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Performing Breast Cancer Stories: Disrupting Narratives and Constructing Selves.

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Submitted in fulfilment of the requirements for the degree of Doctor of Philosophy

Theatre Studies,

School of Cultural and Creative Arts and School of Health and Wellbeing.

University of Glasgow February 2026

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Abstract

This practice-research project uses performance to explore lived experiences of breast cancer and to challenge dominant narratives of ‘courage’ and ‘survivorship’ that have shaped public discourse since the 1980s. While Medical Humanities scholarship has critiqued normative cancer narratives, there is limited research on how theatre can disrupt these conventions by representing the complexities of ‘biographical disruption’ (Bury, 1982). The project takes as catalyst my experience of breast cancer and situates itself within the field of autobiographical and documentary performance, extending the singular auto into a plural form by inviting others with lived experience onto the stage. The practice research explores how verbatim accounts of lived experience can coherently translate that experience. Through autobiographical, verbatim, and documentary methods, the research investigates how diverse first-person accounts, particularly those marginalised within existing representations, can be coherently translated onstage.

By foregrounding intersectional perspectives, the project responds to the dominance of predominantly white, middle class, non-disabled cancer narratives and highlights the need for more inclusive cultural, medical, and aesthetic understandings of breast cancer. Drawing on work that positions autobiographical performance as a site of self-agency and narrative authority, the research addresses the under-theorisation of performance artists working with breast cancer narratives. Funded by the SGSAH AHRC Doctoral Training Partnership, the project contributes new insight into how performance can articulate the disrupted, fragmented, and transformative dimensions of breast cancer self-narrative.

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Finally, to my three babies, Harry, Ella, and Annie: everything I do is for you. You are my reason, and I will always want to make the world you live in a better place.

Author's Declaration

I declare that, except where explicit reference is made to the contribution of others, that this dissertation is all my own work and has not been submitted for any other degree at the University of Glasgow or other institution.

Chapter 1 Introduction

In a culture saturated with pink ribbons and survival slogans, the lived experience of breast cancer is often reduced to a narrative of triumph or tragedy. Yet, behind these dominant scripts, lie stories that resist resolution: they are fragmented, embodied, and politically charged. This doctoral project emerged from my own lived experience of breast cancer and a desire to disrupt how dominant narratives surrounding the disease are staged and understood. In this thesis, I trace cancer's discursive trajectory from the shameful taboo described by Sontag (1978) and Mukherjee (2011) to the now dominant survivor narrative, and what Ehrenreich termed the 'tyranny of positivity' (2008).

While the dominant survivor narrative initially emerged as a radical intervention to counteract the stigma and silence which have historically surrounded cancer, it has since become commodified and, in many instances, has shifted toward an overly simplistic and prescriptive discourse. This prevailing narrative often marginalises the nuanced, complex, and frequently painful realities of living with breast cancer. This thesis contends that there is a pressing need for alternative narratives that foreground vulnerability and offer open, affective accounts of embodied experience. At the same time, it recognises that individuals in the midst of such profound trauma may struggle to articulate their experiences. Thus, this thesis argues that theatre offers an embodied mode of expression through which individuals can communicate their experiences beyond the limitations of language alone. The research invites participants to engage with disruptive narratives- those often rooted in their experiences of marginalisation- and to interrogate and dismantle the normative discourse that perpetuates such marginalisation (Nielson, 2019). Multidimensional, first-person narratives provide patients and their families with interpretative frameworks for making sense of the breast cancer experience. In the absence of such narratives, individuals can feel isolated and disconnected (Park-Fuller, 1999).

The thesis engages with the theoretical landscape of medical humanities and the feminist resistance that shaped it, alongside participatory performance, post-verbatim theatre, and social science methodologies, to consider how collaborative storytelling can reclaim agency, challenge biomedical authority, and reframe vulnerability as a site of resistance. As both a theatre-maker and researcher, I

position this interdisciplinary work within the fields of critical medical humanities and theatre studies, to consider how cancer narratives have been and could be represented in performance.

1.1 Positionality and Experience

This project explores the interconnection of multiple stories to examine how theatre practice can be developed as a means of disrupting dominant breast cancer discourse, which is often framed as overly upbeat. Rooted in my own experience of breast cancer, the practice research situates itself within the area of participatory theatre through verbatim performance, investigating how lived experience can be coherently translated and represented on stage, while acknowledging the challenges of narrative self-representation in the context of serious illness.

My doctoral project builds on four years of theatre training and over a decade of professional practice facilitating drama workshops in both educational and professional settings, including work with North Lanarkshire Council, Cumbernauld Theatre, Gaiety Theatre, Impact Arts, Blue Triangle Housing Association and GIFT Fundraising. My experience of working with applied theatre and theatre-in-education companies such as Baldy Bains and Screen Stage (https://www.stradadrama.com) further developed my collaborative and performance skills through touring, performing, and workshop delivery. In 2017, I established my own theatre company, developing expertise in producing, writing, and dramaturgy, demonstrating my capacity for project management and creative collaboration. My involvement in Grassmarket Projects' *Where it Hurts* (Fringe, Summerhall, 2018) introduced me to theatrical representations of illness and helped build a network that was pivotal to the engagement with and impact of this research.

The competitive University of Glasgow Postgraduate Excellence scholarship funded my MLitt in Theatre and Performance Practice (2019). Just weeks into the programme, I was diagnosed with breast cancer. This radically changed the nature of my creative practice. I was in the throes of cancer treatment during this time and became intrigued by the prescribed narratives and enforced positivity which

seemed to surround the disease. My final Masters' project explored how technology can manipulate narrative structure, offering a translation of the warped time experienced during cancer treatment. This work deepened my understanding of storytelling and autobiography, interrogating two contrasting time constructs within chemotherapy cycles to demonstrate the mental and physical deterioration of the body and mind during cancer treatment.

My experience of serious illness through breast cancer gave me the impetus to harness my agency and challenge narratives that failed to reflect my reality or that of those around me. This thesis therefore positions itself at the intersection of lived experience, creative practice, and critical inquiry. By proposing post-verbatim theatre as a dramaturgical tool for disrupting dominant breast cancer narratives, it seeks to contribute new knowledge to both performance studies and medical humanities.

1.2 Research Questions

Before outlining the research questions, it is essential to define several key terms used throughout the thesis. This thesis explores whether theatre can be developed and deployed to effectively present biographical disruption (Bury, 1982). Biographical disruption is a sociological term introduced by Bury (1982) to describe the unsettling of the social fabric of one's life, when the sense of self is 'radically disturbed' by illness (Trusson, Pilnick, Roy, 2016). Bury contests that illness, especially chronic illness and cancer, are experiences where the structures of everyday life and the forms of knowledge which underpin them are disrupted (Bury, 1982:169). Chronic illness involves a recognition of pain and suffering, often forcing one to face mortality, which are more typically seen as distant possibilities, especially for younger people. In addition, chronic illness brings patients, their families, and wider social circles into the stark reality of illness, 'disrupting normal rules of reciprocity and mutual support' (ibid), with expectations and plans that individuals hold for the future having to be re-examined.

Another key term of reference in this thesis is intersectionality. Here, this can be understood as defined by Routen et al (2023) as ' the understanding of human beings as shaped by the interaction of different social locations- for example,

race, ethnicity, indigeneity, gender, class, sexuality, geography, age, disability/ability, migration status, religion' (Routen et al., 2023). The term intersectionality, however, was originally introduced by Crenshaw in 1989 and 1991, to highlight how the lived experiences and challenges faced by women of colour were often overlooked by both feminist and anti-racist frameworks. Crenshaw (1989) emphasised the importance of examining how race and gender intersect to shape the multifaceted realities of black women's lives. Intersectionality became a concise way to describe a broader, more nuanced understanding of identity- one that recognises how individuals are shaped by overlapping factors such as gender, class, sexual orientation, ethnicity, nationality, and more. As the Routen et al quote above suggests, the concept has since evolved to include a wider range of marginalised groups. This term is particularly relevant in medical humanities research and practice, as it acknowledges how overlapping identities affect access to care, patient experiences, and health outcomes.

Another concept referred to throughout this thesis is the idea of the universal. In social sciences, something is considered universal if it applies to all people, regardless of their culture, history, or situation. In the *Encyclopedia of Critical Psychology*, Universalism 'implies that it is possible to apply generalised norms, values, or concepts to all people and cultures, regardless of the contexts in which they are located' (Kohfeldt & Grabe, 2014). While this idea is important in areas like human rights, ethics, and psychology, it is often debated, especially by those who believe that culture and context shape how people experience the world. Thus, this thesis does not claim that all norms can apply to everyone, but it does support the idea that, in the context of illness, some experiences are shared by many people. Even though these experiences may differ in intensity or be shaped by different factors, not least intersectionality, as described above, I use the term universal to describe those aspects of illness that are recognised by many people experiencing it, in a similar way.

The research questions posed by this thesis are as follows:

1. How have cancer narratives been represented in performance?
2. How can live theatre practice be interrogated to disrupt normative breast cancer discourse, demonstrating the

complexities of both biographical disruptions, as well as the dominant survivor narrative?

3. How can the challenges of narrative self-representation in the context of serious illness, such as cancer, be addressed through collaborative performance practice, when both treatment and recovery can be deeply destabilising?

To guide the reader through the trajectory of this research, the following section outlines the structure of the thesis. Each chapter builds upon the last to develop a critical and practice-led exploration of how post-verbatim theatre, which is discussed throughout this thesis, can disrupt dominant breast cancer narratives.

1.3 Chapter Breakdown

Before outlining the structure of the thesis, it is helpful to offer the reader some guidance on how to engage with its components. As this is a practice-based PhD project, this written component of the overall thesis is intended to complement the creative output rather than stand alone. I therefore recommend the following order of engagement: begin with Chapter One which is the Introduction, proceed to Chapter Two, then Chapter Three, view the filmed performance, A Waiting Game- Full Performance, and then return to the remaining two chapters. This sequence is designed to support a fuller understanding of the research process and its outcomes.

