologises gender inequality and systemic violence against women, in a society where one in four women are known to experience rape or attempted rape (Painter 1991 in ibid.) and one in two girls will be confronted with some form of sexual harassment or unwelcome sexual approach before the age of 18 (Kelly et al., 1991 in ibid.). Apart from failing to acknowledge the effects of sexual violence on individuals, this diagnostic approach also has far reaching implications in terms of how institutions, governments and society, more generally, think about and deal

with gender violence. As Shaw and Proctor argue, if we continue to pathologize distress as a symptom of disorder rather than a sane response to unacceptable realities, 'we not only continue to deny the agency and integrity of people who have already been abused and silenced; we also deny ourselves the grounds for meaningful movement towards the creation of a more acceptable reality' (Shaw and Proctor 2005: 488).

The position of women as patients within psychiatry has aways been a precarious one. As has been widely documented, women could be committed to the nineteenth and twentieth century asylums by their families and husbands for almost any reason; they were unwanted wives, had become pregnant outside of marriage, for their sexuality, because they expressed opinions or characteristics not considered feminine or were considered morally lacking in some way. As psychologist Phyllis Chesler writes in *Women and Madness* 'clinicians, most of whom are men, all too often treat their patients, most of whom are women, as 'wives' and 'daughters' rather than as people: treat them as if female misery, by biological definition, exists outside the realm of what is considered human or adult' (1972: xxi). It has been well documented that many more women than men find themselves developing 'careers' as psychiatric patients and spend significant portions of their lives taking psychiatric drugs, in hospital or therapy (see Chesler, 2005, Breggin, 1993, Showalter, 1985, Ussher, 2011). Peter Breggin argues that the relationship of women to psychiatry 'has an especially insidious quality not found in other institutions' and that 'psychiatric abuses of women exceed the norm in society' in part because of its implementation 'on a one-on-one basis' (Breggin 1993: 402). In the MHTA interviews the insidious nature of this one-on-one relationship is shown over and over again. One particularly vivid example (which I refer to again later) is from Kathleen's interview and illustrates this aspect of psychiatric power unambiguously.

INTERVIEWER: what were the doctors like?

KATHLEEN: Well…I couldn't understand this doctor but …and I think it was my fault again you see, because I don't sort of talk back to them.

He said *'you're stupid'* he said *'you never think' 'you must give up your religion'* and …he was all sort of…I felt he was sort of against me…and finally when I went to see him I never said anything at all…

INTERVIEWER: why do you think he wanted you to give up your religion?

KATHLEEN: well, he said that my religion was too high for me…and it was a substitute for sex, and he said… *'what you need is sex'* which I thought was pretty…err…you know…unpalatable…

INTERVIEWER: when he said those horrible things to you was there anyone else present?

KATHLEEN: No

INTERVIEWER: Did you complain?

KATHLEEN: No

As a patient you might get used to a psychiatrist's ways of 'listening' and learn to say less. As Kathleen states 'eventually I sat there and said nothing at all'. The 'mental hospitals' of the mid-twentieth century, as the old asylums became known, were places where abuse and violence in the form of sexual assault and rape were not uncommon occurrences (Chesler 2005). The sort of 'treatments' on offer in these institutions included seclusion, mechanical restraints, cold-water baths, modified insulin comas and electro-shock. While most people today are treated in the community, and the practices listed above have been largely discredited, except for Electro-Convulsive 'Therapy' (ECT) or electro-schock which is experiencing something of a resurgence, for those who are admitted to psychiatric wards and

hospitals the use of non-mechanical restraint techniques and isolation are currently on the increase. As Mooney and Ava Kanyeredzi (2021: 1703) write about the situation in the UK 'a high proportion of psychiatric inpatients experience Restrictive Practice (RP) during admission'.

The recent BBC Panorama exposé of abuse at the Edenfield centre, showed how verbal, physical and psychological abuse against women particularly (but not solely) have become regular occurrences in one of the UK's largest medium secure inpatient units: An 'undercover reporter filmed staff swearing at patients, mocking their self-harm, using restraint inappropriately and secluding patients for weeks in small, bare rooms' (BBC news, 28th September, 2022).[3] This was taking place in a hospital that had been rated as 'good' by the Care Quality Commission (the UK's governing body for standards in health care). While this revelation might, momentarily, send shockwaves through the media, government and general public, there is little debate or discussion about whether restraint, isolation or forced medication are appropriate 'treatments' for people suffering forms of distress. Likewise there is little acknowledgement of the fact that forced hospitalisations are on the increase across the UK, as the Department for Health and Social Care's final consultation 'Reforming the Mental Health Act' states 'involuntary detentions' have 'more than doubled since 1983' (DHSC 2021). Although, it should be noted that, in the past, as now, voluntary detention has often come with the threat of involuntary detention should a person seek to leave hospital, so how *voluntary*, voluntary treatment actually is remains in question.

Seclusion or solitary confinement has a long history in the psychiatric treatment of women. Elaine Showalter writes about the frequent use of isolation as a punishment for over-talkative, bawdy 'madwomen' in Victorian asylums, where any deviation from 'proper' feminine behaviour was severely punished. At Bethlem, 'women

[3] https://www.bbc.co.uk/news/uk-63045298

were put in solitary confinement in the basement on account of being violent, mischievous, dirty, and using bad language' (Showalter 1987: 81) and in Colney Hatch women were placed in seclusion in padded cells, sedated and given cold baths up to five times more than the male patients (ibid.).

In the MHTA Annemarie talks about what happened to her after losing her son the day after his twelfth birthday. 'I bought him a bike for his twelfth birthday and he was killed the next day by a hit and run driver…' She goes on to describe how she had lost two daughters years before. 'One little girl was only seventeen hours old, and one was three days old. She was a thalidomide baby'. After the death of her son, Annemarie describes feeling severely depressed, self harming and wondering around Kent, 'I needed help and they just shut me in hospitals.'

Describing her treatment by the staff, in response to a question 'what were the nurses like there… were they supportive?' she says:

> No, I found them… all those years ago … I found them a little bit brutish. Very strict. And if you didn't do what they said when they said it, you got put in a side room, and I got put in a padded cell a lot… I was told I was being put in there for my own good. Then whenever I … didn't have a good day, they used to put me in these rooms and … I used to hate them. I used to find them very hard years…

In a similar way Pauline describes her experience of being locked in a side room when she was feeling her worst.

> I wouldn't want to say I was treated any differently from anyone else because I wasn't. […] if you were disturbed, rather than try to spend time with you, to … give you time to settle, the first approach was to put you in one of the side rooms. I mean I have spent as long as two weeks in a side room with a mattress on the floor, they used to dismantle the beds, there would be wooden shutters on the windows of the room and in the door to the room there would be a little, a little sort of peep hole … you know, but there was no light at all coming into that room. They'd leave the light on, the ceilings were very high, and you'd just have a plastic potty. […] I really don't know what was, what was behind the idea, whether the medical staff or the nursing staff really thought that seclusion was going to help you, I really don't know but to be locked in a room, for two weeks, with a mattress on the floor and a potty and no natural light and a spy hole in the door, it was bad, really was, that was the way it was.

Ann speaks about her experience of being sectioned at St Lawrence's hospital in Bodmin in the late 1980s/early 90s:

> Ann: You know I thought 'I'll never get out of this place' …it was a more secure ward…I kept pestering for them to let me out…I was going through a terrible, terrible time. I was objecting to the way some of the patients were being treated and …I was being verbally abusive again. All of a sudden this man in charge…he says 'I've got a little room for you' and he got me by the back, got the back of, the scruff of my neck, and by then the others were all around me and they were running me down this corridor, towards what was the time out room. He said 'I've got a little room for you' and as they took me down…they took me down and they flung me into this room, which was a time out room and it was like a cell […]. I just shouted, kept shouting 'let me out, let me out' …and when I was in there I just could not believe…the walls seemed to be hitting me like and I felt so closed in, so claustrophobic…cos everything was so closed in and it was a like a door that you could see through, there were bars and I was banging, it was a very old ward, this was. I was banging on the door to get out, I kept banging to get out.
>
> Interviewer: this was about twelve years ago?
>
> Ann: yeah, yeah, thirteen years ago […]

The ways in which psychiatrists make their assessments and diagnosis of illness is often based on asking the patient endless questions and the completion of long tick-box assessments. In the MHTA Kathleen talks about her experience of being taken to Horton Hospital and being assessed by the psychiatrist as needing long term treatment.

> When I first came in he said 'do you think any people are talking about you?' I said no …oh no…I said 'well people do talk about you don't

> they?' And I think he understood that…I wasn't paranoid, and then he said 'is anyone following you?' and I said 'no' …and I said 'Doctor', I said…'I …I suffer from depression and anxiety, so that was that.'

It is not only psychiatry that has a problem with listening and whilst I do not have space here to explore the long and complex history of psychoanalysis with listening (see Lagaay 2008), it is worth mentioning in relation to a situation that Carole describes from the late 1970s, that within psychoanalysis the '[f]ear of a crises can lead to the killing of speech, by always postponing it or reducing it to insignificance' (Davoine and Gaudillière 2004: 136). Carole's experience of attending psychotherapy after the ordeal of her 'review' whilst in the Maudsley, provides an illustration:

> I had two years of one-to-one psychotherapy at the Maudsley. They didn't deal with my abuse ever, and at the end of the psychotherapy, the therapist said to me that my problems had stemmed from my guilt at failing to care for my mother adequately and I needed to deal with the guilt that that had left me with. So it was not only wrong, but it denied the fact that I had taken care of my mother…So the whole two years was a completely negative waste of time. Going up to the Maudsley to talk to the wall […] That came to an end in 1978 and I felt very much when I walked away from the Maudsley that's the door shut, I've nowhere to go…but at least I don't have to waste time talking to the wall anymore.

As Carole so clearly states, rather than having any therapeutic value her therapy had become a waste of time, '[a] totalitarian situation [slipped] into the banality of the sessions, perverting the analytic relationship into a scenario of submission' (Milgram, 1974 in ibid.: 137).

2.2 Recovery Narratives: a new way to listen?

As the large psychiatric institutions closed down in favour of 'care in the community', which never really materialised as the much promised alternative, pharmaceuticals have become the primary, often, only mode of 'treatment' and the biogenetic disease model of western psychiatry is more entrenched than ever. The belief that psychiatric illness is caused by chemical imbalances, which require antipsychotics, antidepressants or other medications has led to a very particular model of 'recovery' within psychiatry, one that is dependant on a number of characteristics being present in the patient. Under this model signs of psychological distress can be ascribed to symptoms of mental 'illness' and recovery comes from having the 'insight' to accept a doctor's diagnosis of disease/illness and comply with any subsequent pharmaceutical 'treatment' regime, or 'hope' technology (Franklin 1998: 203 in Blackman 2007: 8).

Lisa Blackman's work shows how the media play a role in defining the relationship between psychiatric patients and recovery, by elevating the status of certain celebrities who have spoken about their recovery from mental illness through the acceptance of their diagnosis and subsequent psychiatric treatment in ways that negate and silence alternative narratives. She offers the example of press coverage of Frank Bruno's diagnosis with bipolar disorder, from being a victim of illness when the Daily Star reported that he was suffering from manic depression, 'but won't accept it' (23 September 2003: 9), to hero just a few weeks later when The Guardian ran the headline, 'My illness could help others' (The Guardian, 4 November 2003 in ibid.: 2) to show how the media reinforces certain societal views of insight, recovery, risk and harm. A number of people have also written about the charity sector's reinforcement of psychiatric tropes around biomedical illness. As Sen (2022) argues anti-stigma campaigns are largely ineffective at reducing

stigma and can also have unintended consequences of promoting the bio-genetic-medical model of psychiatry, creating an even greater sense of division between the 'mentally-well' and those considered 'mentally-ill'. Rather than attempting to change the institutions and structures that stigmatise, pathologise and traumatise, these campaigns often place the onus on those suffering distress to recognise their 'illness', talk about it and seek professional help.

In the twenty-first century a specific type of narrative has been created within the mental-health sector—a way for those who have suffered 'mental illness' to inspire others and reduce stigma—that of the Recovery Narrative.[4] Recovery is not a new concept in mental health care and is thought to have come into being in the 1970s, originally used by mental health activists to challenge psychiatric power, who argued that recovery from distress and madness was possible without psychiatric intervention. These activists advocated peer led services and approaches to mental healthcare based on human rights. However, since the 1990s 'recovery' has become a central paradigm and buzzword in psychiatry, psychology and associated areas of research internationally (Slade, Amering et al. 2008) and has been used (and misused) to describe a variety of practices. There is general agreement among researchers that *real* recovery-based practices involve patients and those caring for them working collaboratively, as Champ states, 'real recovery is done *with* the person rather than to them' (Champ, 1999, p.144 in ibid.: original emphasis).

Recovery Narratives describe a particular form of storytelling that has arisen as the concept of 'recovery' has gained traction in psychiatric and psychological services. In the writing that follows I focus specifically on these narratives which have relevance to listening in psychiatry and society at large, in terms of how

[4] Woods et al (2022) use 'Recovery Narrative' capitalised to denote the specificity of this genre of narrative storytelling. They suggest that perhaps the most well-known example of a Recovery Narrative is Eleanor Longden's 2013 TED talk 'The voices in my head' which has been viewed over 5 million times on YouTube.

'mental illness' is spoken about and, therefore, listened to. According to Angela Woods et al. (2022) the 'Recovery Narrative' is a genre of storytelling that is operationalised by the mental-health sector in specific ways. Recovery Narratives are often commissioned and facilitated by mental health services, mental health campaigns and charities, and are promoted by activist groups as well as mainstream psychiatric services. Woods et al. are interested in the 'structures of intelligibility' of Recovery Narratives and challenge their 'assumed transparency, neutrality and compulsory positivity' (ibid.: 222).

Recovery might have become 'the hegemonic guiding principle of public mental health policy' (Braslow 2013:783 in ibid.: 224) but this does not mean narratives around recovery are homogenous. As Woods et al outline Recovery Narratives can produce diverse accounts, for example, of recovery from 'illness' that has been achieved by adherence to a drug regime; recovery from a personal crisis or traumatic event achieved independently, or even through the rejection of psychiatry. However, despite the variety of reasons that might be offered for recovery, because the narratives 'are actively solicited, circulated and mobilised' (ibid.: 226) they tend to adhere to certain conventions found in a number of 'how to tell your recovery story' guidelines.

Recovery Narratives are often produced for public consumption and performed on platforms where an audience and speaker/writer are brought together for a specific purpose, such as at the beginning of a mental health conference, as part of anti-stigma or fundraising campaigns, and in clinical education settings. They are usually inspirational stories with emotive, personal and transformational content—narratives that Woods et al. argue fall within a 'genre of insight' (Woods, 2012 in ibid.). Those stories which include 'fanciful' elements, that might read as somewhat 'chaotic' or include elements that might be considered delusional or as being in anyway 'symptomatic of schizophrenia' or psychosis (Woods, 2012 in

ibid.) are usually excluded. Recovery Narratives therefore rely on a narrow set of conventions that restricts the kind of stories that get told.

This doesn't mean that all Recovery Narratives are uncritical of psychiatry, but rather, that they reproduce specific relations between narrators and audience, so that even when they are delivered from the perspective of a survivor of psychiatry who rejects dominant psychiatric perspectives, the narrator is seeking recognition from 'the Other that the knowledge they possess about their experiences qualifies as 'insightful'' (Woods et al. 2022: 230). As a result, narratives that express 'irrational' beliefs remain silenced, which, as Woods et al. (2022) point out, is problematic from a Mad Studies perspective, which argues that rationality should not be considered the only source of knowledge. Whilst not always directly related to Recovery Narratives, anti-stigma campaigns have been critiqued along similar lines. Dolly Sen, for example, critiques 'Time to Change', which became a hugely popular and widely known UK anti-stigma campaign that asked 'normal' people to have a cup of tea and chat with someone experiencing mental distress, which, as Sen points out, might work for the 'worried-well' but if you start talking about being God or having demons chasing you it might be harder to find someone to listen (Sen 2022).

Even if the Recovery Narrative can be used to frame diverse understandings of mental distress and a variety of modes of recovery (therapy, support networks, mediation, drugs) and varying degrees of 'transformation' (from living-well with illness to believing yourself cured) the genre bestows on audiences the power to confer on the narrator the possession of *insight* into his / her situation and a common understanding that this insight has come about through a process that includes the rejection of 'unhelpful' or delusional beliefs. This framework is so entrenched within psychiatry, survivor research, media and the multitudes of organisations associated with mental health that it not only limits parameters of

speech but also leads to a very narrow kind of listening, one that cannot hear those voices and stories that fall outside of this 'genre of insight' and 'inspiration'. It is perhaps ironic that 'insight', which is such a powerful concept in psychiatry, the lack of which is often used to justify coercive treatment (Slade and Sweeney 2020), and suggests a privileged view of what is happening in someone else's mind, seems to have become a key measure of recovery (even if it remains implicit) among those promoting narratives of transformation. Being labelled as 'lacking insight' might lead people to give up exploring and valuing their own pasts, and whatever the supposed 'external unintelligibility of a person's experiences, claims to epistemic authority silence those who have 'stories to tell'' (Filson, in Russo & Sweeney 2016:4 in ibid.: 389).

Recovery Narratives have, according to some, been co-opted by mainstream services pursuing neo-liberal agendas to reduce welfare spending and promote back-to-work agenda's (McWade 2015), encouraging an individualist agenda that prevents attention being given to systemic inequalities and class, gender, race and economic discrimination in which mental health is embedded. Bridget McWade is highly critical of UK's use of recovery in its mental health policy, arguing that 'building on a history of medicalization, legislation, and marketization, recovery-as-policy enacts psychiatric patients within a paradox in which the ideal of choice obscures increasingly repressive legislation that extends the powers of psychiatrists to detain and treat people against their will' (McWade 2016: 70). Others highlight the potential for Recovery Narratives to disempower, arguing that 'being made to feel like you have to tell your story to justify your experience is a form of disempowerment, under the guise of empowerment' (Recovery in the Bin in Woods et al. 2022). Disability studies scholar Jijian Voronka argues that within the 'psy-influenced paradigms' (Rose 1998 in Voronka 2019: 13) 'mental health service users' are, in effect, being asked to take responsibility for reducing the discrimination they

experience by sharing their stories with those who might discriminate against them.[5]

In attempting to condense a lifetime of experience into a highly distilled message of hope and inspiration, the ideal of 'recovery' might create the impression that this 'story' is the *whole* story of someone's life. Recovery Narratives, or any narrative produced following similar formulas will inevitably fail to acknowledge the multiplicity and complexity of living with a psychiatric diagnosis. I worry that this tendency to create a narrative that seems to explain a person's recovery journey might become totalising in a similar way to psychiatry's belief that you can capture the essence of someone within a diagnosis. Within psychiatry it has been common for people to be spoken of as if they are their diagnosis, i.e. she is 'schizophrenic', 'bipolar' or 'borderline'. This can become a person's primary characteristic, the very definition of their personhood, and such productions of subjectivity haunt Recovery Narratives and similar 'mental health' initiatives that are concerned with giving voice to 'lived experience' based on ideals of 'insight'.

The idea that you can sum-up a life in a few choice sentences, capture the essence of someone's personal 'recovery' journey, serves only to give credence to the idea that psychiatry can produce subjects from a tick-box evaluation or twenty-minute assessment. Moreover, attempts at creating empathy and understanding among audiences through these 'insightful' narratives might neutralise critical thinking and silence survivors and distressed people who speak from a less 'rational' or easily understandable perspective about the least palatable aspects of psychiatric diagnosis and treatment. With the digital revolution, online Recovery Narratives, found all over the internet, from MIND's website to TED talks, TikTok and YouTube,

[5] As the US Substance Abuse and Mental Health Services Administration (SAMHSA) puts it: Why should you share your story? Because, it helps reduce negative attitudes and stereotypes; it may encourage others to seek help, and it can be a healing and empowering experience for you too (SAMHSA, 2017:3 in Woods et al. 2022) .

create a lasting impression that is difficult to erase later, should you wish to take your recording down. The long-term implications of having your story circulating online to be watched again and again by millions of internet users, who might comment and re-share, are yet to be fully understood for those who are encouraged to share in this way.

In the MHTA oral history interviews, a common response to the question 'why are you telling your story?' is the hope it will 'help others' or to 'help people understand'. While the focus in the MHTA is not on obtaining Recovery Narratives but is more about understanding the treatments, and experiences of people within the context of their wider lives, there are similarities with the Recovery Narrative in the way that testimonial telling within oral history is often framed as being a redemptive act, that might help others, empower the storyteller and reduce negative stereotypes. Oral history like Recovery Narrative is 'a system of enunciability' that ensures 'what is spoken is born in accordance with specific regularities' (Foucault, 1989 in Orr 2006: 9). However, as most oral history interviews unfold over several hours, participants are able to reflect on many aspects of their lives and the narratives that are produced are much more diverse, often ambiguous and contradictory, and, certainly not easy to digest in the way that Recovery Narratives tend to be.

In their analysis of Recovery Narratives, Woods et al. ask 'what aspects of the experience of madness, mental illness and extreme distress are elided or occluded [...]? What happens to the testimonies and stories which fail to conform to the genre of insight and inspiration?' (2022: 231). Elsewhere, Helen Spandler (2017) has written that psychiatry needs a process of truth and reconciliation as 'a way to heal prior damage and provide restitution' to those who have suffered, stating that 'T&R would involve bringing together service users, survivors and refusers of services, with the staff who work/ed in them, to begin the work of healing the

hurtful effects of experiences in the system' (Spandler and McKeown 2017: 83) Such a process would involve a very different kind of storytelling, and perhaps more importantly, a different kind of listening, one that is open and invites stories that are more contingent, ambiguous, that actively seeks to address the many injustices of psychiatry, is prepared to witness accounts of psychiatric neglect, abuse, relapse and cyclical readmission, drug side-effects, the effects of psychiatry on family life, work, and all aspects of living. In other words, listening that produces different relations, that do not rely on survivors being heard as insightful or inspirational.