I will begin this breakdown from Chapter Two, which follows this first introductory chapter:

Chapter Two: Scoping the Field: The Intersection of Medical and Performance Narratives establishes the theoretical and contextual foundations of the thesis, situating the research within medical humanities, feminist performance, and autobiographical practice. It maps the historical trajectory of breast cancer narratives as represented in discourse. Beginning with Sontag's groundbreaking study *Illness as Metaphor* (1978) and supported by Mukherjee's *The Emperor of All Maladies: A Biography of Cancer* (2011), I outline the damaging effects of moral shame associated with the disease, the impact of Sontag's work- including

critiques by Clow and the support which shifted the landscape toward the dominant survivor narrative. I argue that while this narrative was initially intended to offer relief and empowerment, it has since been commodified and appropriated, ultimately reducing visibility of the complexity and disruption caused by the disease. This shift has the potential to leave many individuals feeling unseen and unheard.

Drawing on feminist theory and autobiographical accounts of breast cancer (Lorde, Spence, Park-Fuller), I propose that more disruptive representations are needed to reflect the multiplicity of diverse, intersectional experiences of the disease. I engage with critiques of the survivor narrative (Spence, 1982; Frank, 1995; King, 2006; Ehrenreich, 2010; Sulik, 2011; Williams & Solbrække, 2018), and Nielsen's *Disrupting Breast Cancer Narratives: Stories of Rage and Repair* (2019), to argue that these counter-narratives are essential for illuminating lived experiences. Nielsen suggests that the new knowledge generated through such storytelling could significantly impact patient experience. I then explore theatre practice (Mermikides, 2019; Lobel, 2019; Lehmann, 1999; Shaughnessy & Barnard, 2019; Radosavljević, 2023) to demonstrate its capacity to communicate the multidimensional, complex, and embodied experience of breast cancer. I discuss the limitations of language in relation to trauma and theatre's unique ability to express the ineffable in ways that written text alone cannot. This leads to a critical evaluation of a selected range of existing practice in the field, including works by Lobel (2010), Kimmings (2016), Underwood-Lee (2010), Park-Fuller (1995), and El Zeind (2021), to assess how breast cancer has been represented dramaturgically to date. Through this critique, I conclude that theatre- specifically post-verbatim theatre- can effectively communicate the ineffable, non-linear, and liminal experience of trauma in illness.

Chapter Three, Methodology, aligns with social science discourse and is divided into two distinct but interrelated parts. The first section, Methodological Considerations, outlines the values, ethos, and theoretical orientation underpinning the research. It introduces the methodological approaches adopted-Practice Research (PR) and Participatory Action Research (PAR), through Participatory Theatre (PT)- and the epistemological rationale behind these choices. This section reframes methods as a site of inquiry, meaning-making, and transformative possibility. It positions creative practice not only as

a representational tool but also as a resistant mode capable of revealing alternative meanings, fostering dialogue, and influencing cultural perceptions. Through this lens, the methodology foregrounds the creative agency of lived experience and offers new ways of engaging with the disruptive realities of breast cancer.

The second part of Chapter Three outlines the Methodological Design of the project and explains how activities were implemented in an ethical and considerate manner. It begins with a discussion of the recruitment process (3.3.1), which presented challenges in securing an inclusive sample of participants. I reflect on how these difficulties were addressed by expanding the network and diversifying recruitment strategies.

As the design demonstrates, the research unfolded in three stages: initial taster workshops; relational interviews with individuals with lived experience of breast cancer; and in-person workshops with local participants, culminating in the final output, the performance. I start by outlining the design and the integration of PAR activities into the taster workshops. This section begins with a simple introductory task and progresses to more meaningful exercises, such as photo elicitation, which helped participants anchor their lived experiences in tangible moments or objects.

I then discuss the relational interviews, including the questions asked and the rationale behind them (3.3.3) by drawing on Fujii's assertion in *Interviewing in Social Science Research: A Relational Approach* (2017), that 'in relational interviewing, the data emerges from interaction, rather than interrogation. Research-related knowledge is generated in that interaction' (Fujii, 2017:8). Her emphasis on treating participants with respect and dignity suggests a 'heightened ethical sensibility' (Fujii, 2018:5). It was essential to cultivate an environment that allowed for the expression of richness and complexity drawn from real-life experiences (Rubin & Rubin, 2004).

For the in-person workshops (3.4), activities were primarily drawn from Augusto Boal's participatory theatre methods, which encourage personal intervention (Campbell, 2019). These techniques were introduced early in the workshops to help build trust within the group dynamic. As Campbell notes, Boal's methods enable participants to 'claim agency through personal intervention' (Campbell,

2019). Here, the structure of the workshops is discussed too. The first three weeks focused on devising tasks using both created and gathered data, drawing on Boal's Forum and Image Theatre methods. The final three weeks were dedicated to developing and refining ideas. Through this process- and at the participants' request- their involvement extended beyond the initial scope. They became long-term collaborators, contributing to readthroughs, script development, and ultimately participating in the final performances.

Chapter Four offers a critical reflection on the performance of the practice research play, *A Waiting Game,* which took place on 1 May 2025. This post-verbatim play explores the lived experiences of individuals affected by breast cancer, which are often overlooked in dominant discourse. Moving beyond the prevailing 'pink ribbon' symbolism and survivor narratives, the play challenges mainstream representations by centring personal testimonies on themes rarely spoken about and voices historically marginalised in breast cancer discourse.

This chapter conducts a dramaturgical analysis of aesthetic design within my Practice Research (PR). It examines modes of sensory engagement, ensemble work, and character transitions across scenes to assess their effectiveness in disrupting dominant breast cancer narratives through a multiplicity of diverse experiences. It also considers the rehearsal process and analyses the performance output to demonstrate the value of post-verbatim theatre as a model for challenging discourse. Audience and participant feedback is evaluated to assess the impact of the work. The chapter concludes by unpacking my practice and positioning it within the sphere of post-verbatim theatre as a dramaturgical tool for disrupting dominant cancer narratives.

The thesis concludes by drawing together the project aims and research questions, their execution and the dissemination of my practice and locating it within the framework of post-verbatim theatre. Each chapter contributes to an overarching argument for the value of post-verbatim theatre- not only as a rationale for the methods employed, but as a transformative model capable of challenging and reshaping discourse. The originality of this thesis lies in the development of post-verbatim as a concept and its application within a context where individuals often feel repressed or silenced by prevailing narratives of illness. By documenting how I have enacted this approach, the research contributes new knowledge to the

field, demonstrating how post-verbatim theatre can serve as an instrumental tool for amplifying lived experience and fostering ethical, creative engagement.

1.4 Summary

This introductory chapter has established the purpose, scope, and context of this PhD practice research project, positioning it at the intersection of personal experience, professional practice, and critical inquiry. It introduced my background as a theatre maker and my lived experience of breast cancer and traced the evolution of this research from my taught postgraduate studies, where the seeds of this inquiry first took root. Bridging lived experience with creative and theoretical enquiry, this project responds to the limitations of dominant cancer narratives by foregrounding complexity, vulnerability, and embodied knowledge.

What follows is a multidimensional exploration of how participatory performance and collaborative storytelling can disrupt normative discourses, reclaim narrative agency, and reframe vulnerability as a generative site of resistance, connection, and meaning making. Drawing on theatre and performance studies, feminist theory, and the medical humanities, this thesis positions theatre as a vital artistic and critical practice that enables the articulation of experiences that often exceed the limits of language. Through its embodied, relational, and affective capacities, theatre creates space for complex experiences of illness to be expressed, witnessed, and shared in ways that conventional modes of communication cannot always accommodate.

In doing so, this research contributes to more inclusive and critically engaged understandings of breast cancer while affirming the transformative potential of creative practice in reshaping how illness is represented, communicated, and understood. The supervisory structure for this thesis drew on expertise across Theatre Studies and Medical Sociology, engaging with methods from both, and often in the spaces that these usefully overlap, including, for example, Participatory Action Research and Applied Theatre. However, the primary methodology is performance research. The uniquely ephemeral, immediate, and adaptable nature of performance enables it to cross disciplinary boundaries, foster embodied forms of knowledge, and generate meaningful encounters

between participants, audiences, and lived experiences. Ultimately, this thesis locates theatre as both a method of inquiry, and a distinct mode of knowledge production, capable of challenging dominant narratives and allowing new possibilities for understanding illness, care, and human connection.

Chapter 2 Scoping the Fields: The Intersection of Medical and Performance Narratives

2.1 Introduction

Breast cancer remains the most diagnosed malignancy in women in the UK (CRUK, 2025), yet its discussion is often dominated by upbeat narratives. Since the 1980s, stories of courage, survivorship, and transformation have prevailed in discourse, promoting an image that leaves little space for more disruptive experiences to be articulated (Ehrenreich 2001,2009, King 2010, Frank1995, Mermikides 2019, Lobel 2019) . Although survival has improved, patients' own accounts of living with breast cancer suggest a disconnect between public discourse and lived experience. Whilst these 'positive' narratives are intended to uplift and encourage, they can also suppress anger, grief, and complexity (Ehrenreich, 2008). Moreover, there is a distinct gap in scholarship around lived experience because of a focus on biomedical research (Lobel, 2019).