In writing about the ways in which she has used her own personal narrative of being a street kid in Canada in mental health conferences and other academic forums, JijianVoronka questions how Recovery Narratives constitute those in the audience who figure as the helpers, and practitioners who 'rescue' those narrating their experiences of abjection and distress:

> 'The idea of my recovery uplifts them because it makes them the hero of my story. Understanding me as cured justifies a continued practice of often problematic psychiatric and psy-discipline informed interventions. This is the danger of what my voice can produce [...] My story isn't digested as a critique on the tyranny of sanism as embedded in imperialist white supremacist capitalist cis-heteropatriarchy. Rather it remains a story of tragedy, resilience and recovery. The madwoman can speak as a madwoman—but how else can she be heard?' (Voronka 2019: 22–25).

2.3 'Voiceless' witnesses? seeking the oral in oral history

Oral history has often been presented as a methodology that gives voice to the 'voiceless', that calls on witnesses to history to fill gaps in the record and create 'history from below' (Febvre 1932: 576 in Karpf 2014: 50). However, oral history has often ignored or relegated to 'raw data' the oral recordings and voices of those interviewed, focusing instead on their transcripts. Anne Karpf argues that the very practice of transcribing oral history recordings, which become 'constituted as a kind of raw material that the historian alchemically transform[s]' has resulted in the silencing of voices and that by treating the human voice as 'an invaluable new *source* rather than as a resource in itself' (ibid.: my emphasis) oral historians have not fully valued the possibilities of their medium, viewing the oral/aural dimensions of oral history as incidental.

Renowned oral historian Paul Thompson has acknowledged the uniqueness of the voice in oral testimonies, describing how 'the use of the human voice, fresh, personal, particular, always brings the past into the present with extraordinary immediacy' breathing 'life into history' (Thompson 2000: 21). The voice is often thought to provide clues to a person's inner state, revealing 'the hidden substance of subjectivity, the signified [...] something like the 'truth' of the person to whom it belongs' (Lagaay 2008: 54). This is perhaps one reason why recording voices has become such an important methodology in oral history research, along with the idea, that in speaking, being recorded and listened to by a witness, people are able to recover their voices after years of remaining silent. And yet, despite such acknowledgments, Karpf argues that the 'custodians of real living voices, have often been at pains to embalm them in print, to remove the oral from oral history' (Karpf 2014: 50). Oral historians, like many scholars of the social, rely on interviews as the 'raw material' from which they can produce data in the form of

transcripts, and it is often from these transcripts that books and academic papers are produced. Alessandro Portelli argues that 'expecting the transcript to replace the tape…is equivalent to doing art criticism on reproductions, or literary criticism on translations' (1998: 64 in Karpf 2014) and decries the loss of emotional register in transcripts and other textual artefacts of oral history. And yet despite such proclamations,

> the deep dark secret of oral history is that nobody spends much time listening to or watching recorded and collected interview documents. There has simply been little serious interest in the primary audio or video interviews that literally define the field and that the method is organised to produce (Frisch 2008: 223).

It is, perhaps, not surprising, given the difficulty of storing, cataloguing and making accessible oral history recordings that the original documents tend to be accessed primarily through their transcripts. Behind, what Frisch refers to, as the 'near-universal practice' (ibid.) of transcribing testimonies to text are various assumptions about transcripts being the best way these rich lived-experiences can be effectively engaged by different research communities, being quicker and easier to research, distribute, search, and display, unlike video and audio records which can only be accessed in real-time. Frisch offers a reminder of what is lost when oral histories are only accessed through transcripts, when he states that:

> There are worlds of meaning that lie beyond words, and nobody pretends for a moment that the transcript is in any real sense a better representation of an interview than the voice itself. Meaning is carried and expressed in context and setting, in gesture, in tone, in body language, in pauses, in performed skills and movements. To the extent we are restricted to text and transcription, we will never locate such

> moments and meaning, much less have the chance to study, reflect on, learn from, and share them (Frisch 2008).

Despite such warnings, even a writer like Anne Karpf, who decries the loss of the oral when it is 'embalm[ed]…in print' (Karpf 2014) argues that we mustn't overlook the importance of the transcript and is interested in the oral primarily as an adjunct to the text, to increase interpretive understanding of events, rather than as a way to access alternative forms of knowledge.

As my research shows it is only through listening that the tone and texture of a woman's voice, the way that she says a word or phrase or her breathing, can come to be understood as forms of knowledge produced through the body and in relation with other bodies—not seen, but heard. These moments complicate understanding and allow for ambiguity. You cannot feel breath in a transcript or hear the way a woman says the words 'Tilly Tin Drawers' no matter how true to the interview encounter the transcribed speech is. That is not to say that the transcripts are not important, as Voeglin points out, 'sound does not hold a superior ethical position' over other forms of engagement (Voegelin 2021). However, the speaking, breathing bodies and sounding spaces that open up to me through my listening leave particularly affective traces. Sticky moments which I can conjure and 'hear' resounding many months later.

Listening-*with* is always an active encounter (LaBelle 2021) and in these dynamic encounters listening-*with* oral history recordings I become fully immersed, placing myself in the midst of the interview, listening many times to the smallest moments of interaction. I find myself entering into unsettling relations, being plunged into multiple spatial and temporal realities, experiencing 'the world in its invisibility' (Foisy 2021: 159) not relying on visual clues to orient myself within institutional spaces. As a researcher I get caught-up with the voices, sounds and spaces in a way that reorients me, not as an empathic listener whose engagement might

neutralise or smooth-over critical moments of interaction, but in order to re-open the recorded moment. Listening-*with* oral history interviews through technologies that can record and playback, allows me to attend to a plurality of sonorities (Lipari, 2014), opening up multiplicities of meaning. These stories and narratives can never unfold in any totality but leave 'a trail of always escaping material behind' (Wetherell 2012: 130).

The MHTA recordings are particularly rich and detailed, however, like much research based around interviews, they proceed linearly, starting with birth and ending with the here and now. Such long-form interviews seem to pursue chronological narratives with little recognition of the complexity of memory, which is never simply linear or causative. Lipari refers to the back and forth interview communication as a 'transmission model of dialogue, [which] limits us to spatial thinking wherein language and time are conceived of solely in linear sequential terms, leading to the kind of amnesia that forgets to remember that the past is never past and that the voices and thoughts we hear are not purely our own' (Lipari 2014a: 514-4). Interestingly, the women being interviewed often find ways of subverting this desire for chronology, interrupting the interview proceedings by, for example, introducing unexpected interlocutors into proceedings, remaining silent after a question is asked, or referring to a completely different moment in time.

Discussing the politics of interviewing within documentary film, which has many parallels with oral history interviewing, Trinh-T-Min-Ha writes that it is 'fraught with uneasy questions' (Trinh 1992: 193). She argues that 'interviews, which occupy a dominant role in documentary practices—in terms of authenticating information, validating the voices recruited for the sake of argument the film advances (claiming however, to 'give voice' to the people) and legitimizing an exclusionary system of representation based on the dominant ideology of presence and authenticity—are actually sophisticated devices of *fiction*' (ibid.). When understood in these terms,

oral history interviews, rather than being held up as a research methodology that provides platforms for alternative voices of historical truth to be heard, can instead be understood as staged; for as Trinh-T-Min-Ha claims 'speech is always staged' (Trinh 1992: 194).

Many oral historians view the oral history interview as a dance of mutual discovery during which stories are negotiated and constructed. However, how stories are constructed often depends on the interviewer. There is a rather romanticised view of testimonial interviews that assumes a survivor will be able to talk openly to an empathic witness that 'they been awaiting for a long time.' (Laub and Allard 1998: 809). In so doing, there is an assumption that 'survivors move from a position of being subjected to political violence to a position that entails the promise of agency and the possibility of crafting the meaning of who they are [...]' (Dauge-Roth 2009: 168). This ability depends on there being a suitable person to 'bear witness' thereby generating 'a social space within which survivors can negotiate and, eventually, reclaim on their own terms the meaning of their survival' and in so doing reduce the burden of their trauma (ibid.: 168). However, in most cases the interviewer has an agenda and therefore maintains control over what information is produced. As Holloway and Jefferson, in their work on narrative interviewing, argue, an interviewer can impose control in several ways that include wording questions in their own language, selecting topics for discussion, and, asking questions in a specific order (Hollway and Jefferson 2008: 302). In this way it is the researcher's understanding of what is being said that becomes paramount and listening gets sidelined within a 'transmission model' of communication (Lipari 2014a).

Oral history can become a space in which 'subjects are perpetually reconstituted' and the work of 'identity formation is never over' (Ahmed 2000:7 in Voronka 2019: 24). As Robyn Fivush points out 'if our personal past takes on meaning as we share it socially with others, then the ways in which others listen to, hear, and

interpret our past has implications for what aspects of the past will be validated. Listeners can accept or dismiss, negotiate, cajole, or coerce particular evaluations over others' so that some aspects of experience are voiced and others silenced (Fivush 2006: 4). After all, testimonial ethics is never only about speaking, but is about the 'conditions of possibility of hearing' (Ahmed, 2000:157 in Voronka 2019: 25) or, as I would argue, of listening.

The demands of sense-making and chronology in oral history might ironically lead to blocks in memory. Narratives do not conform to a temporal logic. Like the memories that shape them, narratives are messy, they reach all over the place, linking moments and events in often inexplicable and unconscious ways. Within the oral history interview, a desire to 'discipline' testimonies 'into coherence' (Chadwick 2021b: 80) might create situations in which an interviewee is closed down, or, feels that their memory isn't behaving in the expected way.

In order to understand what I am driving at I offer an example from the MHTA. In Ann's interview, the interviewer, in trying to get a chronological story, overrides Ann—stopping her mid-speech, in what I would describe as a failure of listening—insisting on pre-empting the next question before Ann has had a chance to respond. In this example, the interviewer is trying to grasp whether Ann had been admitted to a psychiatric hospital before the birth of her children. Ann starts to talk about her family giving permission for her to have ECT but gets cut off by the interviewer, twice, who points out that they will come back to her experience in St Lawrence's later. For now, the interviewer simply wants information that will put Ann's story into chronological context. Perhaps there is nothing wrong with attempting to create a chronological understanding of when Ann went into hospital, in order to assist future readers and viewers of Ann's story, but in so doing Ann's opportunity to speak about ECT and her family's part in it is lost, as the interviewer is most concerned with details about the time of admission. Ann is therefore refused a

chance to explore her thoughts and the opportunity to verbalise this part of her story is lost.

INTERVIEWER: *Had you already been admitted by then?*

ANN: pardon?

INTERVIEWER: *Prior to the birth of Stephen and*

ANN: Anthony

INTERVIEWER: *Your second child, you'd already had your admission at the hospital?*

ANN: St Lawrences, yeah

INTERVIEWER: *St Lawrence's which we will talk about in a while*

ANN: Yeah, thats right, yeah, yeah. I had, I was admitted as I said when I was up there before Stephen was born and then they said, they told my sister and my mother that the I was very very depressed and that ECT would help and that that would be the best thing for me and they didn't know much about it and they

INTERVIEWER: *That was before Stephen was born?*

ANN: Before Stephen was born and they said yeah, they gave their permission for ECT and I didn't know what it was, I, they just said it would be treatment day soon.

INTERVIEWER: *Can we come back to that bit*

ANN: Yeah yeah I was in St Lawrence's

INTERVIEWER: *Hang on a second*

ANN: Sorry

INTERVIEWER: *I was trying to get a*

ANN: I had my first breakdown in sixty-five yeah, I came down here

INTERVIEWER: *You had your first child in 1968 and then Anthony was born in the 1970s*

ANN: 1970 yeah, yeah, But before I had Stephen in 1968 I had a period in St Lawrence's

INTERVIEWER: *Yeah*

ANN: And

INTERVIEWER: *Which I want to give some space to talk about a bit later on*

ANN: Yeah thats right, it was St Lawrence's yeah, as I say I remember being taken there but I can't remember waking up and with probably depression and I was heavily sedated and couldn't get out of bed and then my mother came to visit me and I still in bed cos she said 'can't you get out of bed' cos most of the other patients were and I say 'No, I can't' and I was there and then I was becoming more awake during the days and that…'

INTERVIEWER: *can we stop there a second?*

ANN: Yeah, yeah, yeah

INTERVIEWER: *can you stop a sec?*

ANN: There was myself and Stephen and Anthony on the way and the reason I thought about Anthony was there was this lad I had gone with, instead of saying his name was Ken he said his name was Tony, and he was like two fools really…

In this segment of Ann's interview, the interviewer is constantly truncating the conversation, in order to try and bring it back to a time before Ann's admission

to St Lawrence's. After the last 'can you stop a sec? Ann ignores the interviewer, going on to describe in minute detail how she came to be pregnant with Anthony and give him up for adoption. Her speaking, perhaps because of earlier attempts by the interviewer to stop her, is a continuous, dense, unstoppable flow of words, that creates a sense of urgency and highlights the importance for Ann in telling without interruption in a way that makes sense to her.

Perhaps this continuous flow of speaking is an attempt 'to "hold" and "contain" herself?' (Walkerdine et al. 2013: 175). In an article on researching interview transcripts through the lens of transgenerational trauma, Walkerdine et al. (2013) refer to Symington's (1985) psychoanalytic work, in which constant talk is understood to be related to 'the primitive defence' (or second skin), a way to try and create self-containment. Ann's speaking without stopping could be understood as a way to hold and contain herself within this difficult interview situation, to create a continuous 'psychic skin without any holes or gaps through which the self could spill' (Symington, 1985, p. 483 in ibid.). Ann, when allowed to speak in detail about events in her life tends to speak in a hurry, without many breaks in her speech and can speak for a long time without seeming to stop for breath but Symington's analysis of constant talk as a way of attempting to hold the 'self' together rings true, at least for this part of Ann's interview, in which she is relating a particularly distressing part of her life, giving birth to her second son Anthony and feeling that she had no choice but to give him up for adoption. 'It was just a dreadful nightmare for me, this was just like an awful nightmare, you know. I just didn't know how I was going to leave this child…'. While I am wary of attempting to psychoanalyse Ann's experience, particularly in ways that suggest the skin can act as a container for the 'self', Symington's theory of constant talk seems to fit with this part of her interview, where she speaks about not being able to hold on to her 'beautiful golden baby', Anthony, and feeling out of control and desperate at having to give

him up for adoption. This is just one example which illustrates a failure of listening and the need to listen differently within the oral history context.

The speech-centric nature of western society, as Lisbeth Lipari (Lipari 2014a) points out, has led to practices of listening being undervalued, considered useful only for effective 'communication' or for those who work in the so-called 'listening' professions. As a result 'listening has been relegated to a shadowy penumbra or black box—something both there and not there, obligatory but irrelevant' (ibid.: 511). Charities call on people to speak out as part of seeking help, and oral history claims to give voice to the voiceless, but I am left wondering who will listen and how? In the writing that follows I discuss how an understanding of voice configured along new materialist lines allows for and recognises encounters with psychiatric survivors as being produced in an assemblage of relations whereby it is recognised that there is 'more' in the world than can be apprehended by any given perceiver at any particular time' (Brown and Tucker 2010: 235). It is only through practices of diasporic listening-*with* and compositioning that I have been able to attend to that which haunts the archive, that which remains 'elusive, fantastic, contingent and often, barely there' (Gordon 2008: 26).

3. Radically Permeable Voices

Is not voice always already intervening, as a sounded body that searches for its place…

—Brandon LaBelle (2014: 1)

I write about listening primarily in relation to 'voice' in this work because the terminology of voice offers a broad conception of communication not necessarily aligned with language. Voice in this work is not theorised as a 'thing' (Chadwick 2021b: 91) or even 'a' voice but is explored as a process. Instead of focusing on what a voice means, I am interested in what voice does, how it functions and what it produces, and, with how voice emerges through encounters in which the 'radical permeability between bodies … are enacted' (ibid.).

Voice is not simply the sound projected from one body towards another. Voice is 'always already intervening' (LaBelle 2014: 1), or *intra*-vening, to follow Barad's new materialist logic (Barad 2007). This vocal intra-vention is 'lodged within the power dynamics of particular structures—linguistic, familial, pedagogic, governmental etc. A voice that is often underrepresented, overheard and interrupted' (LaBelle 2014: 1). Voice articulates, in its many formulations, resonating structures of power and the lived experiences of those who might otherwise remain unheard.

Human voice, as LaBelle points out, is created through a performance of the mouth that involves the depths of the body, including respiration and breath and, as such, brings us into confrontation with the mouth as a cavity that includes the lips, teeth, gums, tongue and pharynx. The mouth is wrapped up in the voice and vice versa,

such, that to theorize the performativity of the voice is to 'feel the mouth as a fleshy, wet lining around each syllable' (LaBelle 2014). It is through the voice that 'interiors commune with interiors' (Walter Ong in ibid.: 3). Throughout this work I find myself sitting within an uncertain space of liminality, with voices that are present but not actually 'here', listening-*with* women whose lives I have come to 'know' (or rather feel) intimately without ever *knowing* them. Temporal and spatial shifts occur as voices enter me, articulating numerous moments of crisis, transmitting affects and *telling* me things through silences, breaths, words and sounds that I do not always want to hear.

3.1 The grain of the voice

While 'the grain of the voice' in Barthes's famous (1977) essay as Catherine Rudent (2020) points out, refers to language and voice in relation to a specific genre of classical singing (the Leider) as performed by two particular singers, here I use it more generally to refer to the 'noisiness' of the voice—the timbre, depth, hoarseness, softness, roughness, smoothness and other textural, dynamic and pitch elements of the voice. As Rudent states 'the grain of the voice' is to do with those aspects which fall outside of plain expression and communication: it has to do with 'significance (which is meaning in its potential voluptuousness)' rather than signification (ibid.: 184).

It is well recognised that culture, gender, socialisation and all manner of other factors can influence how a voice sounds (Eidsheim 2011) and here I discuss each of the women's voices as they sound to me in their testimonial recordings and the institutional contexts in which their voices have, in part, been formed. Whilst throughout this work I refer to voice through a new materialist lens, each woman has their own 'unique voice' (Cavarero 2005). In this brief discussion I examine the

ways in which certain aspects of their socialisation or institutionalisation might have impacted on the 'grain' of their voices.

Carole (C905/25/01- 06)

We make numerous assumptions about individuals based on their voice. Carole sounds, as she contends, like a middle-class, well-educated woman, but this is not 'her' voice. Her *real* voice would sound with a west country accent. Instead she speaks in clear 'received pronunciation'—the result of elocution lessons at school to 'improve' her singing voice in preparation for Eisteddfods. As Carole explains, she is the only person in her family that speaks like 'this', the rest of her family 'speak in broad Somerset or Gloucestershire dialect.' She goes on to say, '…it's a trick. I mean, it's me, this is my voice, I'm not pretending…I don't speak, I can't speak any other way, but it doesn't reflect either my background or my education…So, it's a sort of, in that sense, it's a sort of fake, but I don't have any control over it'.

This learned speaking voice, with its smooth, clear intonation and well enunciated vowels and consonants has had an impact on Carole's sense of belonging, particularly with her brothers, from whom she was separated for many years until they were reunited in middle age: '…when I go and see my brothers now, I wish I had the, the accent and spoke with the dialect and used the language that they have, but, and I've tried, but I can't, when I do it sounds like someone whose pretending, it's no longer natural' (Carole, 2000).

Annemarie (C905/35/01- 03)

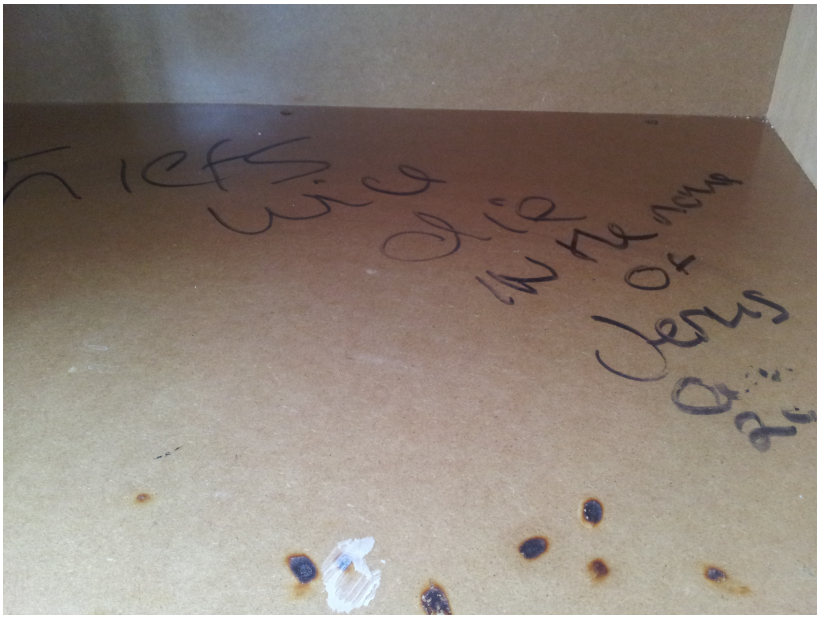
Annemarie was born in Hackney but adopted as a baby and grew up in Kent, returning to Hackney after her divorce, aged 21. She has a very distinctive voice, hoarse and gravelly, speaking in what she calls a 'cockney' accent. She sounds

like a smoker, and during her interview she smokes several times. Annemarie has spent most of her adult life in and out of psychiatric and other institutions and as research shows smoking rates are much higher among psychiatric patients than the general population, with 84% of UK psychiatric patients being smokers, compared to 27% in the general population (Meiklejohn et al, 2003 in Stubbs et al. 2004). Smoking can act as a break during long, unstructured days, however it is well known to have a deleterious affect on health, including on the voice. Despite this there has been a failure to help psychiatric patients stop smoking or prevent new patients from starting. As Olivier et al. point out (2007) some mental health practitioners even believe that smoking improves a patient's temperament and many express concern about removing a patient's only pleasure.