This chapter will first trace the emergence of dominant breast cancer 'survivor' narratives, showing the evolution from a social taboo referred to with metaphorical language, through the reaction occasioned by Susan Sontag's work (1978), to the feminist action by artists, including Jo Spence (1982) and Audre Lorde (1980) that began in response. It will then consider the cultural and psychological impact of the dominant survivor narratives through the work of political activist, Ehrenreich (2001, 2009), as well as other scholars resisting this movement such as King (2016), Sullik (2011), Williams and Solbraekke (2018), and Nielsen's call for disruptive representations in her book *Disrupting Breast Cancer Narratives: Stories of Rage and Repair* (2019). The chapter then explores how theatre might resist and rewrite these narratives, making space for nuance, honesty, and disruption. Through engaging with existing scholarship (Mermikides, 2019, Lobel, 2019, Lehmann, 1999, Shaughnessy and Barnard, 2019, Radosavljević, 2023) and

practice (Lobel ,2010, Kimmings, 2016, Underwood-Lee, 2010, Park-Fuller, 1995, and El Zeind, 2021), this literature and practice review explores how theatre, as a mode of embodied inquiry and creative resistance, might serve to disrupt the normative breast cancer narrative. Drawing upon theoretical frameworks from

medical humanities, feminist theory, and theatre studies, it positions theatre and particularly post-verbatim theatre, as a representational tool and a co-created praxis, which lends itself to engaging people with lived experience of breast cancer in the dramaturgical process.

2.2 Dominant Discourses of Breast Cancer

2.2.1 Taboo and Metaphor

Susan Sontag's *Illness as Metaphor* (1978) was a ground-breaking critique of the symbolic language surrounding illness, which challenged ways of understanding and speaking about cancer. Sontag argued that metaphors can distort the lived experience of cancer and contribute to stigma. She described cancer as a 'dreaded disease' (Sontag,1978:23), not only because of its pathology but because of the cultural meanings attached to it, including associations with repression, punishment, and moral failure (Sontag, 1978). Calling for a 'liberation' from metaphor, Sontag insists that illness should be understood in strictly medical terms to avoid the psychological burden imposed by symbolic narratives (Sontag, 1987:3).

Sontag compares the 19th-century quest to eliminate tuberculosis with the 20th-century efforts to cure cancer, showing how both diseases have been shaped by metaphorical 'trappings' (2). Cancer, like tuberculosis before it, evoked fear and was often seen as a death sentence. She critiques the language used by medical professionals (e.g., 'consuming', 'corrupting', 'insidious') for reinforcing shame and silence around the disease. She also interrogates the symbolic damage of breast cancer metaphors, such as the military language of 'fighting' or 'losing a battle', and the use of cancer as a metaphor for moral decay or tragedy. Sontag highlights how cancer was once viewed as a disease of repression, particularly sexual repression, later shifting to associations with suppressed anger and emotion (Sontag, 1978:13). These cultural myths, she argues, perpetuated suffering and shame. Sontag believes that stripping cancer of its negative metaphors could help patients avoid stigma and reclaim their experience on their own terms.

Written from her own lived experience following treatment for metastatic breast cancer, Sontag's study challenged the dehumanisation of patients by both medical

discourse and cultural imagination. Her work laid the foundation for feminist scholars like Sedgwick (1993), Stacey (1999), and Park-Fuller (1995), who integrated personal illness narratives into theoretical frameworks. Gygax (2009) notes that dialogue between autobiography and theory helped disrupt dominant narratives and foreground the emotional and social complexities of illness, especially the shame that often silences it.

Siddhartha Mukherjee's book, *The Emperor of All Maladies* (2011) supports Sontag's claims about stigma, noting that a cancer diagnosis was once horrific 'not for the disease but the mere stigma of its presence' (Mukherjee, 2011:4). He also explores the language surrounding cancer, observing that 'rolling underneath these medical, cultural, and metaphorical interceptions of cancer over the centuries was biological understanding of the illness' (ibid). Yet, despite Sontag's call to strip cancer of metaphor, Mukherjee's biography is laced with militaristic language. He introduces cancer as a 'war', describing physicians and patients as engaged in battle (Mukherjee, 2011:4).

> Cancer is an all-consuming presence in our lives. It invaded our imagination; it occupied our memories; it infiltrated every conversation, every thought. And if we as physicians found ourselves immersed in cancer, then our patients found their lives virtually obliterated by the disease.

(Mukherjee, 2011:4)

Mukherjee uses words like 'invaded' and 'obliterated' as if describing a warzone. He further acknowledges cancer's sociopolitical impact, describing it as not just a disease of cells, but a disease of stories- one that reorders identity, rewrites futures, and demands new language to capture its grip on human experience. By structuring the book as a biography, he invites readers to view cancer not only through the lens of medicine but also of meaning. The opening chapter makes this explicit, as Mukherjee reflects his own experience as an oncologist and the emotional need to understand cancer through narrative.

In contrast to Sontag's call for medical clarity, Mukherjee's use of metaphor suggests that cancer has become so powerful and embedded in our collective psyche that it demands a narrative form capable of expressing its complexity- whether as a character, a war, or a mythic force. Perhaps metaphor is not just

distortion, but a necessary tool for grappling with the enormity of the disease.

Barbara Clow's (2001) article, 'Who's afraid of Susan Sontag? or the myths and metaphors of cancer reconsidered', challenges Sontag's work by suggesting that it was not entirely representative of the realities of cancer experience at the time. Whilst Sontag's portrayal of the disease as symbolic was compelling, Clow finds her accusation that shame and silence characterise the experience less convincing. Sontag's claim was that illness is not a metaphor. Clow, however, suggests that metaphors are as much a product of the patient's lived experience of the disease as they are impactful on the cancer experience itself. Clow acknowledges that metaphors are not merely imposed from outside but emerge organically from lived experience; this is demonstrated by Mukherjee, when he reports patients asking, 'what are the roots of our battle against this disease' or 'where are we in the "war" on cancer?'. Clow argues that metaphors may help patients articulate the unimaginable, especially when conventional language fails to capture the emotional and existential weight of disease.

Sontag argues that the stigma and dominant narratives surrounding cancer are cultural mechanisms that impact on all of us. But, contrary to Sontag's view that cancer in the first part of the twentieth century dehumanised its victims, Clow argues that many were eager to understand the disease better. She supports this claim drawing on obituaries, medical literature, education, and examples of correspondence with patients living through cancer in the early part of the twentieth century to suggest that it was not the shameful, unspeakable disease that Sontag described (Clow 2021). Sontag draws the comparison between cancer and other illnesses, such as heart disease, questioning why they do not attract such brutal metaphors (heart disease, for example, tends to attract more mechanical metaphors associated with sudden death). Clow claims that cancer at that time was simply a much more horrific disease to live with. People were often terminally ill before they had diagnosis, with visible, festering lesions which were usually symptomatic of mouth, skin or breast cancer. Before antibiotics, infection caused a great deal of discomfort, turning wounds into foul-smelling, painful sores. Even internal cancers, which were easier to conceal, could lead to discharges and loss of bodily functions, resulting in embarrassment and isolation. Mukherjee describes a patient's desire to cut out her whole stomach, which was 'riddled' with cancer, 'sparing nothing', as she put it to him (Mukherjee, 2011:5).

Unlike heart disease, which could go unnoticed until sudden death, cancer was a daily struggle. This, Clow argues, may explain why cancer attracted such powerful and enduring metaphors, not only imposed by society but born from the visceral experience of the disease itself.

Clow's critique of Sontag's claim that cancer is a cultural taboo, however, lacks nuance and fails to account for the broader historical and sociocultural evidence presented by other scholars, including Mukherjee. While Clow argues that cancer was openly discussed in the early 20th-century, scholars like James Patterson (1987) and Claudia Malacrida (2004) reveal that fear, euphemism, and shameful silencing were deeply embedded in cancer discourse well into the middle of the century. Arthur Frank's work, *The Wounded Storyteller: Body, Illness and Ethics* (1995), further supports the idea that patients often struggled to articulate their experiences due to cultural misunderstanding of cancer, whilst Barbara Brenner's *So Much to be Done: The Writings of Breast Cancer Activist Barbara Brenner* (2016) exposes how even contemporary awareness movements can mask emotional repression. These perspectives suggest that Clow's dismissal of Sontag's metaphorical framing overlooks the persistent stigma and silence surrounding cancer across time, gender, and cultural contexts, making her argument historically and sociologically incomplete.

2.2.2 The role of narrative

Despite Sontag's appeal to resist metaphorical thinking around illness, the decades following her publication saw the rise of the cancer 'survivor' narrative- a cultural shift that reintroduced metaphor into the cancer experience. This narrative gained traction in public campaigns and media, portraying patients as fighters who overcome adversity (King, 2006; Ehrenreich, 2009; Brenner, 2016). While this shift offered some, affected by the disease, a sense of empowerment and responded to Sontag's critiques of taboo and shame, it also constructed a narrow and idealised image of living with cancer- reframing it as a battle to be won and casting patients as heroic figures who emerge stronger and wiser. I will now examine the roots of this narrative to contextualise and clarify the need for it to be challenged.

Having been personally diagnosed with breast cancer in the early 21st century,

the pressure to remain positive was overwhelming to the extent that there seemed to be an assumption that there was a better chance of survival when patients are optimistic. I witnessed firsthand the impact this positive, survivor narrative can have, especially when one feels unwell during treatment.

At this point, it is important to clarify what is meant by 'narrative' in the context of this thesis. In *The Wounded Storyteller: Body, Illness and Ethics* (1995), Arthur Frank suggests that narrative is 'a way of experiencing life, not simply of telling it' (Frank, 1995: 22). For Frank, narrative is a means of making sense of illness and suffering, enabling individuals to reconstruct identity and meaning in the aftermath of disruption. Narratives are not merely accounts of events; they shape understanding, foster connection, and influence how illness is experienced and interpreted. As Frank further argues, 'to tell one's story is to make a claim on others' attention and to invite a response' (1995: 17), positioning narrative as a relational and ethical practice rather than a merely personal one.

Building on Frank's work, this thesis understands narrative as a socially constructed framework through which experiences of illness are organised, represented, and made coherent. The stories available to people living with breast cancer are shaped by broader cultural, medical, and social discourses, influencing how illness is perceived by others as well as how it is experienced by those living through it.