Smoking lowers the pitch of the voice, reduces the length of time you can speak before needing to breath again (maximum phonation time), dries the vocal cord mucosa, irritates the vocal cords and reduces breath supply and vocal power (Gonzalez and Carpi 2004). I can hear that Annemarie is a smoker, but perhaps more than that, the grain of her voice creates an awareness of the toll that traumatic life experiences have taken on her.

Kathleen (C905/05/01- 03)

Kathleen is also a smoker, who has spent much of her adult life in psychiatric institutions. She asks for a cigarette break more than once in the course of her interview. She has a very low voice and speaks, slowly, taking long pauses in between thoughts. The tone of her speaking voice is gentle, breathy, and sounds just above a whisper at times, but like many smokers her vocal sounds are noisy, sometimes she rattles and coughs. On first hearing Kathleen I immediately felt affection for her—the gentleness of her tone, long pauses between thoughts and her self-deprecating way of speaking made her easy to listen to. The low, breathy slowness of Kathleen's speaking occurs alongside the almost constant movement of her tongue and mouth which fills her recording with a mouthy noisiness not heard in the other recordings. These sounds are discussed in detail below.



Pauline (C905/31/01 - 04)

Pauline has a distinctive north west English accent, having lived all her life in St Helens near Liverpool. The pace, pitch and the loudness of her speech is often

changing, and in this respect her speech quite dynamic, but I often found myself struggling to listen to her. Whilst I never anticipated a frictionless experience of listening, I was caught off guard by my internal response to Pauline's voice, finding myself irritated by something in her authoritative tone and manner. She often speaks in the third person, as if wishing to put distance between herself and what she is recounting and there is a bitterness in her voice I found difficult to hear. My struggle listening-*with* Pauline is noticeable in the sound work, as her voice is less present and often interjects in direct response or in accordance with the speech of someone else.

Ann (C905/41/01- 05)

Ann grew up in the tenements of central Glasgow, her dad working in the docks. She has a strong Glaswegian accent, despite living most of her adult life in Cornwall. Her manner of speaking, which is very fast paced, speaking in long sentences, with little in the way of breaks, is particularly memorable. As she speaks I feel I can hear her smile and there is real warmth in the tone of her voice. She laughs often, even when recalling difficult memories, and speaks openly and in great detail about her experiences. Like Kathleen, from the moment I first heard her voice I felt a sense of closeness and affection for her.

3.2 Voice-mouth-body-medication

Listening-*with* Tardive Dyskinesia

> *Liquid Largactil has a numbing effect. Slurring speech into an effortful slush, slowing and thickening movement. Horizontal in its catatonic grip she notices the pill spattered paint above her bed, half-chewed residues sprayed white, brown and pink onto the slick green wall. These undigested particles have accumulated; remnants of women here before.*

The assemblage of mouth, mucus membrane, drugs, vocal sounds and respiration comes into sharp focus when listening-*with* psychiatric survivor's voices. Medications might dry the oral cavity or cause an overproduction of saliva, swell the tongue and create involuntary movements and tics, cause a slowing or slurring of speech and difficulty in forming words. If, as LaBelle (2014: 2) argues, 'the mouth functions to figure and sustain the body as a subject . . . within a network of relations', then listening to the operations of voices/mouths from the MHTA might reveal relations at play within psychiatry, as medications and other physical treatments affect the way voices/mouths sound and behave.

An example can be heard in the testimonial recording of Kathleen, who speaks in slow, measured sentences with long pauses in-between. Listening-*with* these pauses, I notice the constant clicks, clucking, licking and sucking noises that fill the space between her words. These sounds are the result of facial spasms and tics, involuntary movements of her mouth and tongue resulting from Tardive Dyskinesia (TD), a condition brought on by years of psychiatric treatment with drugs like Chlorpromazine (Largactil) or 'liquid cosh' as my mother calls it. As Peter Breggin and David Cohen write, 'Tardive Dyskinesia is a common and yet potentially disastrous adverse reaction to all of the neuroleptic drugs. TD involves irreversible abnormal movements of any of the voluntary muscles of the body. It

commonly afflicts the face, eyes, mouth, and tongue, as well as the hands, arms, feet and legs, and torso. It can also affect breathing, swallowing, and speech' (1999: 78).

The constant movements of her mouth and tongue give Kathleen's vocal track a particular character not found in any of the other recordings that I refer to throughout this work. The *tick, tutt, swshhh, phfff, cluck, tch, click, shhh* sounds that are at times wet, thick, staccato and sticky are difficult to describe and almost impossible to transcribe with any accuracy. In a technical note about transcription under the heading 'other phenomena' the suggestion for writing a click sound is <click> and any unintentional sounds between speech should be transcribed as <noise>.[1] Kathleen's sounds are much more varied than a series of clicks, and the word noise tells us nothing about the nature of her vocal sounds. Unsurprisingly, given the difficulty transcribing such non-speech sounds, these vocal noises remain completely unwritten in the MHTA transcripts. They simply never appear. As discussed above, this absence or gap in the textual archive has serious consequences for how history gets (re)produced, for when the oral is treated as precious source material for transcription into text, rather than as an important form of knowledge in and of itself, vital information is overlooked and voices silenced (Karpf 2014).

Listening-*with* the fleshy sounds of Kathleen's constantly moving tongue, the power of the psychiatric institution and the disfiguring impact of its over-zealous drug regime become apparent as all the parts of her moving mouth vocalize, transmitting bodily affects. Kathleen has become a 'pharmaceutical person' to use Emily Martin's words (2006). The many properties of the drug Largactil not only altered her appearance and behaviour during the time it was prescribed, as Kathleen says 'Largactyl [sic] is terrible…you get stupid and fat […]', but its effects can be irreversible, so that long after the prescription has been stopped the many

[1] https://www.cs.rochester.edu/research/cisd/resources/nonwords.html

adverse effects of the drug continue, impacting every interaction, every moment. The drug has effectively taken up 'residence' in Kathleen's body, permanently altering her in ways that cannot be undone (Martin 2006: 276).

I wonder about the effects of TD on Kathleen, not only as it impacts her speaking and vocalisations but also as it effects how she feels, the ways in which she interacts with the world and those around her. How you speak is not only affected by your socialisation, it also has a real impact on everyday experience, as Kathleen shows when she speaks about being given leave from hospital to go into town and her worry that everyone will know that she is from the 'mental hospital'. Perhaps she fears that the way she speaks and her appearance, as a result of TD, will give her away, that the oral, facial and vocal disfiguration marks her out as a psychiatric patient.

She never mentions Tardive Dyskinesia or says anything about the restlessness of her mouth/tongue in her interview. Perhaps no-one has explained to her that these constant movements are a side-effect of medication. For, as Breggin and Cohen (1999) point out, doctors often fail to inform their patients about the possible dangers of TD and despite high numbers of psychiatric patients being blighted by the condition, doctors often fail to notice its onset, or make the mistake of increasing neuroleptic drugs instead of stopping or reducing them in an effort to reduce TD's disabling effects (ibid.). I can never know exactly how TD effects Kathleen's daily life, but had I been researching her interview transcripts or oral recordings only for narrative data, Tardive Dyskinesia in all its excessive non-narratable affects would have been missed altogether. It is only through long processes of listening-*with* Kathleen that the co-enaction of drugs, psychiatry, voice, mouth, body and psyche—a form of what Jackie Orr refers to as 'psychopower' (Orr 2006: 11) emerges.

While the vocal sounds of Kathleen's track undoubtedly contain unspoken, unwritten knowledge about her experience, it isn't necessary to know that the noises in Kathleen's recordings are the effect of Tardive Dyskinesia to be affected by the fleshy sounds of her moving mouth. These noises create forms of intimacy, whether welcomed or not. Listening close-up to the visceral fleshy mouthing of another, to the pulsing tongue and smacking lips, might invite a leaning-in, straining to hear, or perhaps repel a listener, either way, these intimate salivary sounds intensify the affective experience of listening. The mouth, as LaBelle eloquently writes, 'is a vessel piloting numerous utterances and potent silences, so much stuff, as to condition and influence acts of *coming out* as well as *going in*, of entries and exits, and the ways in which we cross boundaries or reinforce their presence; the mouth is first and foremost a device for modulating the limits of the body…deliver[ing] an epistemology founded on processes and experiences of ingestion and incorporation, emanation and expulsion, attachment and loss: a series of knowledge paths defined by this orifice and its generative and volatile movements' (2014: 7).

In the final composition of HMCTL the sounds of TD and Kathleen's constantly moving mouth feature most noticeably in the beginning and the end of the piece, particularly prominent towards the end, when Kathleen is talking about being at Horton for 18 years. By repeating these salivary sounds, the listener is left with the dis/comforting closeness of Kathleen's moving mouth, and the slow, rhythmic, never-ending cycle of her tongue's restless movements, such that it becomes a reminder of the lifelong effects of psychiatric treatment and the many ongoing years of Kathleen's incarceration and that of other women abandoned to psychiatry.

Turning pages

I write here about the experience of listening-*with* Ann turn pages as she lists all of the drugs that she has been prescribed, taken, and their subsequent side effects. About 2 hours and 50 minutes into her interview, and in a long response to the question *'And when they gave you all these different drugs, what did they explain about why you were being given them'* I hear what sounds like a page turn, I'm not sure what it is until, after a long paragraph of speech, I hear another and then as her speech slows, becoming less assertive, turning quite wobbly as she talks about Doctor McJarvis, I hear paper rustling. I'm not sure whether this paper is the interviewers or Ann's but when I listen to the passage of speech again it becomes apparent to me that Ann has prepared for this part of the interview by writing the names of all the drugs she has been prescribed and their side effects on several pieces of paper.

> *Stelazine: I had mania with it, I've had*
>
> *Chlorpromazine/Largactyl: high doses in the early days*
>
> *Haliperidol: has paralysed my legs, unable to walk*
>
> *Sodium Amytal: could not get out of bed the next day*
>
> *Amitriptyline: thats what I'm on at present, sleeping all around the clock*
>
> *long term Lithium: good but got too high and had to be Sectioned also kidney trouble and chronic Psoriasis and weight gain, Sectioned three times for up to ten weeks,*
>
> *Prozac: can't remember*
>
> *Carbamazepine: I came in a rash all over and that had to be stopped*

> *Lustral. Procyclidine, Largactil, Sodium Valproate and Zopiclone: my eyes really hurt, I've had heart palpitations and breathlessness, panic attacks and feelings of fear and terror that I've never had before, they said it was the illness, not the drugs, acute exhaustion, depression, mood swings, sometimes physically but mood always down and that was in the last, fear, fear and agitation. I would take myself to hospital agitated and then come out again as bad as I went in, you know non stop music going through my head then, Doctor McJarvis says they were affecting my liver and that was why I was feeling so bloody awful and I came off them and last year I had no drugs for six weeks but then in August I began getting high again.*

In the simple action of turning a page and the tone of Ann's voice as she reads from her handwritten notes, the pressure applied on Ann as 'patient', the insistence on and of the drugs, the impossibility of the side effects and the inseparability of all these forces becomes apparent. The sound of the page being turned, whilst easily missed, is a profound reminder of memory loss and the difficulty of keeping track of everything that has happened when your brain has been electrocuted, and tampered with by 'toxic' medications (Breggin 1993), or how in the psychiatric context, 'when drugs are causing problems, the solution is more drugs' (Martin 2006: 279).

The page turn sounding points to the urgency of writing it all down, getting the order right, telling a story that makes *sense*, of being able to answer questions that no one outside of psychiatry has ever asked before. Speaking in response to a question about medication in the context of the oral history interview becomes a challenge. Listening-*with*, I understand that Ann has taken on this challenge as a quest to recover her own experience, to remember with accuracy what has happened, to be heard as a reliable witness, after years of being treated simply as a body of problems for psychiatry to solve. Ann becomes a witness to the

very real, embodied effects of pills that Emily Martin refers to when she argues that 'contemporary pills, clean, pure and precisely engineered as their scientific "body" may appear to also have a blood-stained, fleshy "body"' (Martin 2006: 284). This other 'body' is made up of those afflicted by the so-called 'side effects' of the psycho-pharmaceuticals, as well as those who suffer 'unexpected' physical and psychological effects in the medicine's clinical trials. As Martin argues:

> The bloodstained body of the drug is so dangerous and frightening that we want to push it away altogether, but it hides in plain sight in the side effects. Behind the clean, molecular body of the pill is the injured flesh and blood of bodies that haunt both consumers and producers and will not haunt them quietly (ibid.).

The paper in Ann's hands is marked with the residues of these blood spattered, fleshy pill-bodies, and as she recites from its stained pages her speaking becomes an incantation to the effects of pharmkon.[2] The sounding of the turning page and rustle of paper serves as a reminder of the power of the pharmaceutical and psychiatric industries. Unlike the paper prescriptions, completed by so many doctors, one after another, with little understanding or interest in how the whole paper trail builds up, of how the side-effects pile on top of side-effects, Ann's papers have been carefully written, ordered and recited from. Considered in light of the audible knowledge of Tardive Dyskinesia in Kathleen's recording, the page turn and Ann's recitation is an important reminder of the potential pitfalls of relying on transcripts and textual research methods that fail to notice or gloss over the unspoken in the archive. Within the context of the oral history interview, the page turn, rustle of paper in Ann's hands, and very particular tone of Ann's voice as she recites a long list of dugs and their side-effects, is a reminder of the power implicit in a research process that seeks to recover 'truths' from witnesses to the effects of

[2] Pharmakon is a Greek word meaning both remedy and poison.

the psychiatric institution and its methods of 'treatment' and of the epistemological conditions of social research that positions itself as being concerned with hearing the 'voiceless' speak.

What becomes apparent in the course of listening-*with* these interviews is that all of those speaking are *far* from voiceless and that the spaces and contexts of the interview have voice too. Hearing the turn of the page in light of the experiences of psychiatrised women, the page turn *itself* becomes a vocalisation, an autobiographical utterance that is social in the Bakhtian sense and 'engages the embodied knowledge, memory, history and identity of much larger entities than the self' (Lebow 2008: xv). Rather than seeking to give 'voice' to these women, my listening is a way of tracing the 'emergent interplay of voices in the making' (Tuana et al. 2008: 189). In my listening, the turning of the page becomes part of a process of voicing, a kind of assemblage that includes a woman testifying, an interviewer, doctors, prescriptions, blood-stained fleshy pill-bodies, writing hand/ink/paper etc. through which stories about hospitalisation and psychic crises become 'material-semiotic' (Haraway 1997). Sitting within this messy entanglement, listening-*with* the page turning and paper rustling, I am reminded of my own experiences of being face-to-face with 'psy' professionals, caught in a 'therapeutic' dynamic, a performance of psychiatric 'listening' in which every utterance is further proof of their diagnosis and the need for pharmaceutical intervention.

I cannot now recall witnessing Ann Darcy turning pages or seeing her refer to hand-written notes in the MHTA video recordings. I have no memory of this moment from my time watching in the British Library. It is in my mind only as a sound memory —loose leaves of paper rustling and being turned, landing on top of one another…being examined and turned again. My memory is displaced, no longer a memory of the video archive but instead a memory of listening-*with* the

sound in Pro Tools, of isolating the page turn, copying it and reproducing it, one page, after another until the point that it fades out.

So heavily sedated

> *She spent most of the day running up and down behind a row of high backed chairs, trying to work off the effects of the drugs. All the while, a line of women sat in the harsh glare of sunlight, oblivious to her frantic activity, staring silently onto the sweltering tarmac of a half empty car park.*

The phrase 'so heavily sedated' features many times throughout the testimonies, and speaks to the muting effects of psychiatric drugs—which can slow down the body, silence the mouth, turning speech into an almost impossible effort and creating hushed atmospheres on hospital wards. The phrase 'so heavily sedated' is spoken by Ann more than twenty times throughout her testimonial recording. Speaking about her experiences of being hospitalised she says 'I was so heavily sedated there, I didn't know, I didn't know what was, whether I was coming or going. What was happening, what day it was, whether I was sectioned, whether I wasn't sectioned. I was so heavily sedated…'.

As all of the women so powerfully and painfully testify, psychiatric drugs can make you slow, forgetful, they can cause you to slur your words, to stammer, and can cause non-stop facial and body movements, too much saliva to build up in your mouth, dribbling, or, the opposite, thirstiness and a constant dry mouth that makes speech sticky. These are just a few of the common side effects of neuroleptic and antidepressant drugs that might directly effect speech, all of which are documented in the MHTA. 'So heavily sedated' causes feet to shuffle, thickens thinking, dulls the emotions and can cause effects similar to those of ageing, or even dementia like symptoms (Breggin 1993).

Brian Lande writes of army cadets that 'like any other person entering a new social microcosm, [they] undergo a collective pedagogy that does more than remake their mental representations, deliberative ends, self concept, role or discursive repertoire' (2007:106). The same, I believe, can be said for psychiatric patients, who entering hospital 'literally become something different' (Lande 2007: 106). There is nothing like large amounts of sedating medication to change a person's behaviour, impede physical action and thinking. Sedation which makes you so slow that all you can do is lie on a bed for most of the day, or stare out of a window, or at the television.

As well as the sedating effects of drugs, the way the routines of the hospital are implemented produces 'docile bodies' (Foucault 2012). For when a body enters the psychiatric institution, the institution 'breaks it down and rearranges it' (ibid.: 240) in accordance with its own desires and regimes.

As Pauline says in her testimony recordings:

> . . . they had a routine which had to be followed, whatever. The first thing they did to you was get you to get undressed and to have a bath, to wash

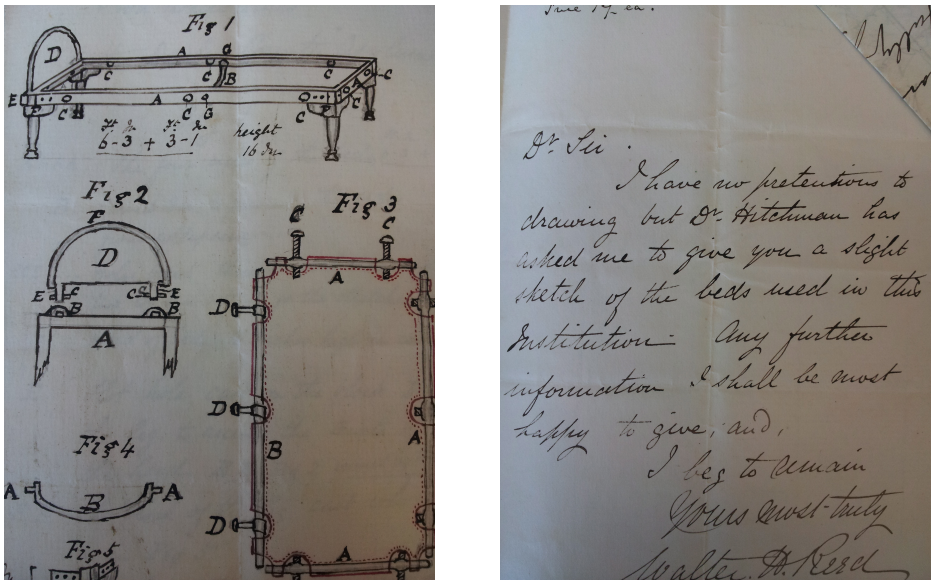


Fig. 3.4: Documents from the Brookwood Hospital archive

> your hair. It wouldn't have mattered if you'd had a bath and washed your hair half an hour earlier, new patients had to do this. Well of course you weren't allowed into the bathroom on your own and in those days I was probably still a little bit shy about bathing in front of someone else …you had to have a nurse to make sure you'd washed yourself properly and your hair was washed and you weren't allowed to put your own clothes back on, you had to wear a nightdress and a dressing gown and as soon as possible you would have to have a pretty thorough physical examination by a doctor.

Being stripped of clothing, belongings and other markers of individual identity is just one way that the institution can make you become 'something different' (Lande, 2007). As Pauline so powerfully states 'the mental patient was the thing you became…yeah, you were a mental patient and that was the category that you, you, you, well you ended up fitting yourself into really because it was no good expecting anything different'. In the psychiatric hospitals of the twentieth century,

as all of the women attest, the role of psychiatric patient was ascribed to you from the moment you were admitted. Carole describes how she was treated when she was first admitted to Broadmoor in the 1980s:

> I was escorted there by prison officers, handcuffed to the inside of a van, and the admission procedure was one of complete dehumanisation and humiliation. I was stripped and made to have a bath in a bathroom that was very public and I spent the first three days, three or four days I think in a seclusion room without any bedding or clothes as I remember, and just simply left alone, in a, in a dark room, which was very frightening. . . .

Your clothes are taken away, your choices removed, medication enforced, your feet begin to shuffle, you try to take up less space, you move slowly, your brain is modified, you think and feel differently. Being so heavily sedated creates a state of helplessness—lying on the floor, hiding in your room unable to fight against the institution that claims to have your safety and best interests at heart. Like being undressed and bathed by strangers, being placed in a nightgown and having your clothing removed, sedation places you in a position of extreme vulnerability as defences are stripped away, and in the large hospitals of the twentieth century, that could be full of noisy and 'disruptive' people in distress, sedation was used liberally as a 'treatment'.

An extreme form of sedation was found in Modified Insulin Coma 'therapy' (ICT) or insulin shock 'treatment' as it was also called, a common 'treatment' in the 1930s, 40s, 50s, and into the 1960s, despite being incredibly dangerous, causing unknown mortality. Prior to the more modern sedatives like Chlorpromazine, which revolutionised psychiatric treatment in the 1950s and beyond, ICT was one of the first widespread somatic treatments, practiced from the early 1930s in parts of Europe and the United States, followed a few years later by Electroshock 'therapy'.

ICT induced patients with hypoglycemic coma through the administration of high doses of insulin to remove glucose from their bloodstreams. Soon after patients would begin to jerk, shake, grimace and sweat profusely as they fell into states of unconsciousness. They would be kept in a coma for up to several hours, five or six days a week, before being brought back to consciousness by the administration of sugar solution. All of this highly complex medical activity would take part in a specially designated area of the hospital, the insulin unit, and could last several weeks or even months (Doroshow 2007). ICT became a popular treatment for those considered to have incurable Schizophrenia, embraced by psychiatrists who saw it as a way of bringing their profession 'closer to mainstream medicine, particularly to neurology' (ibid.: 213), as psychiatry had, until then, been viewed very much as a poor second cousin to general medicine.

In two of the testimonies I was horrified to hear descriptions of insulin coma. And yet interestingly, listening with these moments, the women describing them sound matter of fact, and in Kathleen's case, almost gloss over the experience, moving on quickly to speak about ECT. Perhaps that is, in part, to do with the treatment being so sedating that there is not much to say about it—you are literally put to sleep.

In fact although this is an incredibly dangerous 'treatment' the descriptions of insulin coma were far less distressing to hear than those of women being sedated and left helpless on the floor. In the example below, Kathleen mentions modified insulin in passing whilst talking about her earliest admission to a private hospital, Holloway Sanatorium, in Virginia Waters, and only refers to it once again very briefly.

> Interviewer: And so when you arrived at the hospital did anyone explain to you what will happen, you know, and so on?
>
> Kathleen: No… there was… they were all very pleasant people there… they… gave me modified insulin after a while… umm …or they gave us ECT which in those days there was no anaesthetic… [laughs] … it was terrifying… terrifying…

Later, when asked again about insulin comas, she goes on to say: 'I think…I think I had it every morning…I think we had it and we …carried this little bottle of glucose with us all day, yes…'

Annemarie discusses in a little more detail what insulin coma therapy was but it is still glossed over in a way I found surprising and somewhat disturbing.

> Interviewer: And what sort of treatment did they give you?
>
> Annemarie: Well, I had insulin therapy. They felt that was a good therapy many moons ago. And they'd give you insulin, let you get into a coma, then they… then they'd wake you up and feed you and then you'd sleep. I didn't understand that for years… Excuse me [pause]…

Lobotomy and leucotomy (both forms of psychosurgery that remove or cut into areas of the brain with the belief that severing certain functional parts of the brain would lead to recovery from 'madness') were even more severe and permanent

forms of extreme sedation—the aim of lobotomy being to cut out or sever the part of the brain that was causing 'emotional disturbance', in order to create quiet, compliant bodies, reducing people to shadows of their former selves. As Pauline describes in her testimony:

> …there were groups of people, in different wards, you might meet them in the grounds, and they'd be very quiet people, apparently very gentle people, with not really a lot to say about themselves, and I came in time, to realise that these people were people who'd been, had a lobotomy, in, in, in the years when, well, it seems that lobotomies were done willy-nilly and probably unnecessarily, and they were such sad people because even though they'd had this dreadful surgery, they'd lost everything. They'd lost, they'd lost the essence of their being, they'd lost the person that they actually were and they were still living in the hospital and that was so sad.

The repeating phrase 'so heavily sedated' has stayed with me, for it is a phrase that sums up a lot of my own experience of being a psychiatric patient. Like my mother, each time I was admitted to hospital the first thing I was given was large doses of Largactil, usually in its faster acting liquid form. On one occasion, in my twenties, I was so heavily sedated during my time in hospital that I started to believe the nursing staff were trying to kill me. I felt helpless to fend off the unwanted attention of men on the same ward who would circle around me anytime I dared to leave my room and enter the communal spaces. I also have strong memories of my mother being treated in the psychiatric ward of the local general hospital in the mid-eighties with a drug called Haliperidol, which caused her to suffer paralysis in her face and legs so severe that she could barely speak or walk. As a sixteen year old visiting her I was shocked to find that she couldn't get out of bed or tell

me what had happened to her. She later told me that she felt sure she was going to die on that ward.

'So heavily sedated' is a repeating trope that shows how the effects of psychiatry create conditions that make thinking about alternative futures almost impossible. 'So heavily sedated' keeps you trapped in a never ending present, where there seems to be no past and no future. 'So heavily sedated' is a form of power that desires passivity, a form of violence dressed up as *preventing* violence. It fails to acknowledge that a screaming woman is not a sign of madness but is a sign of life that seeks freedom—of thought, expression, body and mind. 'So heavily sedated' comes about when society refuses a woman's freedom, when controlling her every breath and muscle to the point where she is utterly helpless becomes a routine part of the established practices of 'care'. When so-called unreasonable behaviours cannot be accepted, must not be seen or heard, but instead be restrained and eliminated. As Peter Breggin points out 'drugs are given to women to reinforce their enslavement to the women's role … instead of understanding the women's symptoms as an expression of frustration, outrage, and despair over her place in

the family and society, the psychiatrist prescribes spirit-blunting medications that reinforce the status quo in her life' (Breggin 1993: 401).

Speaking the words 'so heavily sedated', verbalising and naming the effects of psychiatric drugs and 'treatments' becomes a way to speak out against their muting effects. Listening and compositioning -*with* 'so heavily sedated' is a way for me to witness the effects of the psychiatric institution and to mitigate against my own return to this state of forced helplessness. It is a way to bring awareness to states that remain silent and silenced. Sedation is rarely acknowledged as the primary desired outcome of a drug, it is usually treated and talked about as a 'side-effect'. But in listening-*with* 'so heavily sedated' it becomes clear that sedation is often what the institution desires, a *necessary* part of 'treatment', to make your moods and behaviour more amenable, more 'normal', perhaps, more feminine.

Contradictory narratives: Electro-shock as erasure

'Electroshock 'therapy' (ECT)[3] is an act of erasure. Listening-*with* and compositioning are methods for attuning to this erasure that can sound out the ties between women survivor's complex and contradictory experiences of electro-shock and the re-emergence of ECT as a form of psychiatric 'treatment' that is making a 'quiet comeback' (Dukakis & Tye, 2006: 25 in Foisy 2021: 17).

Within the MHTA recordings there are many contradictory stories about electro-shock. These contradictions serve to create silences around this so-called 'treatment'. Within all of the testimonies there is a sense that whilst speaking about ECT as a form of 'treatment' it was also viewed as a form of punishment, even as some of the women argue that it 'helped me' (Annemarie), 'jolted me out of the

[3] Survivors of ECT often speak of 'electro-shock' rather than using the abbreviation ECT which stands for electro-shock therapy or treatment, arguing that electro-shock should not be referred to as a treatment or therapy but rather an abuse which causes brain damage. In this section I use both ECT and electro-shock, as ECT is most commonly used in the MHTA interviews. That is not to say that I consider ECT a valid form of 'treatment' or 'therapy'.

deep depression' (Kathleen) or that it was simply '…a fact of life, it was a fact of life and it didn't bother me having it done' (Pauline). Annemarie describes her treatment saying 'I didn't understand it. I was given ECT…I didn't sign for it, I was told I had to have it, and as I had no one to fight the battle for me, I just …I don't know. It seems they all had their way with me'.

Following this account, when asked about her 'treatment', Annemarie says 'I was on ECT a lot' 'I didn't really understand …all the, when I was first ill all these years ago, what ECT was meant to do, but I found out it helped me. It helped you forget a little while, and then you'd build up anew. You'd start again.' This testimony seems to support the idea that electro-shock works by wiping the slate clean, erasing memories, helping women to forget traumatic events and carry on with what might be highly unsatisfactory lives. As Carole so powerfully states:

> It simply obliterates huge patches of one's memories, and that is one of the reasons that ECT is used in theory, in order to obliterate memories which are causing distress…but it takes everything else with it as well and it takes away your whole sense of who you are and what you are and I do remember after that period…going back to work and not knowing

> the names of my colleagues, people who I'd been working with for a year, I didn't know who they were [...] I've struggled for a long time to try and recapture the details and I simply haven't got them [...] I'm very angry that that part of my life has been taken away from me because I have a right to those memories and to understand what was happening to me then and it's gone... It's like pieces of a broken mirror that I could not glue back together.

Ann describes her initial trust of the doctors who were administering ECT and mentions that her family commented that 'you did seem a hell of a lot better afterwards'. All they told her beforehand was 'you're going for treatment' and as she states her feelings changed during the time she was being given it:

> In the beginning I trusted everybody and I thought 'oh this is alright' but there was one morning when I struggled with Dr Baskerville and 'I don't, I don't like this' you know but really I mean as soon as they put this needle in your arm you were out, as soon as the needle touched your arm you were out and then you were awake and it was all over.

In HMCTL it was important to find ways to composition that allowed for the contradictions of the MHTA testimonies, rather than glossing over differences, so in the work I do not shy away from using voices that say ECT 'helped me'. However, I weave this in with descriptions that are intended to allow the listener to tune into what remains unsaid or unconnected within the testimonies. As the testimonies of Ann and Annemarie show the effects of ECT can be lifelong and devastating. Ann says of her years in and out of psychiatric hospitals, following a great deal of ECT that was initially signed for by her mother and sister, but later refused by her father,

> if anything keeps me out of hospital I'll take the drugs you know, and I just took them, without any information, I just took everything really, and they said my father was a fool not to let me have the ECT cos I would have got quicker, better, I would have got better more quickly but then I found out that ECT destroys irreplaceable brain cells and now they have told me in fact that the brain cells at the front of my brain have died off…

Ann goes on to describe how she wrote to the Neurologist she was seeing, as a result of serious memory problems, and the collapse of the features on one side of her face, to ask if it was because of the ECT and he wrote back saying 'you'll have to ask your psychiatrist' but as she explains the two psychiatrists that organised her ECT 'are now dead and gone, so…'.

Unlike Ann, Annemarie never connects a brain haemorrhage, tumour and terrible neurological symptoms she suffered in middle-age back to the frequent ECT she was administered over years in psychiatric hospitals. According to the ECT website of psychiatrist Peter Breggin,[4] ECT 'causes typical symptoms of severe

[4] http://www.ectresources.org/

head trauma or injury including headache, nausea, memory loss, disorientation, confusion, impaired judgment, loss of personality, and emotional instability. These harmful effects worsen and some become permanent as routine treatment progresses'. In fact, Breggin, among others, argues that women were deemed more suitable candidates for ECT due to their being 'judged to have less need for their brains' (Breggin 1979: 8 in Showalter 1987: 207). Like Showalter, he argues that their perceived improvement after ECT might simply reflect male bias within psychiatry that views the docility and helplessness, that follows treatment, as desirable characteristics in women.

It is well documented that ECT has been, and, still is, used more as a 'treatment' for women than for men, as Bonnie Burstow (2006: 378) points out, women are subjected to electroshock two to three times as often as men. Despite its reputation for wiping memories and traumatic side-effects, in the United States and UK electroshock 'therapy' is on the rise, being used for so-called 'treatment resistant depression', particularly in elderly woman (Dukakis and Tye, 2006 in Foisy 2021), arguably one of the most vulnerable groups within psychiatry. As with many of psychiatry's twentieth century 'treatments' such as insulin shock, leucotomy and lobotomy, according to Christina Foisy (2021) the amnesia surrounding ECT mirrors criticisms of its 'memory erasure' (Andre, 2009: 6 in ibid.: 3). In compositioning -*with* erasure, it was vital to witness these contradictory and uncertain testimonies as an act of recognition for women's experiences. For, wherever a gap remains, it is likely a ghost will fill it and like Cho, I hope, through my listening and compositioning -*with* women's sound recordings, to show how the presence of such a ghost 'compels us to listen to these voices and to hear more than one voice at a time' (Cho 2008: 47). By creating a polyphony of voices through which women can sound outside of their archival and institutional isolation, these women vocalise together, their many voices telling a multitude of different stories.

3.3 A child sounds

Tilly Tin Drawers/don't touch me head

> I used to call her Tilly Tin Drawers, but her name was Hilda Matilda [laughs] and I come up with a cock…the cocky [sic] name of Tilly Tin Drawers, so I got more good hidings, so [laughs]…

Tilly Tin Drawers is the name that Annemarie calls her 'second step-mum'.[5] She describes climbing onto the roof of the farmhouse where she grew up, kicking down the ladder and shouting 'Tilly Tin Drawers'. I can hear her now… 'Tilly tin drawers, Tilly tin drawers…'. The words call out to me and I find myself wrapped in Annemarie's voice, taking me to a place of childhood, both Annemarie's and my own. This singsong, rhyming, alliterative name-calling is perhaps something like a form of 'glossolalia', defined by Oskar Pfister as 'a regression to an infantile state […] that refers back the affective experience of the child' (in De Certeau 1996: 35). I find myself moved by the rhythmic inflection of the words and the defiance in its tone, something like a playground chant, it resonates as a past not fully past; the soundings of a child ghost reaching out beyond the archive, pulling me in. Perhaps this is another moment of enactive witnessing in which listening-*with* Annemarie, to the tonality, timbre and resonances of her voice, her singsong name-calling, I am pulled affectively to *feel* what spills over and bubbles-up in the sounds of her many voices. It pulls me right there, into a child's body. Were I only listening to the recording once, or listening just for narrative meaning, I might have missed the child-voice on its return, but there is something in the listening and re-listening, sounds take hold and become utterly familiar, like a song that you learn as a child,

[5] Hilda Matilda, or 'Tilly Tin Drawers' became Annemarie's second adoptive mother after her first adoptive mother died when she was two years old. Her second adoptive mother was her first adoptive mother's sister, (originally Annemarie's adoptive Aunt). She married Annemarie's adoptive father after her younger sister died, in order to ensure that Annemarie was not taken from his care, as, at that time, adopted children could only remain with parents who were married.

the melody of which you never forget and that might be brought back to life in your memory/mouth at any time. This voice is not merely a re-presentation of a child past, it brings a whole world into being.

'Tilly Tin Drawers, Tilly Tin Drawers'—I isolate the words, copying and pasting the chant so it repeats in quick succession several times, one after the other, experimenting with layering the phrase so that the beginning of one chant starts to sound before the previous chant has ended. As I write this, I hear her again, 'Tilly Tin Drawers', the child is right here although the voice is not sounding and the recording not playing. The young Annemarie is ventriloquized through her adult self, sounding in the moment of the oral history recording in 2000, aged 59, and in my own memory of hearing her through headphones and working with her words in 2019. In the moment of making, of copying the soundwaves that form the words 'Tilly Tin Drawers', and then repeating it on the track of my DAW and layering it, one 'Tilly Tin Drawers' on top of another, temporalities/voices/spaces collide to create a truly polyvocal moment. The prosody, timbre, and pitch of the voice re-sounding in the words 'Tilly Tin Drawers' conjure Annemarie's rebellious taunting of the woman her father married after her first adoptive mother died. The child's voice circulates with other voices and memories of voices, moving in patterns of repetition and compulsion, revealing ghostly affects. The singsong pitch and tone of the words 'Tilly Tin Drawers' reverberate, and in my listening-*with* the child/adult Annemarie my sense of time becomes disorientated by the return of a child and 'the resonance of a return [renvoi]' (Nancy 2007: 12).

The jokey rebelliousness in Annemarie's voice as she says 'Tilly Tin Drawers' perhaps obscures what is revealed in the next few minutes of her recording, which become something much darker and more troubling. It soon becomes clear that her relationship with this second adoptive mother and her much older sons (Annemarie's adoptive step-brothers) was characterised by fear and violence 'I used

to get hidings galore as a kid'. When speaking about her step-brothers, her voice takes on a different, sadder tone. She says of them, 'they weren't very nice to me' and when asked by the interviewer what was she means, she simply reiterates 'they weren't very nice to me'. These words, like 'Tilly Tin Drawers', have a childlike quality, but here the tone and texture of her voice alters completely, becoming painfully strained, she seems almost to have run out of breath, her voice becoming so low and grainy that it sounds quite broken. Her speech is halting and stuttering as she tries to elucidate but she gets stuck as she attempts to speak her own name: 'They were always saying, if anything went wrong, it was Anne's, Anne's, Anne's, Anne's fault, they never called me Annemarie…Anne's fault, and I used to get hidings galore as a kid, so…'.

The stuttering repetition of the beginning of her name as she recounts her sense of loss, and subjection to bullying as the 'adopted' child is painful to hear, 'I was never let to forget that I was adopted, that was it'. Annemarie does not stutter anywhere else in her recording so this moment of difficulty saying her own name stands out. Brandon LaBelle, considers stammering and such hesitation in speech shows the profoundness of the speaking mouth and offers a 'view onto a subject under duress' arguing that stuttering displays the gaps and hesitations that come in the moments before speech—moments where speech literally gets 'caught in the mouth' (2014: 131). Freud saw certain vocal disturbances from 'stammering's and tongue clicking, to unintelligible clacking's, sputtering's and groaning' as manifestations of unconscious conflict (Lagaay 2008: 54). What makes Annemarie's hesitation here so painful is that it is her own name that she is tripping over, not her name as she would say it, but as her bullying older step-brothers said it. It catches in her throat, and she gets caught up saying 'Anne's' as if the memory of her brother's taunts and the violent context of their original verbalisations are too painful and get

stuck, making it impossible to speak her whole name, the name her step-brother's would never use.

The violence of Annemarie's upbringing becomes very clear when she states matter of factly 'I wasn't allowed to cry when I was a kid, and if I cried I used to get a smack round me head for crying. I used to hate anyone going for me head. I think my second step-mother knew it was the only way that she could get me to cry'. The smack around her head brings me up short as I listen. It resonates so strongly with her experiences of ECT after the death of her third child, Robert, when she was administered ECT without anaesthetic. In my repeated listening and later in my compositioning -*with* these moments of violence, despair and loss I find myself making a cut (or jump) from Annemarie's childhood to her experience of ECT. In my mind I see her crouched as a child holding on to her head: 'I used to hold onto my head…'don't touch me head'. Her 'don't touch me head' is a deeply visceral moment in my listening, her voice deep, raw and scratched, damaged by years of abuse, as if it has taken on a patina of pain, or what Cavarero refers to as the 'patina of experienced life' (Cavarero 2005: 1) a voice which seems to me 'feeling made sound' (Panzacchi, 288 in Feldman 2015: 654).

In my compositioning, the jump from the voice of the child who is beaten *'don't touch me head'* to the institutional violence of ECT enacted on Annemarie as an adult *'they used to do it without anaesthetic, they just used to take you in clamp the thing on yer head and that was it'* is joined and brought together by the undercurrent of a repeating breath that I bring into the circle of eight speakers, moving it from one speaker to the next in a circular formation. The movement of this breath, laid over this vocalisation of familial and institutional violence, repeats and lingers after Annemarie has spoken. Working with women's breath in this way, overlaying, repeating and circulating, was a process that enabled me to acknowledge how

violence, both familial and psychiatric, has taken its toll over long years and continues to have material effects.

One hour and forty minutes into her MHTA recording, Annemarie reveals that she suffered a brain haemorrhage whilst working as a security guard at a large football stadium, not long after coming out of The Gordon psychiatric hospital. She tells us that after the haemorrhage and emergency treatment in the Atkinson Morley Hospital it was discovered that she has a tumour in her brain, 'my main artery in my head, the bottom bit's like that, but the top bit's got a growth on it and if it blows, it'd probably kill me. …they said they can't give me the operation 'cos it'd kill me, but I'm dying any rate so…every day's an added bonus' (Annemarie, 2000). This devastating prognosis is delivered with a laugh and in Annemarie's usual, dry, matter-of-fact manner but in the tone and texture of her voice I hear an undercurrent of despair and defeat. Surprisingly perhaps, Annemarie never makes a link between her 'current' condition and being hit around the head or to the electro-shock, but after listening-*with* her talk about the many blows to the head she suffered as a child and the extended ECT she endured as an adult, it is almost impossible not to connect them. Listening closely and compositioning -*with* the

'grain' of Annemarie's voice (Barthes 2009) has allowed me to engage with sound as feeling, and by bringing together these apparently disparate but intertwined moments of Annemarie's testimony, working -*with* her affective vocalisations it is possible to hear her voice as a vital materialisation of embodied, visceral, fleshy experience that never ends.

Mummy says she's not in/mummy mummy what's for dinner?

There is another equally striking and moving moment where the child returns, found in Kathleen's testimony. Towards the end of her 2.20 hour recording at about 2 hours and 10 minutes, Kathleen is asked about her relationship to her mother again:

> Interviewer: Do you think she… during your childhood days, that she… could have observed that you were the worrying type?
>
> Kathleen: I don't think so no…I don't think she had the time or energy, really …I think she had too much else on her mind…
>
> Interviewer: How do you know that?
>
> Kathleen: Well she obviously did because she had to …we had to survive from week to week, you know…I remember once I would have been about three …that would have been 1931 wouldn't it? things were very bad, weren't they? and there was a knock at the door and my mum said to me 'if that's the rent man tell him I'm not in' so I opened the door and it was the rent man and umm I said *'mummy says she's not in'* [laughs] …I've never forgotten that, you know…oh dear, dear…
>
> Interviewer: Just give me a brief picture as to what it was like in your home, during those hard times

> KATHLEEN: It was . . . of course we had no luxury you see. . . none whatsoever, but we always had a good dinner, . . . some . . . well . . . I mean I can't remember when I was little, but from the age I can remember, we'd run in from school saying *'mummy, mummy, whats for dinner?'* . . .

When I listen now to 'mummy mummy what's for dinner?' I feel the child return but it is not because of any change in Kathleen's tone of voice. I don't hear the pitch rise in the recording that I hear in my head when I recall her speaking those words, I have imagined it and am remembering something in the recording that isn't actually there. Maybe it is the story and childlike language, the 'mummy, mummy', that colours my memory of her speaking. I have created an image of a child running in from school shouting 'mummy mummy what's for dinner?' and it is my own memory, my imagining the child calling out that allows me to *hear* the child's voice.