It is important to acknowledge the distinction between narrative and storytelling. Drawing on Walter Benjamin (1973), storytelling can be understood as the embodied and relational process through which lived experiences are communicated, shared, and witnessed, whereas narrative refers more broadly to the structures and frameworks in which those experiences are organised and understood. While this distinction is useful conceptually, throughout this thesis I use the term *narrative* interchangeably to refer to both wider cultural narratives surrounding breast cancer and to the stories shared by participants. This reflects the ways that personal stories and broader social narratives are often deeply intertwined, shaping and informing one another.

This distinction is particularly significant for theatre. As a live and embodied

act, theatre is uniquely positioned as a site of storytelling, enabling participants to recount narratives of breast cancer while also sharing experiential knowledge through performance, aesthetic encounter, and collective witnessing. In this sense, performance becomes a space where dominant illness narratives can be challenged, reworked, and reimagined through the act of storytelling itself.

It is important to recognise that the survivor narrative emerged from a place of resistance to the stigma and silence Sontag described earlier. Cancer holds a unique cultural significance in our socio-cultural landscape, which the survivor movement initially sought to challenge and disrupt. At the time, it represented a radical intervention, a counter-narrative to the dominant associations of death and shame. As with many disruptive movements, however, it was appropriated by Capitalism: commercialised, commodified, and repackaged, until other narratives were overshadowed. What began as a powerful act of resistance became a dominant framework, limiting the diversity of cancer experiences. Sontag's work was instrumental in influencing this resistance, but the survivor narrative- once radical- has since been absorbed into mainstream discourse, often at the expense of more nuanced, complex, and less palatable truths. Narratives can be cyclical. While the survivor narrative was a response to something much worse, its appropriation has now reached a point where alternatives are required.

2.2.3 The limitations to the positive narrative

Since the 1980s, efforts to extract growth from the trauma of cancer have expanded beyond biomedicine, shaping the cultural and political landscape of breast cancer. The belief that positive thinking aids healing has become ubiquitous. In *Smile or Die* (2010), Barbara Ehrenreich critiques this ideology by tracing its roots from the 19th-century 'New Thought' movement and Christian Science- grounded in Calvinist Puritanism- through its use in mid-century sales culture, to 1980s corporate America. She shows how it later permeated evangelical Christianity, academia, the public sector, and most alarmingly, public health. Ehrenreich argued in 2010 that positive thinking dominated modern thinking, which is further supported by more recent scholarship (Lobel 2019, Mermikides 2020, Neilsen 2019, William & Solbraekke,2018), often shifting blame onto individuals when outcomes are poor. Though marketed as empowering, it

can undermine the wellbeing of those affected.

Drawing on her own breast cancer experience, Ehrenreich describes entering ‘Cancerland’, where she felt alienated by the relentlessly superficial ‘happiness' that surrounded her, as well as the soft, feminine messaging and testimonies of gratitude she encountered. Support frameworks often promoted positivity while suppressing expressions of fear or grief, favouring the ‘survivor’ identity over the ‘victim’, echoing the military metaphors Sontag had critiqued decades earlier (Ehrenreich,2010).

2.2.4 Pink Ribbon Culture and Toxic Positivity

The pink ribbon movement promotes a silver-lining narrative around breast cancer, encouraging women to adopt optimism and compliance over critical reflection (Neilson, 2019). In 1990, activist Charlotte Haley created peach ribbons to protest inadequate cancer prevention funding. She attached cards to the ribbon that read: ‘The National Cancer Institute's annual budget is 1.8 billion US dollars, and only 5 percent goes to cancer prevention. Help us wake up our legislators and America by wearing this ribbon’ (Edge, 2014). In 1992, *Self* magazine editor, Alexandra Penney, and cosmetic brand, Estée Lauder, sought to collaborate with Haley. When she declined, citing concerns over their motives, they rebranded the ribbon as pink, chosen for its comforting and non-threatening associations (Poole, 2010), effectively appropriating Haley’s campaign.

This framing often infantilises patients, urging them to embrace gratitude and survivorship while discouraging critique of the systems shaping their experience. In *Pink Ribbons, Inc*. (Poole, 2010), King argues that breast cancer has been constructed as a disease affecting middle-aged, middle-class, feminine white women- a demographic targeted by corporate marketing. She highlights how the pressure to remain positive alienates patients, forcing them to suppress anger, despair, and grief in favour of the ‘tyranny of cheerfulness’ (ibid). Often dominant discourse has reduced breast cancer survivorship to a sea of pink women and men running a ‘Race for Life’(2027) competition, when the reality remains that most people who have undergone breast cancer treatment, would struggle to run a race, due to the aftereffects of surgery and medication. Brenner (2016) advocates for anger as a valid and powerful response, challenging

the unrealistic, sanitised, and feminine portrayal of cancer. Patients often resent the pressure to normalise trauma to fit a narrative that misrepresents their reality (King, 2010).

2.2.5 Psychological Critiques

Suppressing negative emotions and adopting forced positivity can be harmful, especially when it conflicts with a patient's lived reality. Research shows that this pressure, often reinforced by medical culture and social norms, can negatively impact patients (Bortolotti & Antrobus, 2015; Rittenberg, 1995; Savard,2010, Gilbert et al, 2016). Ehrenreich challenges what she regards as a 'cultural obsession with positivity' (Ehrenreich, 2010), arguing that it silences critical thought, fosters self-blame, and ignores structural and biological realities. While optimism can be helpful, it should not be weaponised against those who are struggling. Suggesting that suffering results from insufficient positivity is both misguided and dangerous. Overreliance on positive thinking can cloud judgment and obscure vital understanding. Intuition, fear, and discomfort often prompt life-saving action. In my own case, it was these so-called 'negative' emotions, rather than optimism, that led to a timely breast cancer diagnosis. Staying alert to difficult truths is essential; sometimes, discomfort is what saves us.

Frank (1995) offers a typology of illness narratives: restitution, chaos, and quest, that helps illuminate this shift. The survivor narrative aligns most closely with what he describes as the 'quest story', where illness becomes a transformative journey (Frank, 1995:117). Yet Frank also warns that dominant narratives can marginalise those whose experiences do not conform to cultural expectations (Frank, 1995).

The feminist movement also played a crucial role in both shaping and critiquing this narrative. Early feminist health activism in the 1970s and 1980s challenged the male-dominated medical establishment and advocated for women's autonomy, empowerment, and critical engagement with healthcare systems. Feminist figures like Lorde, in *The Cancer Journals* (1980), rejected the silencing of illness and insisted on politicising the personal experience of breast cancer. Lorde's refusal to wear a prosthesis after her mastectomy became a symbolic act of resistance against societal expectations of female perfection. Four decades

later, Lorde's work is still relevant, with 75% of those who opt to have a mastectomy without reconstruction in 2021, happy to go without a prosthesis. However, 25% of them said that their decision was not supported by their breast care team (Breastcancer.org, 2025).

Spence, a feminist photographer and activist, offered a radical visual and political challenge to dominant cancer discourses. Diagnosed with breast cancer in 1982, she rejected conventional treatments like chemotherapy and instead turned to alternative therapies and phototherapy. From her diagnosis, Spence used photography to document her experience of breast cancer, demanding that viewers become aware of the visual codes that construct ideas of gender, illness and the kind of body that is 'fit to be seen' (Dykstra, 1995: 8). From all the work she documented, the one that I find most powerful is the image *Mammogram* (1982):



> Passing through the hands of the medical orthodoxy can be terrifying when you have breast cancer. I was determined to document for myself what was happening to me. Not to be merely the object of their

> medical discourse but to be the active subject of my own investigation. Here whilst a mammogram is being done I have persuaded the radiographer to take a picture for me. She was rather unhappy about it, but felt it was preferable to my holding the camera out at arm's length and doing a self-portrait.

(Spence, 1988: 153)

Mammogram explores the lack of control expressed by women once their body is constructed as the patient in a medical setting, challenging the ways in which 'medicine, photography, and western culture more generally, fragment and objectify women's bodies' (Bell, 2002). Spence suggests a 'conventionality, coercion, and violence in medicine, using her camera as a weapon to respond, exercising her own right to use her camera in the situation' (Spence and Coward, 1986: 25). During the second wave feminist movement there was a shift from helplessness to empowerment, which invoked some to harness their agency and expose what happens behind closed doors (Jacobs, 1983). Spence demonstrates the violation and humiliation she felt through this aggressive image, confronting the clinical gaze to reclaim agency over the ill body. In another image, she marks her breast with an 'X,' to symbolise further the depersonalised violence of medical intervention (Spence, 1982). Her work exposes the power dynamics of the healthcare system, where patients often feel passive and voiceless. As in my own practice, but using phototherapy, Spence collaborated with lived experience participants, focusing particularly on the disruptive nature of the disease, to reframe personal trauma. This challenges the sanitised survivor narrative and offers a raw, political account of illness. This thesis extends this thread through an exploration of theatre techniques as a mechanism for deploying the embodied and ephemeral nature of the practice, and its potential for framing traumatic events. The transient quality of theatre mirrors the nature of trauma itself: both are experienced intensely in the moment, while resisting permanence, persisting instead through memory, affect, and embodied engagement. Theatre's ephemerality offers a powerful medium through which the complexities of trauma can be represented and be understood.

As discussed previously, Barbara Ehrenreich's essay, 'Welcome to Cancerland' (2001), strongly criticises the survivor narrative and the cultural expectations it places on cancer patients, particularly women diagnosed with breast cancer. Her

work challenges the dominant 'survivor' narrative, which she argues enforces a 'regime' of emotional cheerfulness and gratitude, even in the face of suffering and fear. Ehrenreich describes this as the 'tyranny of positive thinking' (2001), a cultural imperative that demands that patients suppress negative emotions and adopt an upbeat attitude. She notes that 'unhappiness requires a kind of apology' (Ehrenreich, 2001:47), suggesting that expressions of anger or despair are dismissed. In her subsequent book, *Smile or Die: How Positive Thinking Fooled America and the World* (2009), she expands this argument to broader Western culture, arguing that positive thinking has become akin to religious ideology that obscures structural inequalities and discourages political engagement (Ehrenreich, 2009).