When she says 'mummy says she's not in' to the rent man her voice does, however, take on a child-like quality. Throughout most of the oral history recording Kathleen speaks in a low voice with a slow deliberate delivery but in the moment of saying these words it's as if she goes back to the place of childhood and it literally changes her voice. Her pitch becomes higher and her speaking faster—in recalling her child self she embodies her child-like voice—and then she laughs, 'I've never forgotten that, you know'. It is almost as if her child-self presenting in the now makes her laugh, as she finds herself standing in the doorway facing the rent man, 'mummy says she's not in'.

In both of these phrases the deep bond of a child to her mother can be heard—as if an umbilical *chord* in her voice creates a continuous thread from then to now, allowing her to fully connect with these memories not as events that have passed, but as a form of re-living, enlivening the childhood moment. In saying 'mummy says she's not in' Kathleen's voice, speaking the words her mother told her to say, makes

space for the child to reappear in a way that brings her loving and close relationship to her mother right into the space to be witnessed by others. It is a moment where subjectivity is shown to be truly multiple, as Kathleen's younger self is mediated through her speaking voice and the words that she says. The child has never gone away, she sits nested like a Russian doll, within the older woman's 'voice-body' (Connor 2014: 13) to make a momentary reappearance, externalised through the voicing of her much older self. This mediation, according to Tim Ingold (2007) is not a passive connection of two discrete moments or entities, but is a process of transformation. The voice becomes 'a bridge between the sonic, the embodied and the expressive' (Revill 2017: 51) and enacts different relations between 'the body, community, time, the wordly and the spiritual' (Connor, 2000 in ibid.: 52). The voice of the child is a reminder of sound as a spatio-temporal event, whereby 'arcs of rhythmic movement' link multiple moments, transforming the present (ibid.: 53). Listening-*with* this telescoping of time in which a child vocalises through a woman's mouth is a moment of what Pauline Oliveros calls 'quantum listening', in which I am 'listening to more than one reality simultaneously' (Oliveros 2002: 27).

3.4 Cycles of repetition

Uncertain histories

'If the gap is the site of a wound or shameful secret, a breeding ground for ghosts…why would we ever want to know what resides there?' (Cho 2008: 182)

Annemarie often speaks in repeated phrases, which end, unresolved, incomplete, hanging in mid-air:

> Hackney Road, Hackney Road…Hackney Road
>
> Bow Church, Bow Church…Bow Church

They were Jewish. They were Jewish so. They were Jewish…

What Annemarie's frequent repetitions (often in threes) mean I can never really know, but it seems that in speaking in these repeated phrases, Annemarie gets stuck in a moment of remembering outside of her direct experience, reflecting on transgenerational histories that are impossible for her to fully grasp. These transgenerational memories allude to her birth parents, whom she never knew and to the histories of her adoptive parents, even as they remain unspoken, left hanging in the air by an 'umm…' or 'so…' at the end of a sentence. Such repetitions show the poetic, ephemeral nature of oral history, and what Alessandro Portelli refers to as its 'sense of fluidity, of unfinishedness, of an inexhaustible work in progress […]' (Portelli 1991: vii in Abrams 2016: 1).

When asked where her parents were from Annemarie does not or cannot answer, instead invoking their cultural and religious identity, 'they were Jewish, they were Jewish…they were Jewish, so…' This is clearly an important aspect of her adoptive family's heritage, a heritage that Annemarie was not born into and on which she does not expand and yet which comes to the fore of her recollection of them years after they have died. It is perhaps unsurprising that Annemarie refers to their Jewishness as she was born in 1941 and adopted as a baby during the Second World War. The 'so…' that leaves this story partial, unelaborated and hanging in the air connects her personal story to much larger social histories and to other 'stories of history' (Davoine and Gaudillière 2004: xxi). In repeating the words 'they were Jewish, they were Jewish, so…' she alludes to traumatic memory outside of her personal experience, which remains unexplored in the testimonial interview.

French psychoanalysts, Davoine and Gaudilliere (2004) who situate their work at the intersection between social or macro traumas and individual trauma, advocate 'listening to history' in their analysis in ways that enable a link to be made between

individual trauma and much larger social traumas and history, not as cause and effect, but as a way of engaging with those caught-up in generational trauma, whose half stories, silences and 'madnesses' transmit from generation to generation 'pieces of frozen time' (Davoine and Gaudillière 2004: xxx). Approaching Annemarie's 'they were Jewish, so…', as trauma inflected discourse that alludes to macro histories of trauma, requires engaging such half spoken moments and silence, not as lacks, but as meaning-full speech (Mazzei 2007).

These repetitions and story endings that don't finish are spectres that seep into the narrative and, after so many listenings, they start to gnaw away at me. I am left wondering about Annemarie's adoptive parents Jewish heritage, why she was given up for adoption and all the other silences that permeate her repeated and unfinished phrases. With Annemarie's habit of leaving a repeated phrase hanging with a 'so…' or 'yeah' what is left becomes both an excess and a gap, forever unanswered. The repetitions and sentences left undone become signs of a ghost, and of irrepressible feelings that confound containment.

There are numerous other moments in the testimonial recordings that link the women's experiences of familial trauma to macro histories of trauma. In Carole's testimony she refers to her father's absence in the early years of her childhood and his being away at the Korean war:

> The first time I met him and I think I was probably about three and he'd been away, he'd been in the forces again, he'd gone to the Korean war and come home and he came home wearing a khaki uniform and he came down a garden path and picked me up and I didn't know who he was and it was very frightening and the khaki uniform was very scratchy and I didn't like it and I screamed and kicked and had to be put down.

Later she mentions her grandfather's experience of being gassed in the First World War:

> 'My grandfather was a veteran of the first world war, he'd been gassed and had severe breathing difficulties and was barely able to get about by the time he died when I was eight.

These moments are not dwelt on but passed over quickly as a picture is built up of the wider familial relationships and Carole's grandparents roles in the Salvation Army, which get explored in much greater detail over the next ten minutes of the interview. In the psychoanalytical work of Davoine and Gaudillière, psychosis is understood as the manifestation of a break in 'the social link', which might be described as a fracture in the transmission of historically located trauma, often associated with war, across generations. Walkerdine et al. (2013) explain in their social research, analysing interviews using Davoine and Gaudilliere's psychoanalytical work: 'If experience cannot be transmitted across a social group or down a generation, the link that binds them together will be broken. It is broken because the experience is so painful that it cannot be transmitted and has, therefore, entered the silence of social amnesia' (Walkerdine et al. 2013: 275).

There is something about the minute detail in Carole's story of her father picking her up and the scratchiness of his khaki uniform that alerts me to the immense pain and significance of this moment and the many silences that pervade the rest of her testimonial recording in relation to her relationship with her father. As Walkerdine et al. write, 'the participant may strive to present a graspable story of

her life, and in that way present a sense of a 'coherent self'. Nevertheless, such strivings for coherence will in themselves have gaps and silences—breaks that catch the ear of an interviewer…' (Walkerdine et al. 2013: 280). Embracing such moments of remembering, not found in the annals of official history, is part of an epistemological approach that is open to listening-*with* 'stories of history' (Davoine and Gaudillière 2004: xxi), beyond 'the certainty of absolutes' (Foucault, 1991:87 in Trivelli 2013: 105), that allows for the spoken and unspoken, real and imagined and psychic and material of memory.

'My mistake'

In Kathleen's repetitions there seems to be something different at work. Her systematic repetitions occur at very specific points in her narrative and indicate a way of thinking about herself more than about specific events.

> I'm a dreamer, I'm a dreamer…
>
> It was my mistake, it was my mistake. It was my mistake again you see

These moments of speaking in twos and threes might be considered as a 'refrain' (Guattari 1995). A moment in which Kathleen speaks to comfort herself, using a form of self-talk that suggests it was always to be this way. Specifically these refrains feel like a refusal to acknowledge injustices done to her over a lifetime of institutionalisation. They exist in the testimony as spoken silences, unspeakable moments and refusals, in which events, feelings, and experiences are apparently glossed over, their potency reduced to a mere 'mistake' and her mistake at that. This habitual way of speaking has become sedimented, even as Kathleen tells a story of subjectification.

'It was my mistake' has become a way for Kathleen to hold herself 'in place' (Walkerdine et al. 2013: 758). Her voice in these moments sounds childlike, stuck in a mode of self-criticism, a fantasy of her own agency. By refusing to hold the institution, in whose 'care' she remains, to account, she becomes stuck in patterns of self-blame, perhaps as a way 'to manage pain' (ibid.). Referencing Guattari's concept of refrain, Walkerdine writes that, 'fantasy …can take one back toward a re-territorialization, which does not open up but closes down' (ibid.: 760).

Kathleen seems to be refusing herself the chance of a different life, repeating the words, 'it was my mistake' even when she is articulating the sexist tropes of a psychiatrist who says 'what you need is sex' and the violence of an institution that told her 'you are stupid, you never think'. As Bertelson and Murphie argue, refrains 'allow new forms of expression but render others impossible' (2010: 139). Following this argument, Kathleen's refrain and insistence on 'my mistake' might be understood as a form of self-subjection that comforts but also holds her in a repetitious cycle of habituated thought and speech, denying the possibility of things to be otherwise.

3.5 An institution calls

The hoover

> *After years numbed by oppressive routines she welcomed the madness that came from abandoning duties, the brief euphoria of breaking the endless cycles of familial responsibility. How could she know that she would end up in a different space of back-breaking domestic routine? Being awoken at 6.30am everyday—'GET-UP'—to polish endless corridor floors on her hands and knees.*

An awareness of the hoover in Kathleen's recording crept up on me—the hoover being pushed down the corridor, droning quietly in the background, along with

the voices of staff. Such an innocuous sound, it hums faintly, becoming louder as it moves up the corridor before passing into the distance again. This droning, whirring hoover appears several times over the course of Kathleen's recording. What might, at first, register merely as an annoyance, alerts the listener that Kathleen still lives in the confines of the institution.

The hoover provides aural knowledge about the moment of the interview and the space of recording, making me intensely aware that I am listening *in* an institution, to the voices of the institution, the rhythms and regulations that structure the place of confinement from which Kathleen speaks. The space of listening becomes marked out by the background sound, by the noises of other people and things. As this 'organisational cacophony' (Corbett 2003 in Brown, A. Kanyeredzi et al. 2020: 1538) sounds, Kathleen continues to answer questions, oblivious, perhaps, to the hoover and staff speaking in the corridor, used to their presence in the background of her daily life.

Hearing is a key modality through which 'care' relations and security are organised between psychiatric patients and staff on hospital wards (Brown et al, 2020) and Kathleen is so used to the noises of this institution that, perhaps, she no longer notices them, they are simply part of the familiar fabric of her 'home'. In the interview and transcript there is no mention of this background noise and nothing to indicate the hoover as it partakes in the rhythmic life of the institution. These rhythms of daily cleaning become apparent only in my listening, invisible markers of time and space, part of an affective sound environment that remains unacknowledged. Perhaps the knowledge of the hoover in the corridor outside prevents someone like Kathleen from leaving her room, I can never know, as questions about such sensorial effects, of how bodies living within the institution are affected by these sounds, remain unasked.

Psychiatric institutions, like hospitals in general, have particular acoustic qualities. They are often noisy places, reverberating with sounds that can have unsettling affects on the people who work and reside in them (Summers & Happell, 2003; Holmberg & Coon 1999). As Brown et al (2020) point out the design of many psychiatric units, with long corridors converging onto a central open area (a 'cruciform' design) creates highly reverberative spaces that have been known to exacerbate perceptual distortions of distressed patients. Hospitals and other institution's soundscapes are also shaped by the presence of particular 'archetypical sounds' (Truax 2001 in ibid.), for example, 'the sound of keys in locks, ringing bells marking the division of the day, or the reverberations of massed steps and loud chatter in large open corridors'—sounds that frequently have emotional, cultural and social significance and can act as 'powerful markers of institutional life' (ibid.: 1540). To the untrained ear, these can sound like random noises but for people living within the daily regimes of an institution such sounds become meaningful, as a result of 'listening habits' (ibid.), techniques, or 'earwork' a term defined by Cyrus Mody as practiced forms of 'listening, hearing, attuning' (2005: 176).

I have developed my own practices of earwork, engaging my ears and technological apparatus as sensory instruments, listening within the context of a testimonial archive. Earwork can be taken here as a mode for researching historical erasure, which, for example, hears the hoover as a transmitter of subjugated knowledge that relates specifically to institutional space. The concept of earwork comes from an emerging field of research on sensory modes of organizing that argue for 'multi-modal' sensory approaches to lived experience of organizational space (Brown, A. Kanyeredzi et al. 2020). However, in my practice, earwork has not been enacted in order to understand how organisational space might be better designed to improve aural well-being within psychiatric or other spaces, but rather as a form of critical and 'fleshy listening' (Harpin 2018) through which a 'different sensibility' to the

acoustic environment of the oral history interview might be developed (Brown, A. Kanyeredzi et al. 2020). My earwork makes me an earwitness as I attune to the specific social, cultural, political conditions of an aural archive, a practice that is impacted by my own memories and experiences of earwitnessing within spaces of psychiatric incarceration, spaces usually deprived of any pleasant ambience, in which it is vital to adjust one's senses to changing atmospheres, to *hear* the environment for clues.

The fax machine

> *Together the listener and the voice speaking from the wound constitute a kind of storytelling machine, an assemblage of seeing, speaking, and listening components.*
>
> —Grace Cho (2008: 184)

Eighteen minutes into Kathleen's interview I hear beeping, the sound of a fax machine. This fax plays an important part in Kathleen's recording and here I explore its role as a ghostly, uncanny voice. In writing about the fax machine I position voice, not simply as the sound emitting from a human mouth, but as 'a thing that is entangled with other things in an assemblage' (Deleuze and Guattari, 1987 in Jackson and Mazzei 2016: 1), acting with 'agential force' (Bennett, 2010b in ibid.). Listening-*with* the fax and its insistent call, piercing the moment of speaking 18 minutes into Kathleen's oral history recording, opened my ears to the possibility of 'things that have voice' (Ihde 2007).

The object that punctures the membrane of temporality is not named at this point in the interview or in the transcript (except as a beeping noise). It is glossed over in what is left of the recording (the tape is stopped and restarted some unknown time later; 'ok were running' says the cameraman). No one acknowledges that this is a fax machine or that Kathleen is being interviewed in the office of a care

home for elderly ex-residents of Horton psychiatric hospital, still living under the watchful eye of the institution: 'This is The Haven you know, The Haven.'[6]

INTERVIEWER: How old were you when you were evacuated?

KATHLEEN: Eleven

INTERVIEWER: and how old were you when you returned back to your family?

KATHLEEN: Well we came back when the Bath bombs were dropping…the headmistress was very unhappy and she…got the government to allow us to [noise in the background]…

INTERVIEWER: Just carry on…just carry on…

KATHLEEN: what's happening?

INTERVIEWER: Just carry on…

KATHLEEN: she got the government [loud beeping noise in background]…to allow us to return, so we didn't wait 'till after the war, which was the original idea, you know…

INTERVIEWER: do you want to cut, you want to stop? [loud beeping noise still]

CAMERA: 'Yeah' 'okay…were running'

The fax machine intrudes like some kind of emergency warning, insistent and disorientating—'what's happening?' Kathleen asks in a childlike voice. In this moment of interruption temporality collapses. That the fax intrudes at the very moment Kathleen recalls returning to London aged 14, during the bombing of

[6] The Haven is a residential care home, built in the grounds of Horton Psychiatric Hospital before the hospital closed in 1997, in order to house long term psychiatric patients deemed too old or institutionalised to live in the community.

Bath, is uncanny; breaking through in a moment of emergency (Eng and Kazanjian 2003),[7] interrupting the oral history interview proceedings, neither as an object or subject but as 'intervener' (Latour, 2004: 75 in S. Bennett 2010: 9). Thinking about the voice of the fax challenges the idea of voices belonging only to speaking human subjects, unsettling what voice is. The fax in a posthuman reading can be brought into view as a ghost, a psychic apparatus with agency, part of an assemblage whose 'unconscious mechanisms' cannot be contained in discreet bodies. Rather than privileging the human speaking voice, posthumanism requires that we challenge the boundaries between 'what *has* a voice and what doesn't' (Jackson and Mazzei 2016: 2, emphasis in original).

In compositioning -*with* this agential voice, the fax, becomes a structuring device, and by isolating and repeating its shrill beeping I am able to bring it into play with other voices, subjectivities, narratives, feelings and memories, a psychic catalyst evoking, at once, a fire alarm, air raid siren, and multiple moments of crisis. The fax resonates in numerous ways with descriptions and memories from the other oral history interviews, intra-acting with other moments in which an alarm sounds. For example, Ann speaks at length about the experience of being sectioned after going into hospital voluntarily, and of setting off a fire alarm:

> I went in voluntarily and they put me on a seventy-two hour section… and they said that I had been actively aggressive… I was shouting and bawling and it was worse in a way, cos they grabbed, they put, it was the time out room again and I hated it, but I thought I can't, they took everything away from me, my handbag and everything. This is was I don't like, they'd take all my handbag, I had a bag and they took it away from me … and they… I was being disruptive and they, put me in the

[7] Eng & Kazanjian draw on Walter Benjamin's notion of animating the remains of history—'the past is brought to bear witness to the present—as a flash of emergence, an instant of emergency and a moment of production' (2003: 5).

> time out room again … and they take everything away from you, your jewellery and everything, you know, take everything away from you, your watch…and as I went down, as they took me down to the time out room I smashed a fire alarm, cos I thought 'I'm letting people know whats going on in this place' you know, you don't need this when you're ill, and the fire alarm went off and I was in the time out room [laughs].

In Carole's testimony, part of which is brought into play with the fax machine, she talks about the moments leading up to and then setting fire to a box in her office:

> I had to be at the theatre at about seven o'clock that morning and before I was even in my uniform, I was called to the stage door because a child had been skate boarding outside and had crushed his fingers…broken his fingers and had severe lacerations …That was the beginning and it went on the whole day. It was one emergency, one trauma after another. Somebody had a broken leg…someone collapsed in one of the restaurants, somebody had a very severe asthma attack…and by the middle of the afternoon I just felt completely disconnected from what was going on…helpless to do anything to help anyone…and my overwhelming need was to get out of the building, but I couldn't get out because my job was to stay there as long as there were other people there. …I was smoking a cigarette …and I had a box under my desk which was a wastepaper bin, I lit a cigarette and I put a match in the box, knowing I was starting a fire, it wasn't an accident and I walked away from it, went out and shut the door…and by the time I'd gone up two flights of stairs the fire alarm went off…

From twenty-three women's recordings I had unwittingly selected three that featured an alarm in some form, either within the narrative or, as in Kathleen's

testimony, an actual sounding alarm. Connecting these traumatised testimonies, their many entangled voices and bringing them into play with the repeating trill of the fax machine, became a way to trouble time and space and unsettle the linearity and horizontal motion of individual oral history narratives. Juxtaposing different stories and voices, I was 'traumatising the text' (Cho 2008) in a form of 'foraging and disfiguring—raiding for fragments upon which other narratives can be spun and misshaping and deforming the testimony through selective quotation and amplification' (Hartman 1997:12 in ibid.: 44). Staging words and memories in ways that recognise the restlessness that comes from trauma, when, to quote Judith Butler, 'all that happens has already happened, will come to appear as the always already happened…entangled and extended through the force of repetition' (2000: 64 in ibid.).

Throughout this work I ask questions about what has been disavowed and 'forgotten' in the history of women's psychiatrisation, and how women might remember what has happened when the treatments we have been given and the stories we have been told about ourselves, our brains and our 'mental illness' seem to be trying to make us forget. In working with the fax in Kathleen's recording, taking its sound out of time, giving it its own track and space to sound, I am able to play with its insistent call, separating one shrill pulsating moment in the fax's sound, the 'dadadadadada-da' before copying this voice and repeating it multiple times. Underneath the pulsating 'dadadadadada-da' of the fax's high notes is a lower humming sound, interwoven with the fragmented narratives and voices of three women who remain caught between a failed remembering and the impossibility of complete forgetting, creating the disturbing feeling of being in a state of perpetual emergency, as trauma plays out in what feels like a repetition of the same events, over and over again.

Place names

> *What is lost is only known by what remains of it, by how these remains are produced, read and sustained'*
>
> —Eng and Kazanjian (2003: 2)

> *How can one look at ambiguous personal and collective histories, and the traumas that reside in the spaces of not knowing, without reproducing the same kind of epistemic violence that induced those traumas?*
>
> —Cho (2008: 18)

In Grace Cho's work trauma exerts its pull, in part, through the repetition of words. In her telling of haunting and the Korean diaspora, certain words repeat themselves in different places, across different generations, texts, spaces, times and mediated perceptions. These words … 'yaggongju. Yankee whore. Western princess. GI Bride […]' (ibid.) are the sort of words that can "rule an entire family's history" (Abraham and Torok 1994: 176). The words that haunt the MHTA are of a different nature to Cho's, they are not insults or names given to 'mad' women, they are the names of places, the hospitals and wards into which women were committed again and again.

Removing these hospital names from the women's recordings and compiling them into lists they sound with their own energy and emotional charge. Spoken out loud, hospital names become affective transmitters of multiplying associations and meanings, freighted with the heaviness of secrecy and shame. Some of the names are so recognisable that even without personal knowledge they have a familiar ring as places to be avoided, unmentionable names, swathed in silence. Hospital names can haunt families and whole communities, towns and neighbourhoods. These closed places spoken in whispered voices, or in the form of a joke or threat

'if you carry on like that you'll be taken to…' (Carole, 2000). Hospitals, perched on hills, hidden behind stone walls and shrubbery, places on the margins located just far enough away to be out of sight but close enough to be a reminder of what could happen if you have the misfortune to go 'mad'; places where lives were lost and forever changed.

Brookwood. Ridgewood. Rainhill. St Lawrence's. Oakwood. Banstead. The Maudsley. Broadmoor. The Gordon. Gart Navel. Horton. Long Grove. The Haven. Cobar ward. Holloway Sanitorium. Liner ward.

These words call for a performance of affect, that, 'arises in the midst of *in-between-ness:* in the capacity to act and be acted upon' (Gregg and Seigworth 2010: 1). For, when you are 'taught to keep quiet and not ask too many questions, you can't resist pulling on that thread of familiar silence once the edges of the fabric have begun to fray' (Cho 2008: 2). And as the fabric starts to unravel all you can do is call on ghosts—to invoke affects, as 'things that happen' (Stewart 2007: 2) both on and off the page, in the research and in the researcher herself.

> *How many times have you been in hospital?*
>
> *Can't you remember? Try to remember.*
>
> *Brookwood, Ridgewood, Ward 4, Ridgewood, Ridgewood, Ridgewood…*
>
> *Where was I?*

As a child the name 'Brookwood'[8] loomed large and silent in our house. It was the name we never dared speak, the unmentionable place to which my mother was first committed against her will in March 1976, when I was five. A place where terrible things happened, things that would change the course of my mother's life forever. Brookwood, such a seemingly innocuous name, is a station stop between

[8] Brookwood Asylum, the second Surrey County Asylum, opened in 1867 to ease pressure on the first Surrey County Asylum, Springfield at St George's in Tooting and housed 650 'pauper lunatics'. By 1937 it held 1,753 men and women on a vast 150 acre self-sufficient site near Woking. It closed down in 1994.

Fig. 3.13: Main administration building, Brookwood Hospital circa 1890, copied from the Brookwood Hospital Archive

Fleet, where I grew up, and London, Waterloo, on the same line that my parents commuted along on a daily basis at different points throughout my childhood, a station I passed every time I went to London. Even now, every time I pass through Brookwood station on the journey 'home' I scour the horizon for clues, seeking out a glimpse of the old hospital buildings (now a luxury housing estate) with its looming gothic clock tower, despite knowing that there is no way to see it, tucked away behind dense coniferous woods. The only landmark visible from the station is the vast Brookwood cemetery that runs parallel to the train tracks and which contains the unmarked graves of those who died in Brookwood asylum.

In 2010 I started filming my train journeys through Brookwood back to Fleet. I filmed out of the window as the train passed through or stopped at Brookwood station. I didn't do anything with the footage, it sits taking up space on a hard drive somewhere. I don't know what I expected to come of it but I felt the need to make a record of the station, whose silent name haunted me growing up. A place whose resonances I didn't understand until my late teens when mum and I started to speak about all the hospital admissions, these gaps in both our lives. It was impossible

to comprehend the violence that had occurred during a short admission in 1976; events that would never be believed by family, doctors or police and yet which unfolded in every breakdown that followed. The label of 'mad woman' designated her and uncountable others to the status of *unreliable* witness, destined not to be believed, 'it is your illness speaking.' The familial shame and silence attached to this time runs so deep that what it conceals can never be fully understood and it was this aching silence I wanted to explore when I started compiling hospital names from the MHTA.

As with the breath-tracks, I started by taking out words, removing everything from each woman's recordings except the place names—towns, countries, streets, schools, hospitals. It took a long time and on creating tracks for Carole and Ann I was unsatisfied with the results, merely a chronology of every place associated with their lives. However, listening closely with these tracks the names of psychiatric hospitals and wards began to stand out, sounding differently to other places. I started removing all the other places and then stringing together the hospital names exactly as they came up in the spoken narratives, often repeated and out of chronological order. In isolating the hospital names it became possible to listen-*with* memories of institutions without all the detailed narrative attached to them, re-sounding names heavy with resonances and reverberations.

> *Holloway Sanatorium, Long Grove, Rainhill, Banstead, Oakwood, The Maudsley, Broadmoor Lunatic asylum, St Lawrence's, Gart Naval, Liner Ward…*

The hospital names ring out, resonating, vibrating, pulsating, sounding with an energy difficult to define. So much information, sounding in isolation they call the listener to another place and time. Time stops as the pitch of a woman's voice rises, through, for example, the sounding of the word *Rainhill.* If the hoover droning in the corridor is the sound of the institution making its call, then the names of

psychiatric institutions being recited constitute an affective vocalisation *about* those institutional sites.

As I copy and repeat hospital names in the Pro Tools timeline, placing them on multiple tracks, layered one on top another, they become densely textured, merging into one another until a single name cuts through, sounding above the others. At times names are almost impossible to hear—my ear fails to separate out sounds in the build up of voices, at other times a hospital or ward name sounds with a harshness and clarity that is piercing. Displacing place names from the testimonies and layering them affords greater awareness of the pitch, loudness and tone of individual words, as one institution's spoken name sounds above the others. Layering and repeating names, they build in volume and intensity. In my compositioning with this build-up I decide to create a break. At 2 minutes 50 seconds the sounding names stop, there is a short gap, a momentary pause, a silence. After a couple of seconds, just long enough to feel released from the cacophony, the names start again. This momentary break and return becomes a way to alert listeners to repeated cycles of incarceration common to so many women. Just when you think you've escaped the psychiatric institution you find yourself back inside.

These institutional names carry the weight of so much loss. Listening-*with* the tracks singularly or layered on top of each other, as in the final composition of HMCTL, I experience the sense of multiplying moments of feeling—soundings of distress, despair, anger and fear. It was only on creating these hospital tracks that I realised how frequently the same names got repeated throughout each woman's testimony and the many different ways in which these names were voiced. Removing hospital names from all contextual information the words take on different qualities. At one point Annemarie repeats the words 'Oakwood, Oakwood, Oakwood, Banstead, Banstead, Banstead…' and with each repeating name she sounds more

distressed, her voice getting louder, the pitch higher, sounding increasingly urgent. In a similar way when Pauline repeatedly says 'Rainhill; Rainhill; Rain-hill' her pain becomes palpable and searing.

It is difficult to say exactly what it is in the speaking of hospital names that moves me—whether the tone of voice, the pitch and the way the voice rises sand falls within the word, the texture of the speaking voice, its grittiness, hoarseness or something less apparent, like timbre, but in gathering institutional names together they speak to the collective loss and silencing of generations of women held within them.

The constitution of these place names makes them easily recognisable as psychiatric hospitals if you have familiarity with the sameness of such names. The '-wood' in the second part of the name, for example, or the '-moor' or '-hill' that might have indicated the physical environs of the place a hospital was originally built. These names can sound like idyllic places, and seeing them written down it might be possible to gloss-over the harsh realities of institutional life, imagining, instead, the asylum as some sort of bucolic retreat. But however they are constituted, asylum names assembled together are thick with resonances and listening-*with* them sounding one after another and layered on top of each other, they become palpable reminders of women's institutional lives, taking on a life of their own.

3.6 Sounding memories

Sound is not spoken about explicitly within the MHTA interviews. Multiple questions are asked about the appearance of hospitals, wards, dormitories and grounds, but questions about how they sound remains unasked. Despite this apparent lack of interest, listening-*with* the recordings and searching through transcripts there are numerous examples of sounds being recounted, particularly

when the women are recalling how a place felt. Women describe sounds, even sounding out a memory of the place or people, as the examples below show.

Carole, speaking about being in the Maudsley Hospital in the late 1970s, says: '…there was a lot of shouting, screaming and banging of doors…'. In response to being asked to describe her experience of being admitted to Broadmoor she recalls:

> I spent the first three days […] simply left alone in a dark room, which was very frightening because there were all sorts of noises going on outside and I had no idea what my surroundings were […]'. I wasn't spoken to with any sort of kindness or gentleness but very harshly, I was simply ordered to do this or do this.

Speaking about the appearance of the building she says '…it was built after the model of a prison with high walls, barred windows, tremendous locks everywhere, huge amounts of locks […] every corridor has several locked doors. Every room has locks on it and the staff carry huge bunches of keys at the end of long chains …'.

These sounding memories are recollections that, in the mind of the reader or listener might conjure sounds—keys jangling on the end of long chains or turning in locks, shouting, harsh speech. As Dolly Mackinnon's (2017) historical research on soundscapes of the nineteenth century asylum and Brown et al's (2020) research on a modern forensic psychiatric ward illustrate, hospitals are very particular sound environments and their sounds have at least as much impact on those residing within them as their visual appearance as 'patients and staff are not simply immersed in the soundscape of the hospital, they are also 'captive' within it' (Brown, A. Kanyeredzi et al. 2020: 1542). The organisation and management of acoustic environments often parallel panoptical forms of visual surveillance,

as staff in psychiatric hospitals become attuned to specific sounds 'their earwork is primarily concerned with distinguishing acoustic signs of distress, potential aggressive behaviour or inappropriate conduct' in their concern 'with the collective mood of patients' (Brown, A. Kanyeredzi et al. 2020). Framed as a concern about the atmosphere of a ward, the fear is that if one patient is shouting or screaming, this might 'infect' other patients, such that staff lose control of the ward. A belief in the need to control atmospheres leads to interventions focused on reducing acoustic signs of distress. Locked psychiatric wards often resound with distressed voices. For patient's, shouting and other sounds might be a sign to retreat to your room because something is about to kick off. For staff it might be seen as a reason to come out of the office en masse to investigate what is going on, perhaps leading to medicating whoever is 'disturbing' the atmosphere.

In the MHTA interviews there is nothing to suggest that any thought has gone into how survivors experienced the sound world of the hospitals they were in and how this might be transmitted through oral telling. However, there are clues to the sounding environment of the psychiatric hospital which can, at times, be heard through re-vocalisations. For example, when asked what Long Grove was like,

Fig. 3.15: Brookwood Hospital circa 1890, copied from the Brookwood Hospital Archive

Kathleen sounds another person's voice, recalling that it was 'terrible' and goes onto to explain 'we got up at six in the morning, the sister so-called, came in and shouted 'GET-UP'... six o'clock in the morning, and we had to polish the floors, no cup of tea, no breakfast, we had to polish the floors before anything... and... she always shouted... she always shouted.' The 'GET-UP' is capitalised in the transcript, a visual clue perhaps that this is a memory being 'ensounded' (Ingold 2007). However, the clue it gives is off in terms of what it suggests, as the 'GET-UP' is not delivered as a shout. Rather, the words are hissed, in such a vicious, and menacing way that Kathleen seems to be sounding the feeling that these words created. It is a truly astonishing moment in which Kathleen's whole character seems transformed. In this moment Kathleen recreates an affective encounter, that continues to resound in her memories of Long Grove many years later after her time there. This way of conjuring and sounding other people's voices was a feature of all the women's recordings and is described in more detail below.

3.7 Speaking in other voices

In my listening-*with* the MHTA, the horizons of voice have reached beyond the fleshy interiors of throats and mouths to include non-human voices, and as I have explored, the voice of drugs, and psychiatric treatments, even the voice of a page being turned and the fax machine. This inclusive framing moves me towards new-materialist and posthuman conceptions of voice that extend beyond horizons of the human and ideas of voice as something that interacts between 'constant' bodies (self/other, human/media technology) that exist separately from their relating. Voice, throughout this work, like subjectivity, is conceived as always, already relating and co-constituting, produced in 'enactment[s] of entanglement' (Mazzei 2013: 733).

Milla Tiainen (2013), Norie Neumark (2017) and Lisa Mazzei (2013; 2016), frame voice as relational, sensory, perceptual event that is ontologically 'elastic' (Tiainen 2013: 384). Tiainen refers to the ways in which new materialism, as an 'expansively employed label' but with an 'emphasis on emergence' (ibid.: 385), inflects the voice with 'capacities and potencies' (Coole and Frost, 2010:10 in ibid.). This is not to remove human subjects from an analysis of voice but recognises that voice can never simply be the property of a self-contained individual or stable subject. Words spoken in interviews and legible in transcripts can be decoupled from a single 'intentional, agentic, humanist subject to move towards voice [...] as an assemblage, a complex network of human and nonhuman agents' (Mazzei 2013).[9]

[9] It is important to note here that there is a potential danger in approaching voice from a posthuman perspective that 'rest(s) on a kind of anti-humanist negation of subjectivity ...(where) subjectivity becomes a no-place or waiting room, through which affect as autonomous lines of force pass on their way to something else' (Wetherell, 2012:123). These posthuman lines of thought enable a consideration of the 'more-than-human' but must be produced 'without excising the force of human complicity from these worldings' (Manning, 2016:233-4). This is particularly important when working with women's traumatised voices. To theorise these women's recordings merely as vessels through which affects pass would be to bury them all over again, to discount the truth and urgency of their words, sounds and voices.

Foucault argues that '[the self] is not a substance. It is a form, and this form is not primarily or always identical to itself' (2000: 290–1 in Reavey 2010: 318). Like voice, the self as a 'form' is constantly in formation, and as such the self is continually varied, depending on the settings in which it emerges. As Brown and Stenner write, 'if it is possible to speak of a subject at all then it must be done with reference to the "various forms" subjectivity takes and the multiplicity of relationships and connections that pertain between these forms' (2009: 168 in ibid.: 319). Relationships between past and present are produced by 'a subject/self that is perpetually in a state of becoming' (ibid.: 319), as opposed to any constant, or predictable self. Self is a process that is ongoing, always partial and unfinished rather than a fixed 'substance'. And as Reavey writes 'the spaces wherein the self unfolds literally leave their mark on any subsequent recollection of this self' (ibid.).

Women speak in voices not their own, invisible ghosts, conjured in air. These disembodied, spectres bought briefly back to life in women's mouths, tongues, lips and throats—future interlocutors from the past.

No conversation is ever simply between two people. Testimonial speech, however, is often framed in terms of call/response, between a individual interviewer and interviewee. When speech is framed within a linear spatial model, a single utterance appears to be followed by another in a back and forth relay of speaking and listening, from past to present. In his theory of dialogic speech Bakhtin writes that no utterance is ever free of 'the thousands of dialogic threads' of social communication and that all speakers are engaged with many past speakers (Bakhtin, 1981:271 in Lipari 2014b: 517).

> 'Dialogism's utterance is far from an isolated act of a sovereign individual. It isn't even a duet between two speakers. It is more like an ensemble in which the simultaneous interplay of multiple, different

> discourses—distant and proximal, already spoken and not-yet-spoken—produce meaning at the moment' (Baxter 2007: 123 in Lipari 2014b: 518).

In my listening-*with* five women speaking from the MHTA many characters appear in the space of the interviews, not simply framed within a narrative telling of events, where other people are mentioned as part of 'the story', rather they are voiced into being by the women who modify their own vocal registers to re-sound another person speaking. Carole, Kathleen, Annemarie and Ann, frequently conjure other speakers into being, particularly when recalling difficult or traumatic events. For example, when Carole recalls being left with relatives as a child when her mother was in hospital, she says 'So it wasn't easy, it wasn't an easy time and I have a memory of being argued over *'well, I can't have her, she'll have to go somewhere else'* and we'd be moved on'. In that moment her voice changes as she interjects with a voicing of speech directly from the mouth of someone else. This way of voicing shows how 'memory ebbs and flows in and out of the folds of time and place, unsettling a sense of place and enlivening and disjoining a sense of time' (Neumark 2017: 35). Carole's speaking *'well, I can't have her, she'll have to go*

somewhere else' is a form of return to another place and space that pulls her out of her current reality and respatializes her experience, bringing her aunt into the present moment and puncturing any attempt at a linear storying of events. In this moment Carole's memory and speaking do not adhere to any chronological temporality but reveal history as it is lived.

On another occasion Carole speaks her father's words, recalling how after her mother's funeral he told his children *'that's it, it's over, she's gone, we don't talk about her, were going to put all this behind us.'* These are not simply someone else's words being brought into the future present. These are not voices past. By giving voice to other's words and speech, reanimating the way words were spoken, the women are bringing key interlocutors, often perpetrators of some violence, right into the testimonial moment to be witnessed by a listener who wasn't there to witness the original event.

In Kathleen's audio track, about 45 minutes into her interview she is asked about her experience at Long Grove:

> Interviewer: What was Long Grove like?
>
> Kathleen: Terrible. Dreadful.
>
> Interviewer: In what way?
>
> Kathleen: Uhmm... oh it was horrible. We got up at six in the morning, the sister so-called, came in and shouted *'GET-UP'*...

A few minutes later she goes on to talk about her treatment by one particular psychiatrist:

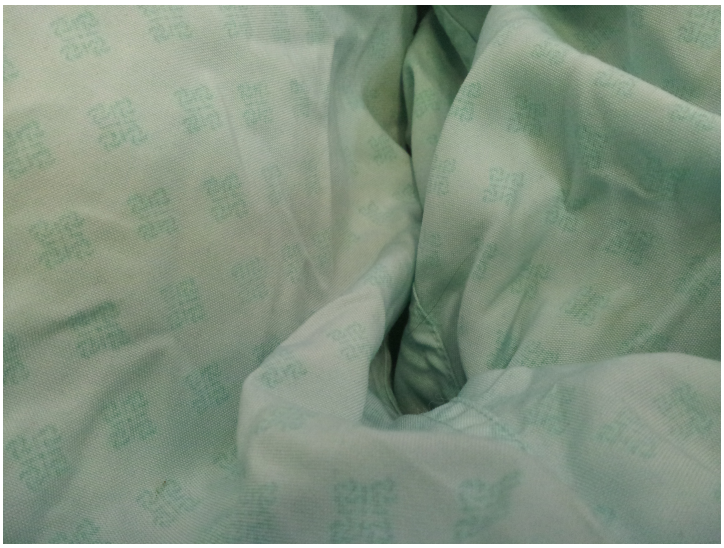
> Kathleen: I couldn't understand this doctor... but... and it was my fault again you see, because I didn't sort of talk back to them ... He said *'you're stupid'* he said *'you never think' 'you must give up religion'...'*

> INTERVIEWER: Why do you think he wanted you to give up your religion?
>
> KATHLEEN: Well, he said that my religion was too high for me…and it was a substitute for sex, and he said: *'what you need is sex*'

Two moments stand out in this polyvocal speech, which is far more complex than a two-way dialogue suggested by the interview format. The 'GET-UP' discussed earlier, in which Kathleen hisses the matriarchal figure of the 'sister, so-called' into being, bearing witness to the demands on women 'patients' as a domestic labour force within the asylum, woken early to polish floors. The second, even more disturbing moment, when Kathleen, voicing her psychiatrist, says *'what you need is sex'*, raising the spectre of institutional misogyny and psychiatrists' beliefs about women and sex that date all the way back to Plato and the 'wondering womb' as a cause of women's madness.[10] As Jane Ussher points out woman's madness has often been put down to the 'deprivation of male company' and 'regular sexual intercourse' has been viewed as a cure (Martin, 1987:16 in Ussher 1992: 79). In both examples, other people are conjured into the room with such force, it is as if they have a peculiar vitality of the kind that Spinoza ascribes to bodies when he writes 'each thing, as far as it can by its own power, strives to persevere in its own being' (Spinoza 1996: 75). As Kathleen's voice changes, her body becomes a medium through which an assemblage of other bodies speak, illuminating the institutional patriarchal structures that haunt current psychiatric practices.

Like Ann recalling the man who told her *'I've got a little room for you…I've got a little room for you'* as he prepared to drag her to a time-out room, the menacing voices of traumatic and violent experiences of hospitalisation persist. Although they might sound illusory, for these are voices that sound from long-

[10] 'The womb is an animal which longs to generate children. When it remains barren too long after puberty it is distressed and straying about in the body and cutting off the passages of breath, it impedes respiration and brings the sufferer into extreme anguish and provokes all manner of diseases besides' (Plato in Ussher 1992: 79)



dead bodies, they become alive and material in Kathleen and Ann's mouths as their tone of voice changes and takes on a different character. In these vocal performances, the gap between the dead and the living collapses and time, in its worldly coordinates, breaks down. These moments happen when 'chronology has no p(l)ace, where multiple temporalities present themselves without any one of them being present,[and] the very coexistence of time-beings disassembl[es] the allegedly determinate distinction between individual and collective, memory and history' (Barad 2017: 74). They are moments that explode clock time, or what Walter Benjamin calls 'homogenous empty time' and that Karen Barad refers to as the time of capitalism and colonialism, and which we might consider to be the time of the western psychiatric/pharmaceutical/industrial complex. These voices are not objects of the past but 'enchanted material' that live, as vital and forceful now as then (Jane Bennett 2010).

Like listening to a child return in the voice, these vertiginous moments of voicing trouble common understandings of space and time, as we witness events previously thought to be long over but happening now. They show how memory, listening and speaking are never linear and those thought to be long-dead live on. Traumatic

memory particularly has the ability to disturb time and space. Listening-*with* these disturbing, spectral voices it becomes clear that 'memory is not a matter of the past but recreates the past each time it is invoked' (Karen Barad interviewed in Tuin and Dolphijn 2012: 67). This understanding of voice and memory sits with a view of listening-*with* as a diasporic mode of perception in which voices erupt, producing entangled and ghosted bodies that have become distributed across time and space. Working in Pro Tools I could isolate and listen to these other interlocutors, not as past voices, but as people speaking now, cutting through narrative, interjecting forcefully in a moment of being. In this context these unexpected voices speak to me of the very material conditions and sociocultures of psychiatry. Testimony never represents simply a record of the past. Rather, these agential voices are materialities that deepen the historical present and shift my listening away from listening to reality and towards listening-with 'the real' as it cuts through sedimented layers of history. Voices as a collective assemblage that recognise 'the self that speaks is also always an assemblage' (Cho 2008: 25) a 'constellation of voices, concordant or not, from which I draw my voice' (Deleuze, 1987:84 in ibid.).

3.8 Listening and gathering spaces

Brandon LaBelle writes about listening as a form of creativity; a pathway towards 'enriching human relations, for nurturing and caring for the limits of the body and for struggles over recognition' (LaBelle 2021: 8). Listening holds within it the possibility of generating spaces of attention; a slowing down and thickening of time that permits dwelling on the said and the unsaid and all the resonances between. It is a way of drawing presence, creating openings for the future and ultimately of 'being-with' (Nancy 2000: 154).