Ehrenreich's work also challenges cultural ignorance. Her refusal to adopt the survivor narrative can be seen as an act of resistance against a discourse which reduces the complexity and diversity of cancer experiences into a single, idealised storyline of positivity and resilience. Moreover, Ehrenreich questions the commodification of illness. She notes how breast cancer awareness campaigns often serve corporate interests before patients' interests, with pink ribbon products marketed 'aggressively' despite questionable links to actual research funding. Gayle Sulik's *Pink Ribbon Blues* (2011) extends this argument, discussing the commercialisation of breast cancer culture. Sulik says that survivorship has been commodified through branded merchandise, awareness campaigns, and corporate partnerships, often at the expense of meaningful advocacy and patient autonomy (Sulik, 2011). She argues that the 'she-ro' figure, an idealised, hyper-feminine survivor, reinforces gender norms and emotional expectations, leaving little room for alternative points of view (Sulik, 2011).

In their 2018 essay, 'Cancer Coiffures: Embodied Storylines of Cancer Patienthood and Survivorship in the Consumerist Cultural Imaginary', Williams and Solbrække explore the symbolic and narrative role of hair loss in cultural representations of cancer in Western media. Along with authors already mentioned they list Steinberg (2015) as one of those who have protested the 'tyranny of positivity' surrounding cancer survivorship. They do, however, challenge Steinberg's suggestion that alternative counter-narratives which challenge the dominant discourse and are rooted in lived experience are starting to become more mainstream. Williams and Solbrække (2018) suggest that,

although Steinberg's framing is significant, it lacks complexity, as the representational field is not yet inclusive enough. The reality of cancer experience 'not only comprises many competing and intersecting narratives but its "other" embodied stories are also, and more importantly, contradictory' (Williams and Solbrække 2018). Instead, Williams and Solbrække assert that 'successfully overcoming normative narratives of cancer necessarily entails new, but still somehow normative story lines' (2018). As Williams and Solbrække argue, identity is shaped through diverse and intersecting categories, such as race, gender, class, and sexuality, which complicates any attempt to define a singular counter-narrative (2018). This tension is particularly relevant to performance-based practice research, where theatrical form becomes a site for negotiating identity, agency, and representation. Williams and Solbrække (2018) refer to Medical Sociologist, Catherine Oakley's (2017) calls for a 'medico-cultural materialist' approach to health that deals with intersecting categories within the framework of the 'patient-consumer' (ibid). As my own research seeks to explore, these categories do not operate in isolation but overlap and reshape one another. Williams and Solbrække state that cancer narratives must move beyond opposing frameworks and instead embrace contradiction, complexity, and multiplicity (Williams and Solbrække, 2018). This thesis responds to that challenge by exploring how post-verbatim and postdramatic theatre can facilitate more nuanced representations of illness which resist simplification and reflect the lived realities of diverse bodies and identities.

The evolution from Sontag's shame argument to the survivor narrative reflects a complex interplay between empowerment and constraint. While survivorship has offered visibility and agency to many, it has also produced new norms that can exclude, commodify, and simplify the lived experience of cancer, and in particular, breast cancer. The voices of Spence (1982), Frank (1995), King (2006), Ehrenreich (2010), Sulik (2011) and Williams and Solbrække (2018) remind us that resistance, complexity, and critique are essential components of any illness discourse.

2.3 Disrupting the Dominant Narrative

Emilia Nielsen's work has been fundamental to my research. She argues in *Disrupting Breast Cancer Narratives: Stories of Rage and Repair* (2019), that

disruptive and therefore more realistic characterisations of breast cancer serve a critical function in illuminating cancer experiences, with the potential to create new knowledge which could benefit the patient experience (Nielsen, 2019). Her book explores the issues with mainstream breast cancer discourse, particularly the dominant ‘happy survivor’ narrative shaped by pink ribbon culture. Instead of reinforcing optimism and emotional conformity, Nielsen foregrounds stories that express anger, grief, and complexity which she calls ‘politically insistent’ illness narratives.

This practice research aligns with Nielsen in its quest to challenge dominant narratives by presenting a multiplicity of real-life, diverse, and disruptive representations of cancer experience. It aims to resist the extremes of the excessively cheerful portrayals or the shaming of the disease, instead speaking openly about the complex, intersectional, and often painful reality of breast cancer, and what it means to live with and through it. Nielsen suggests that performing patienthood and the standardised narratives which have become expected and accepted from those with lived experience of the disease are damaging. Breast cancer culture is embedded in normative narratives, as well as the expected performance of patienthood in breast cancer survivorship. Nielsen touches on ideas around performance and performativity, challenging Judith Butler’s theory that performance is a ‘bounded act’ (Butler, 1990), to acknowledge its role in expanding understanding in cultures of illness. She explores how patienthood is not a fixed or passive identity, but one that is actively performed and shaped by cultural expectations. Nielsen argues that the normative breast cancer narratives, mainly the survivor narrative and pink ribbon culture, encourage emotionally regulated roles, such as the cheerful survivor, which align with broader social norms around femininity, gratitude, and resilience (Nielen, 2019).

These roles are shaped by institutional structures, media representations, and gendered expectations. Performativity is imbricated in the performance of patienthood in response to illness in the everyday, which not only includes emotional expressions like hope, gratitude and positivity, but also bodily routines such as participating in treatment, attending support groups, and engaging with public awareness campaigns. She suggests that these repeated acts constitute a kind of expected way of being, that reinforces dominant

cultural narratives while marginalising more disruptive or emotionally complex experiences (Nielsen, 2019).

Nielsen insists that alternative narratives which express rage, grief and pain can challenge this performative script. By foregrounding stories that deviate from the expected emotional arc, much like those this project will prioritise, she demonstrates how illness narratives can become a site of political and personal repair, shifting public discourse away from conformity and toward authenticity. Nielson suggests that Butler's theory could be redeployed beyond the notion of repeating 'theatrically stylised acts', to a deeper, more relevant elicitation of performativity, and 'non-essentialised constructions of identity' (Nielson, 2018:131). The identities which are demanded culturally of patients require feminist resistance and must be challenged to reconsider the ethics that surround them.

There remain limited spaces where people can freely communicate their lived experiences of breast cancer that disrupt these normative narratives in the way that this thesis project proposes. Fear, distress, or what could be perceived as a victim mentality, are discouraged in the pink ribbon culture. As discussed in section 2.2.3, Ehrenreich suggests that the cultural landscape is tainted with 'religious fervour' (2001) and devoid of the feminist activism that one might expect from a women's health issue. There is a normative, standardised and therefore acceptable narrative which fits the discourse. The 'early detection' narrative seeks to normalise breast cancer and to repair the fit, feminine body with a wig, breast prostheses, and reconstruction (Neilson, 2019). This project will demonstrate that not everyone's experience allows for this, nor indeed does everyone want it. In most cases the experience is not linear, but complex and fraught with traumatic difficulties, which are often difficult to articulate through words alone- metaphors or not.

The embodied nature of performance can extend Neilsen's suggestion of the power of words alone to disrupting narratives, to facilitate a more nuanced framework where participants can articulate and negotiate their lived experience in an embodied way. The immediate, ephemeral, and versatile nature of theatre can facilitate real-life accounts that reflect the dynamic, whole-life experience of illness in all its emotional, social, and embodied dimensions. We will now turn

our attention to the theatre and performance landscape that surrounds cancer narratives to support and validate the essential need for this practice research project.

2.4 Theatre and Performance Practice

Having drawn upon theoretical frameworks from medical humanities to consider the evolution of dominant cancer discourse thus far, I will now consider how cancer has been represented through theatre. Through existing scholarship (Mermikides, 2019; Lobel, 2019), this section will explore the theoretical frameworks which have been used to present illness and particularly cancer in the realm of performance. I will introduce the practice of Lobel (2008), Kimmings (2016), Underwood-Lee (2008), Park-Fuller (1995) and El Zeind (2021), to explore how theatre can creatively resist and disrupt normative breast cancer narratives. I will then discuss how my own project builds on this, to present theatre about breast cancer as a multidimensional, multi-sensory, embodied inquiry. Drawing on the work of Lehmann (1999), Shaughnessy and Barnard (2019) and Radosavljević, (2023), I will present theatre and particularly post-verbatim theatre, as a representational tool and a co-created praxis, positioning this project as a unique enquiry which engages people with lived experience of breast cancer in the dramaturgical process.

In her monograph, *Medicine and the Human* (2020), Alex Mermikides asserts that:

> Medical performance has a vital role to play in the 'critical' revisioning of the 'medical humanities' core business. This is especially the case, I argue, when it allows us to rethink and reimagine 'the human' within interdisciplinary and inter-sectoral contexts and encounters.

(Mermikides, 2020:172)

Scholarship exists across Medical Humanities which challenges dominant cancer narratives; there has yet, however, to be a study examining the potential of theatre to disrupt normative breast cancer discourse through representing the complexities of the lived reality of the disease. Nielson emphasises the importance of disrupting normative breast cancer discourse through representing the complexities of what sociologists' call 'biographical disruption' (Bury, 1982). As

discussed in the introduction to this thesis, biographical disruption characterises the unsettling of the social fabric of one's life, when the sense of self is 'radically disturbed' by illness (Trusson, Pilnick, Roy, 2016). This project extends Lobel's work, *Theatre and Cancer* (2019), where he suggests that it is inside a 'political/relational model of understanding cancer where a collection of stories that involve people of different race, class and national origins would be critical' (Lobel, 2019:3). Multidimensional, first-person stories provide patients and families with models for processing their experience of breast cancer (Park-Fuller, 1995). Without these, patients can feel isolated. The dominance of 'upbeat' narratives renders invisible more vulnerable accounts of what happens during and after treatment. Despite notable exceptions (e.g., Lorde, *The Cancer Journals*, 1980 and Spence's *Mammogram*, 1982, as discussed in section 2.23), representation of cancer narrative is predominantly produced by white, middle-class, and non-disabled artists (Kafer, 2013). More diverse and inclusive cancer narratives may impact how it is addressed medically, culturally, and aesthetically (Lobel, 2019). An intersectional approach stresses that cancer does not happen in isolation; different lenses inform how people's lives are understood and experienced. This project falls in the intersection between (auto)biographical performance and medical humanities. To further explore how performance can translate and represent complex and traumatic experiences, I now turn to the dramaturgical styles of post-verbatim and postdramatic theatre. These forms, with their emphasis on fragmentation, multiplicity, and affect, offer a compelling framework for staging the emotional intricacies of illness.