Voices in the multi-speaker studio

The first time I listened to women sounding through eight studio monitors (speakers), arranged around the edges of a multi-speaker studio I was surprised and underwhelmed by the muffled quality of the sound. The recordings, so full of character, intimate textures and noise when listened through headphones, seemed to be squashed, dull and flat, lacking in character. This soundproof studio, designed to be a dead space where recorded sounds can be heard without interference, with all of its soft surfaces, carpets, fabric covered walls and ceiling and cushioned seating created a dry, anechoic, listening experience, without reverberation or echo, reducing the intimate noisiness of the women's tracks, rendering the recordings quite lifeless. The space muffled women's voices, perhaps something like a padded cell, where sound is swallowed up, such that a voice remains damped down even when it is crying out, in stark contrast to the reverberant, echoey hospital corridors and dormitories.

Listening through headphones gave me access to women's voices that was powerfully intimate and the sense that all these voices are sounding within me. Susan Hiller refers to listening to voices through headphones as a 'kind of seduction' (Horlock and Hiller 2004 in interview with Mary Horlock). Bodily sounds like the gurgle of a stomach picked up by a lapel microphone create a sense of vocalising bodies becoming folded into each other, as my own body sounds/her body sounds in mine, becoming thoroughly enmeshed. This intimacy was sometimes too much and when I moved to the multi-speaker edit suite I was glad to remove the headphones, which had, at times, felt like an instrument of discipline, a form of physical restraint; filtering and directing what I could and could not hear.

Spatialising the sound into a multi-speaker arrangement provided a new dynamic for the work, that allowed me to sit among the women, surrounding myself with

their voices. I decided to use an octophonic (8 speaker) arrangement, as the dry speech sounds that I was working with did not lend themselves to a standard 7.1 multichannel arrangement where one of the speakers is a subwoofer. When I started to spatialise for speakers, I had assumed I would use one speaker for each person so that the same voices would appear from the same speakers throughout the piece, however, it became clear that this created a relatively static experience, which was unbalanced, as two or three speakers were much more vocal than the others. Also, thinking about these voices as diasporic it made sense to allow them to speak from multiple speakers around the circle, so that they are not always sounding from the same position.

Whether listening through multiple speakers or with headphones sound is always spatial. Auditory experience, according to Georgina Born (Born 2013: 3) has the 'capacity to reconfigure space'. The space that sound creates or 'auditory space' is not fixed and bounded, it is not an object with clearly demarcated boundaries but is flexible, dynamic and in-process. Just like bodies and voices, sound is always in flux, and listening-*with* these voices (using the terminology of voice in its broadest sense) space is constantly being reconfigured.

I developed HMCTL to be listened from beginning to end, with listeners seated in a circle, facing the speakers rather than each other, so the inner circle of listening bodies face outwards and the outer circle of speakers face inwards. By directing the gaze of listeners away from each other I hoped to create a space more compatible to listening in which the gaze would fall on a relatively blank space where the eyes could rest. In reality when the piece was played at the Big Anxiety Festival (2019), floor speakers were arranged around a square(ish) room hidden behind long white curtains and the listeners reconfigured the space, moving chairs and arranging the seating to suit themselves.

Listening events were also planned for April 2020 in the old boardroom of the Bethlem Royal Hospital, in the original Administration block of the hospital, which is now part of the Museum of the Mind but was originally used for patient's review panels and other board meetings. The boardroom's wood panelled walls, wooden floors, large windows and high ceiling create a highly reverberant space. The piece would have been set-up around the long boardroom table which seats about 25 people, with listeners seated around the table and the speakers spaced around the outside. Unfortunately these events were cancelled due to the Covid pandemic and at the time of writing are still to be rescheduled.

Listening with other people creates a completely different experience to listening alone. The first time I listened with someone else, in the multi-speaker edit suite, there was a tension not there when I listened alone. We sat in semi-darkness listening together. I was taking notes, listening with a critical ear, and was taken by surprise at the end, to find tears spilling down my face. There was a sense of great relief to have someone else listen and I felt unburdened, finally, someone was listening to *our* long silenced voices.

Later that summer I shared the work with two groups working for Certitude, a mental health/learning disability charity in South London. Due to the constraints of the space, cost implications, etc., I was only able to share a stereo version and used two speakers placed on a desk at one end of the room. Chairs were arranged roughly in a semi-circle, in front of the speakers in a bare meeting room with two windows looking onto a brick wall outside. There was only just enough space for all twenty or so people. The self-selecting audience came from across different parts of the organisation, from those working directly with 'service-users', project managers, administrators, to the CEO, some with personal experience of psychiatric treatment or working within psychiatric hospital settings.

The 'me' in the work's title speaks to my desire to be held within a shared listening space, away from the long self-enforced isolation of listening-*with* voices through headphones. Sitting and listening with these groups, I felt their listening as a form of tenderness for my own experience. Although my voice is not present in the piece, simply being in a collective space—listening together—was a form of sharing that felt intimate. I became part of a body of listening and felt held and heard.

I created this listening space primarily for those women, one generation removed, who, like my mother, were held at a distance from their communities and families within psychiatric institutions for weeks, months and years at a time. Listening-*with* and compositioning have been ways for me to confront this isolation and engage audiences, creating encounters and the possibility for connection. As Carole (MHTA 2000) says of her experience of being in psychiatric hospitals, 'there [was] very much a feeling of being lost from the world, of being stranded.' In its final iteration, the listening circle of the multi-speaker sound installation is an attempt to create a space of tenderness and care, where the collective experiences of psychiatrised women can be heard and felt. Listening-*with*, our bodies become open to sounds that do not merely resonate as signifiers, sounds that are neither in me or outside of me, mine or yours. To listen in this way is 'to be at *the same time* outside and inside [sound], to be open *from* without and *from* within' (Nancy 2007: 13–14).

4. Final words

> *I had heard stories that were not true, with parts that had been left out, and in the end I wrote new ones, slightly altered repetitions of past events, … countless stories that are neither true nor whole. In the end the only story I can tell is an affective expression of memory that is not bound by a subject but lives in what we might call a diasporic unconscious.*
>
> —Cho (2008: 191)

The testimonies of the MHTA are full of speech, silence, gurgling stomachs, sucking, clicking tongues, long pauses, contradictions, uhms, ahhs and lost breath. Through this practice research I have developed ways of listening-*with* and compositioning that have enabled me to attune to the many silences that haunt the archive—silences as likely to occur in the fast paced speech of a woman testifying to violence, as in long pauses and forgotten or unspoken memories, and that arise in the chronological demands of oral-history interviews and their transcription to text, and, in psychiatry's insistence on diagnostic listening. This work engages-*with* trauma and gaps in memory, in order to attend to that which is not immediately audible 'but is nonetheless powerfully real;…what appears to be in the past but is nonetheless powerfully present' (Gordon 2008: 42). And through this engagement, encountering and listening-*with* women's voices and testimonies, my body has become enmeshed in 'psyche-world-body entanglements' (Blackman 2012: 24)

that have made it possible to register the ongoing effects of trauma and injustice, even as they remain unspoken.

My embodied entanglement has, at times, made the research extremely slow and painful, and, even now, when I listen-*with* these women my feelings and experience are never the same, the affects that register are unpredictable and unstable. Listening is never finished and does not progress linearly, it is 'inherently disruptive' (Westerkamp 2019: 46). In this work listening-*with* becomes a gesture that extends beyond the articulated, it stretches the ears (and body) 'with an intensification and a concern' (Nancy, 2007: 5 in Heddon 2017: 28); a form of recognition, nurture and solidarity, and as a way of becoming through the experience of 'being-*with*'.

Much of the beauty of sound is in its ephemerality and dissipating nature, its constant newness—for as quickly as sound registers, it disappears, and every listening creates something new. Voice is always mutable and multiple, never a single 'thing' or object emanating from a single individual or identity, but arises through processes of co-enaction. Through an expanded understanding of voice and listening it has been possible for me to think about an archive of voices as an assemblage, undoing simple binaries of interviewer/interviewee, speaker/ listener, transcriber/reader and utilising the concept of assemblage 'as an orientation [...] an ethos of engagement attuned to the possibilities of socio-spatial formations to be otherwise...' (Featherstone 2011: 162).

This research developed as a result of lived-experience. Over the years, I have tried, and, failed, to ignore my experiences within the psychiatric system, turning away from any engagement with 'mental health'. However, as a significant vein of experience flowing through several generations of my family, running away eventually became impossible. My desire to develop practice research through making with sound derives from a deep-seated need to express something about the experiences of psychiatrised women that might challenge the ways we are

viewed and treated, and in this respect it might be considered as a form of creative practice as psychosocial research that 'work[s] *from and with* lived experience, examining the subjective aspects of that experience in dynamic relation to social, material and institutional settings' (Jill Bennett et al. 2019: 186, emphasis in original). For example, my work listening and compositioning-with Ann's repeating phrase 'so heavily sedated' generates tangible, somatic knowledge about the impact of sedation on psychiatrised women's bodies, including my own, and reveals entanglements and relations within the work that are, at once, social, subjective, immaterial, material and institutional.

This writing has provided the theoretical and cultural context for researching-*with* women that challenges the structures and institutions that have attempted and, inevitably, failed to contain them. The writing and practice sit together within Manning's conceptual framework of minor gestures, which draws on Deleuze and Guattari's concept of the minor as 'a gestural force that opens experience to its potential variation' and in which the 'minor works the major from within' (Manning 2016: 1). According to Manning, neither the minor or major is fixed in advance. Instead, the minor is a force that courses through the major's structural tendencies, unsettling its structural integrity and complicating and questioning its normative propensity. Manning argues that grand gestures in macro-politics are assumed to be where change happens, simply because it is easier to identify major shifts rather than cataloguing the many 'nuanced rhythms of the minor' (ibid). However, as my research demonstrates, it is minor shifts, such as finding new ways of listening-*with* breath, that can initiate subtle changes needed to create the conditions for transformation. The minor is open to flux and is dynamic, with a degree of variability and mobility not found in the major, but 'because of its wildness it is often seen as unrigorous, flimsy, its lack of solidity mistaken for a lack of consistency' (ibid.: 1) and thus it gets cast aside as irrelevant or forgotten.

In making work that listens-*with* voices of women who have been systematically silenced by the psychiatric institution, I create a minor gesture in the hope of making ripples, sound waves, that might disturb the majority discourse around 'mental health' and psychiatry—a discourse that insists on measuring those, who, at times, struggle with distressing thoughts, beliefs and feelings, against a false normal, finding us lacking every time.

I made the decision to work with only sound from the women's original recordings and keep electronic processing to a minimum, rather than rely on the processual capabilities of editing technology because I wanted the affective experience of encounter to come from the testimonial recordings rather than from any external or heavily processed sounds or music. I did try using a sound processing software programme called Kenaxis[1] as a way of building some automation into the sound editing process. I was able to use this to modulate pitch and slow down or speed up the recordings and tried processing different parts of the recordings, for example, placing the names of medications, or a phrase like 'so heavily sedated' within the 6 loop players and setting each one to play at slightly different speeds and times. This experimentation did yield some interesting results, but, on the whole, the voices that came out of this process sounded strangely robotic and were unrecognisable from the original recordings. In the end I decided only to use a tiny section of these experiments in the last two minutes of the work, as the sounds and voices begin to fade away, however, I have included some of my more interesting Kenaxis experiments here as examples of the work I did.

Mother:

Diagnosis:

[1] Kenaxis is a sound processing programme that consists of 6 loop players each with a 12 band parametric equalizer, granular synthesis and other features that allow you to layer sounds, modulating the pitch and speed using a number of special features.

Broadmoor:

All Voices:

In addition to using Kenaxis, I experimented with piling voices from different soundtracks on top of each other, within Pro Tools, in order to make it difficult to pick out a single voice, impairing meaning and creating something closer to noise than speech. However, I decided against using these heavily 'accumulated' voices (Lane 2006), as the experience of listening to an almost incoherent babble, in which voices collided and fought for space, made me feel deeply uncomfortable, sounding like I was trying to recreate the effect of hearing voices or psychosis, turning women's voices into the very symptomology and diagnostic reading my work resists, rather than timeless witnesses of the lasting material and immaterial effects of psychiatry. In these moments of experimentation I was reminded of the experience of watching and listening to a performance of Jocelyn Pook's song cycle 'Hearing Voices' (2015). I had been in the audience for an earlier iteration of the work, with full orchestra, in 2012 and had found myself moved to tears. But listening to its new incarnation three years later (having by now started my research, and just a few months after my own hospital admission) it felt like I was listening to voices and instruments representing women going 'mad', instruments seemingly out of control, playing fairground music at ever increasing speed, as a woman on stage repeatedly sang lines like 'nutty as a fruitcake'.

In foregrounding listening (as earwork, diasporic and listening-*with*) I recognise that sound is 'generative of a diverse range of experiences' that remain tied to a specific 'context' (LaBelle 2010: xvi), with 'an inherent performative and social orientation' (Drobnick 2004: 10). If, as Jim Drobnick states, the aural 'affirm[s] a connectedness to the social' (ibid.) then listening-*with* becomes a mode of relation and a distinct practice of care (Kanngieser 2012) that, in my research, is shaped by histories of loss and legacies of injustice. Working with an archive that I conceived

to be distributed through its listening enabled me to attune and connect to the social as an ethical and political act of solidarity and tenderness that recognises the potential for transformation. By paying particular attention to the archive's 'nonnarrativizable' acoustic phenomena—the tone and texture of voice, the sound of a page being turned, a fax machine beeping, the hoover droning, repeated words, mouth noises and breath—my listening is directed away from a story about loss towards an affective encounter with sound that registers the 'loss of loss'(Butler 2003: 467).

This work engages with the unconscious, disrupting the 'unspoken power dynamics' of much academic arts research (Cho 2008: 45) and I have experimented with auto-ethnographic forms that are shaped by my entanglement with multiple bodies and psyches. The testimonial archive is not a 'thing' a container or mere repository, it is living and breathing, spatially oriented and dynamic—alive with voice. In acknowledging the traumatised and haunted nature of testimonies, I move away from representing women as fixed, fully knowable through their stories and speech, towards a recognition of the non-narratability of experience that operates at the level of what is neither forgotten nor fully remembered.

Listening-*with* points to forms of perception that are spectral and distributed through multiple receptive bodies and technologies, spaces and times, through 'technological apparatuses . . . that make [listenable] the trauma that one's [ears] could not [hear]' (ibid.: 174).[2] This is particularly germane to the creation of sound work for installation in public spaces, on SoundCloud, played through speakers and headphones, shared and distributed. In such work, voice is not represented as a unique projection emanating from a clearly bounded individual body/speaker but rather, voices, issuing from speakers and headphones, can be heard as always

[2] Cho's original quote is about how technological apparatus make it possible to see trauma, I have removed the words 'visible', 'eyes' and 'see' from this sentence.

multiple, sounding out-of-time, distributed through various temporal and spatial configurations—perceptual, technological and social assemblages. Through such assemblages, the archive is constantly reimagined and transformed through its unpredictable, material and immaterial affects. These stories are everywhere, they circulate—ghosts transmitting across and through generations, 'silent' histories that can never be contained in *an* archive or in me. They demand to be heard, seeking out audiences to create 'new assemblages of listening' (Guattari 1995: 63 in To 2015: 77), these voices long to speak.

I have engaged with a body of work that conceives trauma as a force with powerful agency that is never finished, keeps coming back and is on its way, constituted and transmitted through cycles of visibility and invisibility, audibility and inaudibility, remembering and forgetting. All of the elements of the work that exist as sound, image or text, have come into being through critical processes of listening, writing and thinking -*with*, each modality providing me with new ways to listen—'aesthetically and ethically, sensorially and semiotically' (Neumark 2017: 27). The transgenerational transmission of trauma illuminates how unspoken, silenced, shameful histories are a potent force, often wreaking havoc, as they transmit across and through generations and bodies, seeking escape routes, and linking with other ghosts 'as a voice for the future' (Cho 2008: 8).

My practice has created space for these ghosts. Being-*with* and bearing witness to trauma in ways that do not attempt to complete or have the final say *about* the other, that do not replicate epistemic injustice or the violence of representation, but instead create opportunities for vulnerable encounters—for what Bracha Ettinger refers to as wit(h)nessing. By bringing an (h) into the word witnessing, Ettinger stretches its meaning, from being about witnessing in the testimonial or juridical sense to being-*with*. This being-*with* or beside, as Griselda Pollock (2010) points out, involves more than being in solidarity, there is an inherent risk in this openness.

This wit(h)ness translates to working-*with* voices, so that rather than conceiving of myself as simply affected *by* women's voices through bearing witness to their testimonial speech, I can move to a position in which I understand myself as composed of voices, 'becoming-*with*' (Haraway 2016) their multiple elements and relations (Chadwick 2021a).

Through working-*with* I acknowledge what voices do, how they 'are living movements and relational exchanges' (Chadwick, 2021(a): 2) that involve and invoke the intra-mingling and entanglement of many different elements and energies including power relations, embodied and socio-material histories. The breathy, vocal embodiments activated in this work are marked by the discourses in which they are embedded, including patriarchal and sanist discourses and 'socio-atmospherics' (Choy & Zee 2015 in Chadwick 2020: 3) that might manifest as 'a kind of thick, oppressive, hostile, suffocating fleshy-affective 'atmosphere' [...] or as a visceral and embodied sense of 'breathlessness' associated with the lived experience of being [psychiatrised/female] in [an anti-mad/sanist/patriarchal] society' (ibid.). Throughout this praxis I have developed a new ethics of listening-*with* and, in its final iteration, HMCTL becomes an offering, a vital, emergent space for tenderness and the creation of new relations-*with* women who have suffered the catastrophic loneliness of trauma and the terrible failure of psychiatry to listen.

Bibliography

Abraham, N. and M. Torok (1994). *The Shell and the Kernel Volume 1*. Ed. and trans. by Nicholas Rand. The University of Chicago Press.

Abrams, Lynn (2016). *Oral History Theory*. London and New York: Routledge.

Barad, Karen (2007). *Meeting the universe halfway: Quantum physics and the entanglement of matter and meaning*. Durham, N. C.: Duke University Press.

— (2017). 'Troubling time/s and ecologies of nothingness: Re-turning, re-membering, and facing the incalculable'. In: *New Formations* 92.92, pp. 56–86.

Barthes, Roland (2009). *The grain of the voice: Interviews 1962-1980*. Evanston, Illinois, USA: Northwestern University Press.

Bennett, Jane (2010). *Vibrant matter: A political ecology of things*. Durham, N. C.: Duke University Press.

Bennett, Jill, Lynn Froggett and Lizzie Muller (2019). 'Psychosocial aesthetics and the art of lived experience'. In: *Journal of Psychosocial Studies* 12.1-2, pp. 185–201.

Bennett, Sarah (2010). 'Reforming the Institution: the wall as memory archive'. In: *Journal of Media Practice* 11.3, pp. 199–214. URL: http://sarahbennett.org.uk/currentPracticeWWPR1.html.

Bertelsen, Lone and Andrew Murphie (2010). 'An ethics of everyday infinities and powers: Félix Guattari on affect and the refrain'. In: *The Affect Theory Reader*. Durham and London: Duke University Press. Chap. 6, pp. 138–156.

Blackman, Lisa (2007). 'Psychiatric culture and bodies of resistance'. In: *Body & Society* 13.2, pp. 1–23.

— (2012). *Immaterial Bodies: Affect, Embodiment, Mediation*. London: Sage.

— (2015). 'Researching affect and embodied hauntologies: Exploring an analytics of experimentation'. In: *Affective Methodologies: Developing Cultural Research Strategies for the Study of Affect*. Ed. by C. Knudsen B.T. & Stage. Basingstoke: Palgrave Macmillan. Chap. 2, pp. 25–44.

Born, Georgina (2013). *Music, sound and space: Transformations of public and private experience*. Cambridge, UK: Cambridge University Press.

Boscacci, Louise (2018). 'Wit (h) nessing'. In: *Environmental humanities* 10.1, pp. 343–347.

Breggin, P. R. (1993). *Toxic psychiatry: Drugs and electroconvulsive therapy: The truth and the better alternatives*. HarperCollins UK.

British Library and Mental Health Media (1999/2000). *Mental Health Testimony Archive*. Oral History Archive, British Library - C905/05; C905/25; C905/31; C905/35; C905/41.

Brown, S., A. Kanyeredzi et al. (2020). 'Organizing the Sensory: Ear-work, panauralism and sonic agency on a forensic psychiatric unit'. In: *Human Relations* 73.11, pp. 1537–1562.

Brown, S. and I. Tucker (2010). 'Eff the ineffable: Affect, somatic management, and mental health service users'. In: *The Affect Theory Reader*. Ed. by Melissa

Gregg and Gregory J. Seigworth. Durham and London: Duke University Press.

Burstow, Bonnie (2006). 'Electroshock as a form of violence against women'. In: *Violence Against Women* 12.4, pp. 372–392.

Butler, Judith (2003). 'After Loss, What then?' In: *Loss: The Politics of Mourning*. Ed. by David Eng and David Kazanjian. Berkeley: University of California Press.

Campbell, D. (9th Apr. 2021). *Extent of mental health crisis in England at 'terrifying' level.* Guardian Newspaper.

Caruth, Cathy (1996). *Unclaimed Experience: Trauma, Narrative and History*. Baltimore: John Hopkins University Press.

Cavarero, Adriana (2005). *For more than one voice: Toward a philosophy of vocal expression.* Redwood City, California: Stanford University Press.

Chadwick, Rachelle (2020). 'Methodologies of voice: Towards posthuman voice analytics'. In: *Methods in Psychology* 2.100021.

— (2021a). 'On the politics of discomfort'. In: *Feminist Theory* 22.4, pp. 556–574.

— (2021b). 'Theorizing voice: toward working otherwise with voices'. In: *Qualitative research* 21.1, pp. 76–101.

Chesler, P. (2005). *Women and Madness.* London: Palgrave Macmillan.

Chion, Michel (1999). *The Voice in Cinema.* New York: Columbia University Press.

Cho, Grace M. (2008). *Haunting the Korean Diaspora: Shame, Secrecy, and the Forgotten War.* Minneapolis: University of Minnesota Press.

Clough, P. T. (2000). 'A familial unconscious'. In: *Qualitative Inquiry* 6.3, pp. 318–336.

Clough, P. T. (2004). 'Future matters: Technoscience, global politics, and cultural criticism'. In: *Social Text* 22.3, pp. 1–23.

— (2007). *The Affective Turn: Theorizing the Social.* Ed. by P. Clough with J. Halley. Durham and London: Duke University Press.

— (2009). 'Reflections on sessions early in an analysis: Trauma, affect and 'enactive witnessing''. In: *Women & Performance: A Journal of Feminist Theory* 19.2, pp. 149–159.

Cohen, D. and P. R. Breggin (1999). *Your drug may be your problem.* Cambridge, Massachussets: Perseus Books.

Connor, Steven (2014). *Beyond words: Sobs, hums, stutters and other vocalizations.* London: Reaktion Books.

Cox, Christoph (2009). 'Sound art and the sonic unconscious'. In: *Organised Sound* 14.1, pp. 19–26.

Cvetkovich, Ann (2012). *Depression: A Public Feeling.* Durham: Duke University Press.

Dauge-Roth, Alexandre (2009). 'Testimonial Encounter: Esther Mujawayo's Dialogic Art of Witnessing'. In: *French Cultural Studies* 20.2, pp. 165–180.

Davoine, F. and J. Gaudillière (2004). *History Beyond Trauma: Whereof one cannot speak, thereof one cannot stay silent.* New York: Other Press.

De Certeau, Michel (1996). 'Vocal utopias: glossolalias'. In: *Representations* 56, pp. 29–47.

DHSC (24th Aug. 2021). *Consultation outcome: Reforming the Mental Health Act.* URL: https://www.gov.uk/government/consultations/reforming-the-mental-health-act/reforming-the-mental-health-act.

Dillon, Jacqui (2011). 'The Personal *is* The Political'. In: *De-medicalizing misery: Psychiatry, psychology and the human condition.* Ed. by M. Rapley; J. Moncrieff; J. Dillon. Palgrave Macmillan. Chap. The Personal *is* The Political, pp. 141–157.

Dolar, Mladen (2006). *A voice and nothing more.* Massachusetts, USA: MIT press.

Doroshow, Deborah Blythe (2007). 'Performing a cure for schizophrenia: insulin coma therapy on the wards'. In: *Journal of the history of medicine and allied sciences* 62.2, pp. 213–243.

Drobnick, Jim (2004). *Aural Cultures.* Alberta, Canada: Yyz Books.

Eidsheim, Nina Sun (2011). 'Sensing voice: Materiality and the lived body in singing and listening'. In: *The Senses and Society* 6.2, pp. 133–155.

Eng, D. and D. Kazanjian (2003). 'Introduction: Mourning Remains'. In: *Loss: The Politics of Mourning.* Ed. by David Eng and David Kazanjian. Berkeley: University of California Press.

Ettinger, Bracha L. (2006). *The Matrixial Borderspace.* Vol. 28. Minneapolis: University of Minnesota Press.

— (2011). 'Uncanny awe, uncanny compassion and matrixial transjectivity beyond uncanny anxiety'. In: *Psychoanalysis in French and Francophone Literature and Film.* Ed. by James Day. Amsterdam: Brill, pp. 1–30.

Farinati, Lucia and Claudia Firth (2017). *The force of listening.* Vol. 6. Errant Bodies Press.

Featherstone, David (2011). 'On assemblage and articulation'. In: *Area* 43.2, pp. 139–142.

Feldman, Martha (2015). 'The Interstitial Voice: An Opening'. In: *Journal of the American Musicological Society* 68.3, pp. 653–659.

Filer, Nathan (2019). *The Heartland: Finding and Losing Schizophrenia.* London: Faber & Faber.

Fivush, Robyn (2006). 'Voice and silence in autobiographical narratives'. In: *Reading On* 1, pp. 1–17.

Foisy, Christina (2021). 'Sounding Madness: The Ethics of Listening in Janet Frame's Faces in the Water'. PhD thesis.

Foucault, Michel (2012). 'Docile Bodies'. In: *Theatre and Performance Design.* Abingdon, Oxon.: Routledge, pp. 239–242.

— (2019). *The History of Sexuality 1: The will to knowledge.* London: Penguin.

Frank, A. W. (1995). *The wounded Storyteller: Body, Illness and Ethics.* Chicago: University of Chicago Press.

— (2005). 'What is dialogical research, and why should we do it?' In: *Qualitative Health Research* 15.7, pp. 964–974.

Frisch, Michael (2008). 'Three dimensions and more: Oral history beyond the paradoxes of method'. In: *Handbook of Emergent Methods.* Ed. by S Nagey Hesse-Biber and P Leavy. The Guildford Press, New York. Chap. 11, pp. 221–238.

Gilligan, C. and J. Eddy (2017). 'Listening as a path to psychological discovery: An introduction to the Listening Guide'. In: *Perspectives on medical education* 6, pp. 76–81.

Gonzalez, Julio and Amparo Carpi (2004). 'Early effects of smoking on the voice: a multidimensional study'. In: *Med Sci Monit* 10.12, p. 656.

Gordon, Avery F (2008). *Ghostly Matters: Haunting and the Sociological Imagination.* Minneapolis: University of Minnesota Press.

Gorton, K. (2007). 'Theorizing emotion and affect'. In: *Feminist theory* 8.3, pp. 333–348.

Gregg, M. and G.J. Seigworth, eds. (2010). *The Affect Theory Reader*. Durham and London: Duke University Press Books.

Guattari, F. (1995). *Chaosmosis*. Sydney: Power Publications.

Haraway, D. (1988). 'Situated knowledges: The science question in feminism and the privilege of partial perspective'. In: *Feminist studies* 14.3, pp. 575–599.

— (1997). 'The virtual speculum in the new world order'. In: *Feminist Review* 55.1, pp. 22–72.

— (2016). *Staying with the trouble: Making kin in the Chthulucene*. Durham, N. C.: Duke University Press.

Harpin, Anna (2018). *Madness, Art, and Society: Beyond Illness*. London and New York: Routledge.

Heddon, Deirdre (2017). 'The Cultivation of Entangled Listening'. In: *Performance and Participation. Basingstoke & New York: Palgrave Macmillan*, pp. 19–40.

Hemmings, Clare (2012). 'Affective solidarity: Feminist reflexivity and political transformation'. In: *Feminist Theory* 13.2, pp. 147–161.

Henriques, Julian (2010). 'The vibrations of affect and their propagation on a night out on Kingston's dancehall scene'. In: *Body & Society* 16.1, pp. 57–89.

Herman-Lewis, J. (1992). *Trauma and Recovery: The aftermath of violence-from domestic abuse to political terror*. New York: Basic Books.

Hollway, Wendy and Tony Jefferson (2008). 'The free association narrative interview method'. In: *The Sage Encyclopedia of Qualitative Research Methods*. Ed. by Lisa M. Given. Sevenoaks, California: Sage, pp. 296–315.

Horlock, Mary and Susan Hiller (2004). 'The Voice as Body: An interview with Mary Horlock'. In: *Aural cultures*. Ed. by Jim Drobnick. Alberta, Canada: YYZ Books, pp. 136–145.

Hornstein, Gail A (2009). *Agnes's jacket: A psychologist's search for the meanings of madness*. New York: Rodale.

Ihde, Don (2007). *Listening and Voice: Phenomenologies of Sound*. New York: SUNY Press.

Ingold, Tim (2007). 'Against soundscape'. In: *Autumn Leaves: Sound and the environment in artistic practice*. Ed. by Angus Carlyle. Double Entendre Paris, pp. 10–13.

Jackson, A. Y. and L. A. Mazzei (2016). 'Thinking with an agentic assemblage in posthuman inquiry'. In: *Posthuman Research Practices in Education*. Ed. by Carol Taylor and Christina Hughes. London: Palgrave Macmillan, pp. 93–107.

Järviö, Päivi (2015). 'The Singularity of Experience in the Voice Studio: A dialogue with Michel Henry'. In: *Voice Studies: Critical approaches to process, performance and experience*. Ed. by K. Thomaidis and B. Macpherson. London and New York: Routledge, pp. 25–37.

Kanngieser, Anja (2012). 'A sonic geography of voice: Towards an affective politics'. In: *Progress in human geography* 36.3, pp. 336–353.

Karpf, Anne (2014). 'The human voice and the texture of experience'. In: *Oral History* Autumn, pp. 50–55.

Knudsen, Britta Timm and Carsten Stage (2015). *Affective Methodologies: Developing Cultural Research Strategies for the Study of Affect*. Basingstoke: Palgrave Macmillan.

LaBelle, Brandon (2010). *Acoustic Territories: Sound culture and everyday life.* London and New York: Bloomsbury Academic.

— (2014). *Lexicon of the Mouth: Poetics and politics of voice and the oral imaginary.* London and New York: Bloomsbury Academic.

— (2021). *Acoustic Justice: Listening, performativity and the work of reorientation.* London and New York: Bloomsbury Academic.

Lagaay, Alice (2008). 'Between sound and silence: Voice in the history of psychoanalysis'. In: *Episteme* 1.1, pp. 53–62.

Lande, Brian (2007). 'Breathing like a soldier: Culture incarnate'. In: *Embodying Sociology: Retrospect, Progress and Prospects.* Sociological Review Monograph Series. Blackwell Publishing / The Sociological Review, pp. 95–108.

Lane, Cathy (2006). 'Voices from the Past: compositional approaches to using recorded speech'. In: *Organised Sound* 11.1, pp. 3–11.

Laub, Dori (2013). 'Bearing witness, or the vicissitudes of listening'. In: *Testimony: Crises of Witnessing in Literature, Psychoanalysis and History.* e-book. New York: Routledge, pp. 77–94.

Laub, Dori and Marjorie Allard (1998). 'History, Memory, and Truth: Defining the place of the survivor'. In: *The Holocaust and History: The known, the unknown, the disputed and the re-examined.* Ed. by Michael Berenbaum and Abraham J. Peck. Bloomington: Indiana University Press, pp. 799–813.

Lebow, Alisa (2008). *First Person Jewish.* Minneapolis: University of Minnesota Press.

LeFrançois, Brenda A, Robert Menzies and Geoffrey Reaume (2013). *Mad matters: A critical reader in Canadian mad studies.* Canadian Scholars' Press.

Leimbacher, Irina (2017). 'Hearing voice (s): experiments with documentary listening'. In: *Discourse* 39.3, pp. 292–318.

Lipari, Lisbeth (2014a). *Listening, Thinking, Being: Toward an ethics of attunement*. Pennsylvania: Penn State Press.

— (2014b). 'On interlistening and the idea of dialogue'. In: *Theory & Psychology* 24.4, pp. 504–523.

Maharaj, Sarat (2009). 'Know-how and No-How: stopgap notes on "method" in visual art as knowledge production'. In: *Art and research* 2.2, pp. 1–11.

Mahasep, Elisabeth (2023). 'Government must get a "firmer grip" on mental health crisis, says watchdog'. In: *BMJ* 380. DOI: 10.1136/bmj.p324. eprint: https://www.bmj.com/content/380/bmj.p324.full.pdf. URL: https://www.bmj.com/content/380/bmj.p324.

Manning, Erin (2016). *The minor gesture*. Durham: Duke University Press.

Martin, E. (2006). 'The pharmaceutical person'. In: *BioSocieties* 1.3, p. 273.

Mazzei, L. A. (2007). *Inhabited Silence in Qualitative Research: Putting poststructural theory to work*. New York: Peter Lang Publishing.

— (2013). 'A voice without organs: Interviewing in posthumanist research'. In: *International Journal of Qualitative Studies in Education* 26.6, pp. 732–740.

McWade, Brigit (2015). 'Temporalities of mental health recovery'. In: *Subjectivity* 8, pp. 243–260.

— (2016). 'Recovery-as-policy as a form of neoliberal state making'. In: *Intersectionalities: A Global Journal of Social Work Analysis, Research, Polity, and Practice* 5.3, pp. 62–81.

Micale, Mark S and Roy Porter (1994). *Discovering the history of psychiatry*. Oxford University Press, USA.

Millett, K. (1991). *The loony-bin trip.* London: Virago Press.

MIND (2023). *Mind reveals true extent of crisis in mental healthcare with more than 17,000 reports of serious incidents in past year alone.* URL: https://www.mind.org.uk/news-campaigns/news/mind-reveals-true-extent-of-crisis-in-mental-healthcare-with-more-than-17-000-reports-of-serious-incidents-in-past-year-alone/ (visited on 01/2024).

Mody, Cyrus (2005). 'The Sounds of Science: Listening to Laboratory Practice'. In: *Science, Technology, & Human Values* 30.2, pp. 175–198.

Mohl, P. C. and R. B. Carr (2015). 'Listening to the patient'. In: *Psychiatry, 2 Volume Set.* Ed. by Allan Tasman et al. John Wiley & Sons. Chap. 1.

Mooney, Michelle and Ava Kanyeredzi (2021). ''You get this conflict between you as a person and you in your role… that changes you': A thematic analysis of how inpatient psychiatric healthcare staff in the UK experience restraint, seclusion, and other restrictive practices'. In: *International Journal of Mental Health Nursing* 30.6, pp. 1703–1712.

Nancy, Jean-Luc (2000). *Being Singular Plural.* Redwood City, California: Stanford University Press.

— (2007). *Listening.* Trans. by Charlotte Mandell. New York: Fordham University Press.

Neumark, Norie (2017). 'Voicing memories'. In: *SoundEffects-An Interdisciplinary Journal of Sound and Sound Experience* 7.2, pp. 31–44.

Oliveros, Pauline (2002). 'Quantum listening: From practice to theory (to practice practice)'. In: *Culture and Humanity in the New Millennium: The Future of Human Values.* Ed. by Kwok Siu Tong; Chan Sin-wai. Chinese University Press NT, Sha Tin, Hong Kong, pp. 27–41.

Olivier, David, Dan I Lubman and Richard Fraser (2007). 'Tobacco smoking within psychiatric inpatient settings: biopsychosocial perspective'. In: *Australian and New Zealand Journal of Psychiatry* 41.7, pp. 572–580.

Orr, J. (2006). *Panic Diaries: A Genealogy of Panic Disorder.* Durham, N. C.: Duke University Press.

Parr, Hester (1998). 'The politics of methodology inpost-medical geography': mental health research and the interview'. In: *Health & place* 4.4, pp. 341–353.

Parr, Hester, Chris Philo and Nicola Burns (2003). ''That awful place was home': Reflections on the Contested Meanings of Craig Dunain Asylum'. In: *Scottish Geographical Journal* 119.4, pp. 341–360.

Paterson, Brodie et al. (2013). 'Corrupted cultures in mental health inpatient settings. Is restraint reduction the answer?' In: *Journal of Psychiatric and Mental Health Nursing* 20.3, pp. 228–235.

Pedwell, Carolyn and Anne Whitehead (2012). 'Affecting feminism: Questions of feeling in feminist theory'. In: *Feminist theory* 13.2, pp. 115–129.

Pollock, G. (2010). 'Aesthetic Wit(h)nessing in the Era of Trauma'. In: *EurAmerica: A Journal of European and American Studies* 40.4, pp. 829–886.

Rapley, Mark, Joanna Moncrieff and Jacqui Dillon, eds. (2011). *De-medicalizing misery: Psychiatry, psychology and the human condition.* London: Palgrave Macmillan.

Read, John and Joanna Moncrieff (2022). 'Depression: Why drugs and electricity are not the answer'. In: *Psychological Medicine* 52.8, pp. 1401–1410.

Reavey, Paula (2010). 'Spatial markings: Memory, agency and child sexual abuse'. In: *Memory Studies* 3.4, pp. 314–329.

Revill, George (2017). 'Vocalic space: Socio-materiality and sonic spatiality'. In: *The Question of Space*. Ed. by Marijn Nieuwenhuis and David Crouch. New York: Rowman and Littlefield.

Rice, Tom and Steven Feld (2021). 'Questioning acoustemology: an interview with Steven Feld'. In: *Sound Studies* 7.1, pp. 119–132.

Rolnik, Suely (2011). 'The geopolitics of pimping'. In: *of Creativity*, p. 23.

Rudent, Catherine (July 2020). *Against the 'Grain of the Voice'*. URL: https://laviedesidees.fr/spip.php?page=article&id_article=4847 (visited on 27/04/2023).

Russell, Catherine (1999). *Experimental Ethnography: The work of film in the age of video*. Durham and London: Duke University Press.

Sen, Dolly (2022). 'Pathologize this'. In: *The Big Anxiety: Taking Care of Mental Health in Times of Crisis*. Ed. by Jill Bennett. London and New York: Bloomsbury Academic.

Shaw, Clare and Gillian Proctor (2005). 'I. Women at the margins: A critique of the diagnosis of borderline personality disorder'. In: *Feminism & Psychology* 15.4, pp. 483–490.

Shotter, John (2013). 'Agentive spaces, the "background", and other not well articulated influences in shaping our lives'. In: *Journal for the theory of social behaviour* 43.2, pp. 133–154.

Showalter, Elaine (1987). *The Female Malady: Women, Madness and English Culture, 1830–1980*. London: Virago.

Slade, Mike, Michaela Amering and Lindsay Oades (2008). 'Recovery: an international perspective'. In: *Epidemiology and Psychiatric Sciences* 17.2, pp. 128–137.

Slade, Mike and Angie Sweeney (2020). 'Rethinking the concept of insight'. In: *World Psychiatry* 19.3, p. 389.

Spandler, Helen and Mick McKeown (2017). 'Exploring the case for truth and reconciliation in mental health services'. In: *Mental Health Review Journal* 22.2, pp. 83–94.

Spinoza, Benedict De (1996). *Ethics*. Ed. and trans. by Edwin Curley. London: Penguin.

Stewart, Kathleen (2007). *Ordinary affects*. Durham and London: Duke University Press.

Stoler, Ann Laura (2002). 'Colonial archives and the arts of governance'. In: *Archival science* 2, pp. 87–109.

Stubbs, Jean, Camilla Haw and Liz Garner (2004). 'Survey of staff attitudes to smoking in a large psychiatric hospital'. In: *Psychiatric Bulletin* 28.6, pp. 204–207.

Talukdar, Shashwati (2004). 'You Have a Voice Now, Resistance Is Futile!' In: *Frontline Feminisms*. Routledge, pp. 330–336.

Thompson, Paul (2000). *The voice of the Past: Oral History*. Oxford: Oxford University press.

Tiainen, Milla (2013). 'Revisiting the voice in media and as medium: New materialist propositions'. In: *NECSUS European Journal of Media Studies* 2.2, pp. 383–406.

To, Nathan (2015). 'Diasporic montage and critical autoethnography: Mediated visions of intergenerational memory and the affective transmission of trauma'. In: *Affective Methodologies: Developing Cultural Research Strategies for the Study of Affect*. Ed. by Britta Timm Knudsen and Carsten Stage. Basingstoke: Palgrave McMillan, pp. 69–93.

Trinh, Thi Minh-Ha (1992). *Framer Framed.* New York and London: Routledge.

Trivelli, Elena (2013). 'Assembling memories and affective practices around the psychiatric history of Gorizia: A study of a remembering crisis'. PhD thesis. Goldsmiths, University of London.

— (2015). 'Exploring a 'Remembering Crisis':'Affective Attuning'and 'Assemblaged Archive'as Theoretical Frameworks and Research Methodologies'. In: *Affective Methodologies: Developing Cultural Research Strategies for the Study of Affect.* Ed. by C. Knudsen B.T. & Stage. Palgrave Macmillan.

Tuana, Nancy et al. (2008). 'Viscous porosity: Witnessing Katrina'. In: *Material Feminisms.* Ed. by Stacy Alaimo and Susan Hekman. Vol. 188. Bloomington: Indiana University Press.

Tuin, Iris van der and Rick Dolphijn (2012). *New materialism: Interviews & cartographies.* London: Open Humanities Press.

UK, Disability Rights (n.d.). *BBC Panorama exposes abuse of patients.* (Visited on).

Ussher, Jane M. (1992). *Women's Madness: Misogyny or Mental Illness?* Amhurst: University of Massachusetts Press.

— (2011). *The madness of women: Myth and experience.* Routledge.

Voegelin, Salomé (2010). *Listening to noise and silence: Towards a philosophy of sound art.* Bloomsbury Publishing USA.

— (2019). *The political possibility of sound: Fragments of listening.* New York: Bloomsbury Academic.

— (2021). *Sonic Possible Worlds, Revised Edition: Hearing the Continuum of Sound.* Bloomsbury Publishing USA.

Voronka, Jijian (2019). 'Storytelling beyond the psychiatric gaze: Resisting resilience and recovery narratives'. In: *Canadian Journal of Disability Studies* 8.4, pp. 8–30.

Walkerdine, V., A. Olsvold and M. Rudberg (2013). 'Researching embodiment and intergenerational trauma using the work of Davoine and Gaudilliere: History walked in the door'. In: *Subjectivity* 6, pp. 272–297.

Watkin, Christopher (2007). 'A different alterity: Jean-Luc Nancy's 'Singular plural''. In: *Paragraph* 30.2, pp. 50–64.

Westerkamp, Hildegard (2019). 'The disruptive nature of listening: Today, yesterday, tomorrow'. In: *Sound, Media, Ecology*, pp. 45–63.

Wetherell, Margaret (2012). *Affect and Emotion: A new social science understanding*. London and Thousand Oaks, California: Sage, pp. 1–192.

Winterson, Jeanette (2012). *Why be happy when you could be normal?* London: Random House.

Woods, Angela, Akiko Hart and Helen Spandler (2022). 'The recovery narrative: politics and possibilities of a genre'. In: *Culture, Medicine, and Psychiatry* 46, pp. 221–247.