2.4.1 Post-Verbatim Theatre

Central to this research will be the development of a verbatim play, using data gathered through community-engaged methods to authentically represent the lived experiences of those affected by cancer. Verbatim theatre, first defined by Derek Paget in 1987, in his article, *'Verbatim Theatre': Oral History and Documentary Techniques* (Paget, 1987), is rooted in the transcription of lived experience and traditionally centres the voices of ordinary people. It expands autobiographical performance by bringing multiple perspectives to the stage, often within the framework of documentary theatre. While its origins lie in post WW2 interest in lived experience and political activism, contemporary approaches, such as those outlined by Peters and Burton (2024) and discussed in

Chapter Three, emphasise collaboration, ethics, and community engagement.

This project will use verbatim methods to challenge dominant narratives and foreground intersectional, inclusive perspectives on illness. Though the play will draw directly from participants' spoken words, it will also be inspired by post-verbatim thinking (Radosavljević, 2023), as a key consideration in its development will be how theatrical form- through sound, movement, and fragmentation- can heighten emotional resonance and offer new ways of engaging with trauma beyond language alone.

Post-verbatim theatre, like postdramatic theatre, moves away from linear storytelling and the primacy of text. Postdramatic theatre, as theorised by Hans-Thies Lehmann (1999), prioritises image, sound, space, and embodiment over plot and character development, whilst post-verbatim theatre also questions the authority and rigidity of testimonial truth, embracing fragmentation, multiplicity, and creative interpretation- an approach particularly suited to representing trauma, which often resists coherent narration. As Linsley and Walsh (2012) note, 'many written accounts of trauma are prefaced by the assertion that language cannot adequately describe the experience' (Linsley and Walsh, 2012). Creating space for non-verbal and sensory expression allows participants to share their experiences without the pressure of linguistic clarity.

Lehmann's framework of postdramatic theatre reflects a broader cultural shift from a text-based society to one dominated by image and sound, where meaning emerges through sensory engagement rather than traditional storytelling (Lehmann, 1999). This perspective informs Radosavljević's concept of the 'post-verbatim shift', an artist-led transformation of practice that embraces multiplicity, fragmentation, and creative interpretation to deepen audience engagement and expand the possibilities of testimonial theatre.

In their volume, *Performing Psychologies: Imagination, Creativity and Dramas of the Mind,* Nicola Shaughnessy and Philip Barnard (2019) explore performance's ability to deepen our understanding of psychological states and challenge societal perceptions of mental health and neurodiversity. The volume brings together psychologists, therapists, performance scholars, and healthcare professionals to examine how performance in both traditional and community settings can serve

as a cognitive and affective medium to reimagine how psychologies are performed, and how performance itself can become a transformative tool for empathy, healing, and insight. Shaughnessy and Barnard (2019) emphasise the 'complexities of the human mind' and 'the potential of performance to translate cognitive distress' (28).

Drawing on Lehmann's assertion that 'dramatic theatre proclaims wholeness as the model of the real' (Lehmann, 1999:6), they argue that this model collapses when fragmentation and dissonance become the dominant aesthetic in certain conditions. They explore how modes of 'postdramatic' performance 'offer visceral, non-linear and discordant spaces for exploring dis/embodied minds and emotions' in the processing of trauma or change (Shaughnessy and Barnard, 2019:28). Although Shaughnessy and Barnard do not explicitly use the term post-verbatim (nor do they directly address cancer- their focus is on performance's capacity to translate psychological cognition), it is implicit in their description of the form as a means of expressing the ineffable and aligns with the concerns of this thesis. This project extends their enquiry to explore how theatre can translate the multifaceted and disruptive impact of breast cancer on a person's psychological and practical wellbeing. It considers how this complexity might be addressed through techniques that resonate with post-verbatim theatre, methods that, while not explicitly named as such by the authors, are evident throughout their work. I will now turn my attention to the field of medical performance, situated within the broader discipline of medical humanities, where the work of Shaughnessy and Barnard is positioned, and where mine also aims to be located.

2.4.2 Medical and Cancer Performance

Alex Mermikides traces the term 'medical performance' to the final essay in Philip Auslander's *Postmodern Theatre* (1997) and Petra Kuppers' *The Scar of Visibility* (2007), and later expands on it in her own book *Performance, Medicine and the Human* (2020). She argues that performance offers a radical and interrogative lens through which to rethink the lived experience of illness and medical encounters, suggesting that the convergence of performance and medicine in the early twenty-first century warrants recognition as a distinct strand of practice.

This evolving landscape now encompasses a wide range of forms, from

documentary, verbatim, and autobiographical representations of illness, to body art involving medical technologies, theatre-based medical education, and applied theatre in clinical settings. In *Performance, Medicine and the Human* (2020), Mermikides explores how theatrical performance can illuminate, challenge, and reframe our understanding of medical experience and human identity. Drawing on posthumanist theory and autobiographical material, she examines how embodied performance can express the fragmented, relational nature of the self in medical contexts. Challenging dominant biomedical narratives that often reduce the human body to a clinical concept, Mermikides proposes that theatre's semiotic power can convey the complexity of lived experience, suffering, and care, suggesting that 'medical performance can involve a relationality, mutuality and interdependence across medicine and performance that manifests the very notion of "entanglement"' (Mermikides, 2020:167).

Mermikides references Angela Woods and Anne Whitehead's call for a 'more 'intertwined' and 'entangled' relationship between medicine and the humanities' (2016:110) in their introduction to *The Edinburgh Companion to the Critical Medical Humanities* (2016), extending beyond the binaries that underpinned the first wave of medical humanities (patient/doctor, illness/disease, medicine/humanities). Instead, they advocate for qualities of 'mobility, fluidity, movement: a creative boundary-crossing in and through which new possibilities can emerge' (2016: 8). Through interdisciplinary analysis, Mermikides positions performance as a vital tool for reimagining the ethics and aesthetics of medicine. My research is central to this landscape, engaging with (auto)biographical storytelling through documentary and post-verbatim theatre to interrogate dominant narratives surrounding illness and patient experience. I propose a dramaturgical approach that foregrounds a multitude of experiences and embraces participant-led creative outputs, portraying a polyglossia of representations.

In *Theatre and Cancer* (2019), Lobel proposes that cancer performance should be recognised as its own genre, shaped by the unique attributes of the disease and the artists who engage with the condition. While acknowledging overlaps with disability and illness performance, Lobel highlights cancer's particular dramaturgy, marked by rupture, uncertainty, and embodied transformation.

Lobel explores the experience of diagnosis as a personal precedent, a gap in time after which an individual's overall understanding of the world is shifted; he suggests that diagnosis can, as Frank (1995) describes it, cause a 'narrative wreckage' to one's life, leaving an immediate feeling of 'otherness' (Lobel, 2019). This disrupts the narrative of life and sense of self. When something unexpected happens, such as illness, the scripts need rewriting, and 'the shock of the experience can be partly absorbed by the telling of a new story' (Lobel,2019:9). Through the work of Kimmings, Sprinkle and Stephens, Spence, and his own autobiographical practice (which I return to later in this Chapter), Lobel explores how artists with lived experience of cancer navigate this narrative void. He considers what is at stake when language fails, and how performance can offer a space to rehearse, rewrite, and reclaim stories that illness has disrupted.

According to Lobel, there are universal characteristics which set cancer performance apart from other performances. He suggests that the one-in-two odds of getting cancer in a lifetime makes the audience an active participant. There are 'no dispassionate or disinterested makers or audiences' (Lobel, 2019:1) in this context. Theatre, when about cancer, leaves the spectator reflecting on how cancer could affect or has affected their lives. These sensitivities around the subject could account for the lack of disruptive cancer narratives available. Lobel identifies a gap in existing scholarship, supported by Neilsen (2019) and Williams and Solbrække (2018), arguing that a collection of stories involving intersections of people from diverse cultural backgrounds is essential to broaden the sociopolitical understanding of the disease. While he acknowledges this need, however, his work stops short of addressing it directly. Building on the foundations laid by Lobel, this project takes up his suggestion by developing a multiplicity of intersectional, multicultural, and multidimensional narratives of lived experience on stage. Following Lobel, it also interrogates dominant narratives through acts of disruption, targeting not only the narratives themselves but also engaging experimentally with theatre's semiotic artifice and its potential to translate embodied experience in resonant and affective ways. I now turn my attention to existing performance work that resists the survivor narrative, in favour of a more inclusive representation.

2.4.3 Existing 'Cancer Performance'

In this section, I examine existing performances that engage with cancer, situating my own practice within this emerging field. Following Lobel's suggestion that cancer should be recognised as its own genre of performance, I refer to such work as 'cancer performance' (Lobel, 2019). Through a review and analysis of selected examples, I will contextualise my research and highlight the need for broader, more diverse representations of the disease. Having reviewed the field of contemporary performance in the English-speaking world, I have found that it includes very few plays that address cancer, and even fewer that specifically engage with breast cancer. This literature review is not intended to be exhaustive; rather, it reflects a subjective selection of works that I consider particularly relevant to the development of my own practice. I have identified five artists and their performances that are particularly valuable for their disruption of dominant narratives- both in content and in the theatrical strategies they employ, which align with the aims of my own work. They are also the artists and performances that resonated most deeply with me, either during my own experience of breast cancer or in navigating its aftermath as part of my recovery. As such, they became the impetus for this project, inspiring me to explore the extent to which theatre and performance can have an impact beyond the stage. While this focus necessarily excludes other significant contributions, such exclusions are beyond the scope of this thesis. A limitation of this research is that I was unable to experience all these performances in the same way. I attended *Rebel Boob* in person, but ideally, would have seen each work live. I have, however, engaged with all available materials (such as recordings, scripts, reviews, and artist reflections) to gain insight into the form, content, and substance of each piece. The nature of my engagement is outlined in each reflection.

Despite growing interest in illness narratives, there remains a notable absence of alternative perspectives in cancer performance (Park Fuller, 1995; Lobel, 2019; Kimmings, 2017; Mermikides, 2020). There is a pressing need for such narratives to bring cancer into dialogue with 'every other illness, disability and non-normative experience' (Lobel, 2019:21). The five works discussed here attempt to confront normative frameworks by embracing and representing the raw, complex, and often disruptive lived experience of cancer. In doing so, they

demonstrate the potential of theatre as a medium for facilitating meaningful dialogue around illness.

2.4.3.1 A Pacifist's Guide to the War on Cancer

My first encounter with cancer performance came just months after my own diagnosis, through the playscript and recordings of *A Pacifist's Guide to the War on Cancer* (2020). The production, which was a musical, was created by Bryony Kimmings in collaboration with Complicité Associates, The National Theatre, and Lobel, stemmed from a conversation between Kimmings and Judith Dimant, then Producer at Complicité. During a meeting about future projects, Dimant disclosed her recent breast cancer diagnosis. Kimmings immediately proposed creating a piece of theatre around the subject (Kimmings, Lobel and Parkinson, 2016).

From the outset, Dimant was clear that she did not want the production to represent her personal story directly (Cooke, 2020). Instead, she envisioned her experience as a catalyst for a broader, more universal exploration. The aim was to examine the lived realities of cancer- not just the disease itself, but the emotional, social, and systemic experiences that surround it. This included challenging dominant narratives perpetuated by charity campaigns and Hollywood portrayals, which she found frustrating and reductive as a patient (National Theatre, 2022). The production sought to reflect the difficult and disruptive realities of people living with and through cancer in everyday life, how it permeates the mundane and influences every decision. The representation on stage of issues such as maintaining relationships, holding down jobs, and navigating the financial implications of cancer is vital, because these challenges are rooted in real-life experience. Yet, the stories we most often hear continue to reinforce a normative, survivor narrative (Kimmings, 2022).

The performance opens with a voice-over from director and writer Kimmings, reflecting on how cancer touches all of us, posing why we don't talk about it more. The performance follows Emma, who is introduced in the first scene: a young single mother to baby Ewan, frantically getting ready for the day, much like any new mum. It captures one day in her interaction with cancer as she faces the possibility of her baby son's diagnosis. The opening number captures the chaos of

her thoughts: rush hour traffic, a guy she fancies who may have swiped left, her baby not sleeping, and cancer. As Emma makes her way to the hospital, we meet the other characters: Gia, Laura, Mark, Stephen, and Shannon as they converge in a hospital waiting room. As Emma sits, the dressing room comes to life with each character reflecting on their situation, their understanding of cancer and an insight as to why they are there. They are then joined on stage by a large, brightly coloured blob, which personifies cancer, and gives an in-depth definition of the disease. This 'blob' remains on stage throughout the performance, eventually to be joined by others. Each time a patient speaks, the rest of the scene freezes, signalling a shift into their internal monologue.

The performance explores themes such as infertility, rare cancers, denial, acceptance, and fear, through characters based on real people. For example, Shannon is inspired by collaborator, Lara Veitch's, story, which is both complex and disruptive. Lara inherited a rare condition called Li-Fraumeni Syndrome (LFS), which carries a high risk of developing multiple cancers. By age 27, she had experienced five. Her mother, grandmother, and great-grandmother all died of cancer, each carrying the same genetic mutation. The play explores Lara's fears about having children, knowing there's a 50% chance of passing on the gene. This is embodied through 18-year-old Shannon, who has just discovered she's pregnant and must make a difficult decision. Kimmings cleverly channels Lara's fears into this fictional narrative, helping the audience grasp the harrowing, complex challenges of the disease.

The play unfolds over a single day in the lives of these patients, capturing moments of diagnosis and transition. Emma interacts with each of them: in group therapy, she learns about Shannon's dilemma; she witnesses Laura's denial as her doctor recommends hospice care, which she resists for the sake of her eight-year-old daughter. Emma overhears Stephen's conversation with his mum about sperm banking, infertility, and the pressure he feels- not just from her, but from the fear of being seen as a cancer patient at work. She also sees Mark's struggle with poverty and Gia's frustration with the relentless positivity, asking, 'Why does it always need to be positive?'

When Emma's baby receives a cancer diagnosis, she is finally admitted into the 'kingdom of the sick'. We watch her unravel as the other characters begin to

confront their own realities. The play ends with a meta-theatrical moment: actors, real cancer patients, and a voice-over from Kimmings converge in a raw, live expression of truth. Each actor mimes as the real person recounts their experience in voice-over, and Kimmings shares her own story, revealing that Emma was, in fact, based on her and her son's illness.

As the performance toured, this moment was extended to include the audience. They were invited to speak aloud the name of someone they had known or lost to cancer. This created a collective act of remembrance: a live memorial that acknowledged the depth of loss present in the room. By resurrecting these ghosts, the performance not only honoured individual grief but also helped the audience situate their own experiences within a broader social understanding of cancer's pervasive impact. It was a moment of communal reflection, underscoring cancer's unique and often unspoken place in our lives.

The performance was disruptive in multiple ways, extending beyond its content into its aesthetic choice, particularly through movement and sound. Kimmings employed a grid onstage, expressed through choreography and lighting, to signify the many different paths cancer patients might take. The grid, a loaded symbol, also evokes the prescribed and regimented nature of cancer treatment, reflecting the structured world of patienthood and medical appointments. These paths led to various doors, each representing a different outcome. As Emma attempts to follow others in her quest for answers, she is repeatedly blocked by the blob, a visual metaphor for cancer. When she finally enters the 'kingdom of the sick', her instinct is to escape. At that moment, the ensemble transforms into a mass that drags and pushes her inward, using movement to embody the overwhelming force of metastasising cancer cells.

Reflecting on the early stages of the creative process, Kimmings says, 'I felt like it had to be a musical; it allows us to speak about the unspeakable' (Kimmings, 2022). This reinforces the idea that spoken language alone is often insufficient to convey profoundly traumatic experiences. While the form differs, this concept aligns with post-verbatim theatre (Radosavljević, 2023; Shaughnessy & Barnard, 2019), discussed earlier in the chapter, and its capacity to articulate the ineffable.

Composer Tom Parkinson, notes in the playscript's introduction that 'cancer has

its own sonic universe' (125) which he sought to explore:

> Harmony is slowly pulled out of a recording of a hospital ventilation system; the pulsing ambience of the waiting room subtly changes key as a scene falls into song; instead of motivic development in traditional terms, cells of rhythmic and melodic material metastasise throughout the show.

(Kimmings, Lobel & Parkinson, 2016:125)

Parkinson's approach demonstrates music's ability to communicate the complex, multi-sensory experience of cancer in an embodied way. His compositions not only reflect the emotional landscape of the disease but also mimic the biological behaviour of cancer cells. Much like in my own work, sound becomes a vehicle for giving tangible form to an experience so deeply complex that words alone could never fully capture it.

The musical form supported the presentation of multiple characters and narratives, allowing audiences to follow individual stories while the ensemble wove in and out, maintaining focus and cohesion. Kimmings deliberately avoided the sentimental tropes often seen in mainstream media, which typically centre on middle-aged, middle-class, non-disabled individuals who either survive treatment or die- both framed as heroic or inspirational. Instead, she explored the nuanced realities that exist between these extremes. In discussing the writing process, Lobel challenges the notion that 'cancer is a gift', calling it a fallacy. He highlights that, in many countries, access to treatment is financially inaccessible, and lives often begin to unravel before treatment even starts (Lobel, 2022), suggesting that the gift trope is in fact born from a place of relative privilege.

This work offers a comprehensive portrayal of disruptive and complex cancer narratives, reflecting the depth of care and research invested over the course of a year. The real-life collaborations, made explicit at the end of the performance, lend authenticity and emotional weight to the multidimensional and intersectional representations that were present on stage. Kimmings and Lobel were clearly intentional in crafting diverse and inclusive depictions of those living with the disease. While the play addresses cancer broadly rather than focusing on breast cancer specifically, it has had a significant impact on my own research. Early in

my experience, it demonstrated how aesthetics- but particularly sound- can deepen a multifaceted understanding of traumatic experiences, and how absurdity and humour can broaden the spectator's perspective. My work, however, will differ in its development: it is not a musical, nor is it designed for a large-scale audience. Instead, it centres on participatory theatre, which will shape many of the creative decisions and outcomes of the project.

2.4.3.2 Ball by Brian Lobel

Lobel previously created an autobiographical performance based on his first-hand encounter with testicular cancer at the age of 20. His one-man play, *Ball* (2008), which I accessed through recordings and the playscript, drew attention for its controversial humour- a style not typically associated with cancer narratives. Park-Fuller described it as 'a refreshingly new perspective' (Park-Fuller, 2008). Humour, however, served as a powerful technique for Lobel to critique the hyper-masculinity and heteronormativity he observed in portrayals of testicular cancer, particularly in role models such as Lance Armstrong. The play also addresses disruptive themes including infertility, survivorship, sexuality, recurrence, and the pressure to embody a heroic figure.

Ball opens with 'Eye of the Tiger', a deliberate parody of the hyper-masculine, heroic fighter metaphors often surrounding cancer, and discussed previously in this chapter, using the iconic *Rocky* theme tune- a film about a fighter. The music abruptly stops, leaving Lobel alone on stage, responding to a doctor. When he notices the audience, he introduces himself and his 'ball' in a conversational tone, sharing his cancer story through anecdotes, reflections, and commentary. Lobel describes his one-man show as 'the perfect metaphor for being sick: one body on stage, isolated and vulnerable' (Lobel, 2019:11).

What initially appears lighthearted soon becomes a powerful insight into the enduring struggle of a young man who is terrified, isolated, and confused. Lobel recounts his diagnosis at age 20, first in disbelief, then with the sudden realisation that he was being treated as a priority, which, for a cancer patient, is rarely a good sign. The disease had spread to his abdomen and lungs. He then walks the audience through his overwhelming experience at the sperm bank. He describes the discomfort of this hyper-sexualised environment from the perspective of a

young, gay, and sexually inactive man and how he ‘felt like he had been transported into some low budget homemade fetish porn’ (Lobel,2012:45), with soft lighting, loads of *Playboy* magazines which had pages ripped out and one huge masculine leather chair.

Lobel endures this, only to discover that he is, in fact, infertile. He addresses this grave issue with humour, speaking of HIV tests and the vulnerability of feeling as though everyone knew he was ‘a big gay virgin’ (Lobel,2012:43). At one point, Lobel hops around the stage screaming ‘VIRGIN, VIRGIN, VIRGIN!’ (ibid), a moment that pokes fun at the insecurities and conversations typical for a 20-year-old man, reminding us that he is, above all, just that. This moment provokes laughter, even amid the trauma, because it humanises Lobel and grounds his experience in youthful vulnerability.

Then comes what Lobel himself calls ‘the dark section’ (Lobel,2012:55), a part he initially wanted to leave out but was encouraged to include. It covers the recurrence of his cancer and the earth-shattering news that, after all he had endured, it had returned. He takes us through another deeply traumatic operation, followed by a stem cell transplant, culminating in an email projected over Destiny’s Child’s ‘I’m a Survivor’, in which he declares to the group email: ‘I am a survivor’ (Lobel, 2012:64).

He re-enters dressed in bicycle shorts and a Lance Armstrong cycling top, once again nodding to the pressure he felt to embody the masculine hero. This section, which leads to the end of the performance, addresses Lobel’s struggle with the role of ‘survivor’. He continues to use humour as he recounts attending a stem cell transplant reunion picnic, where he takes part in a hula hoop contest designed for children. He describes competing against eight nine-year-old girls, determined to win. On stage, Lobel transforms into a sporting hero, comparing himself to Lance Armstrong and declaring, ‘I need to be a hero. A role model. A survivor!’ (Lobel, 2012:66) as he spins the hula hoop while speaking about all he has endured and the love and support he received, frequently interrupting himself with ‘Come on Brian, focus. Don’t think about that’ (67) only to get carried away again in overwhelming thoughts, and then interrupt himself once more. Eventually, the hoop falls. This moment demonstrates that cancer does not end when treatment ends. In many ways, it marks the beginning of

processing everything that has happened. Up to this point, Brian has kept going, kept moving, kept talking, almost like an endurance piece- much like the patient during treatment. But only when it is all over is there space to think- this is when it hits us, when the metaphorical hoop falls.

In this moment, Lobel appears deflated and shouts, 'I did not realise this was a life sentence' (Lobel,2012:69). He speaks of the constant resistance between wanting to let go and feeling the need to prove himself. We watch him struggle until the hoop finally drops- and he lets go. An image of Lobel is then projected on screen: thin, extremely pale, and visibly sick, yet looking determined to win. This image is a harrowing reminder that, beneath the playful laughter, this man has truly endured an ordeal. In that moment, when he had nothing left, he was still striving to become what he thought a survivor should be- demonstrating the unhealthy pressure that the survivor narrative can impose. In the end, he lets go, and we learn, in a tragic yet humorous twist, that he actually won the competition by default because the little girl forgot to clap. We see him celebrate. Then, blackout.

Ball is disruptive in both its language and the theatrical techniques used to communicate the cancer experience on stage. Lobel's use of aesthetics- through music, lighting, and costume- is particularly effective in creating a multisensory experience that provokes the audience to consider illness from multiple perspectives. For example, when Lobel discusses his stem cell transplant, he stages a fashion show with loud music ('Sex Bomb' plays) and moving lights, recalling a particularly difficult part of his experience through farcical parody. He exits the stage and then re-enters wearing pyjamas with red hearts and plastic tubes taped to his bare chest. Lobel walks like a model, with exaggerated movements and his head held high. A voiceover announces: 'Central line double lumen catheters, centimetre-thick tubes protruding from my upper right boobal region', as he refers to the collection as part of the 'Cancer Chic clothing line' (Lobel,2012:63).

By juxtaposing tragic descriptions, such as 'walking down the sterile hospital corridor attached to your monitor' or 'sleeping after taking your twenty to thirty pills daily', with the phrase 'Ooh, sexy' (Lobel,2012:64), Lobel not only hints at the heightened, delirious, and fragmented experience induced by medication, but

also demonstrates his immersion in this world. When something becomes your reality- and indeed your normality- humour can become a vital coping mechanism. At times, it may be the only thing left when you are pushed to your limit.

It also seems at times that Lobel attempts to transfer his own experience of discomfort under the medical gaze onto the audience. This is particularly evident when he talks of the discomfort he suspects they feel, professing his aim to give it a 'forum'. This leads to a conversation about masturbation, before asking them to join him to check their genitals or breasts. He turns off the lights, starts to read the self-check exam instructions, and then shouting 'gotcha', abruptly switches them back on, as if catching them in the act. Perhaps this is his way of communicating the humiliation he struggled to articulate in his own experience, through words. There is also a childishness to this joke, which accentuates Lobel's youth.

Lobel's performance is shocking, funny, and heartbreaking all at once. The final scene culminates in the realisation that his declaration of being 'a survivor' was only the beginning of what he calls 'a life sentence' (Lobel,2012:69), illustrating the biographical disruption discussed in the introduction to this thesis, and the liminal state in which he remains. As my own work aims to address, cancer infiltrates every part of life and is far from the neatly packaged experience often portrayed in dominant narratives. Lobel's autobiographical performance cleverly demonstrates this by using playful humour to expose deeper issues. He contextualises his individual story, highlighting what is unique to a 20-year-old gay man struggling not only with a cancer diagnosis, but also with the broader challenges of identity, sexuality, and youth. In doing so, he locates these intersecting experiences within their own distinct cancer narrative.

2.4.3.3 Titillation by Emily Underwood-Lee

Emily Underwood-Lee (2010) also uses humour to resist and disrupt the survivor narrative associated with breast cancer in her performances, *Titillation* (2010) and *Titillation Grade 3* (2014), which offer vital contributions to feminist autobiographical performance, particularly in the context of breast cancer narratives. Born from her own lived experience of breast cancer, a double mastectomy, and a BRCA1 diagnosis, *Titillation* marks a transitional moment in

Underwood-Lee's practice- shifting from the trauma focus of her earlier work (*Patience*, 2009) toward a more reflective and playful embodied engagement with illness.

Patience documents her experience of receiving a diagnosis while pregnant, again highlighting the complex, multifaceted experience of the disease: life does not stop because you get cancer. *Patience* traces the unimaginable decisions she faced: determining how early it would be safest to deliver the baby to begin chemotherapy, whether to compromise the baby's health to prioritise surgery, and whether to start treatment to protect herself. The performance raises questions about love, death, motherhood, and illness. It is staged simply, with only a chair and table, accompanied by a film projection of medicalised images- scans, surgical documentation, and footage of her daughter's birth- intercut with slow-motion scenes of Underwood-Lee playing with her daughter in a park. These scenes are artificially saturated with colour, which she describes as an attempt to evoke the 'idealised images of maternal life found in adverts for baby milk, nappies, and other products aimed at new parents'. Typically performed as an installation, Lena Šimić observes that *Patience* 'is slow, very slow, and oftentimes silent', suggesting that 'it doesn't explode; it silently demands my attention' (Underwood-Lee, Šimić, 2019:133).

Titillation, by contrast, actively demands attention. It confronts the politics of visibility and objectification, placing the cancer-marked body centre stage and challenging audience discomfort. The performance opens with Underwood-Lee dressed in a hospital gown and heavy makeup. As she leads the audience into a room decorated in a sparkly, burlesque-style set, she begins to dance seductively, telling them she will dance and take her clothes off. She then speaks into the microphone, recounting how she learned what it means to be a woman:

> 3.I wanted to be a ballerina
>
> 5.I watched her leave for a night at the theatre. She wore an electric blue dress, a blue broach, and a blue clip in her hair that sparkled brighter than sapphires.
>
> (...)
>
> 17. I had my tiny waist and fantastic tits, and I seduced a rockstar.

> 19. I thought I could conquer the world. This is how I learned to be a woman. (Underwood-Lee, 2024)

She returns to this style at the end of the play, stating:

> 30. I got the first scars and lost my hair.
>
> 31. The left breast went.
>
> 32. The right breast went as well.
>
> 37. My ovaries are next on the list. This is how I forgot to be a woman. (Underwood-Lee, 2024)

These two sections frame a comical yet disturbing performance in which Underwood-Lee uses seductive dancing that gradually becomes less sensual and more clown-like. Her facial expressions grow exaggerated, her eyes widen, and she adopts a manic persona, suggesting perhaps how one feels as their body becomes less recognisable, or indeed the absurdity of viewing the cancer-marked body through a lens of sexualised femininity. Simultaneously, the performance critiques the persistent objectification of women's bodies, even in the context of illness. The juxtaposition of learning and forgetting how to be a woman foregrounds the political dimensions of female embodiment. These numbered phrases present a more sinister tone, acknowledging that when our bodies no longer fit that script we feel like less of a woman. This is further emphasised through her nostalgic reflection on a teenage crush on Patrick Swayze and the hopes she once held, underscoring the tension between youthful aspiration and the realities of illness and bodily transformation.

The performance was developed further for *Titillation Grade 3*, as part of the Fem Fresh programme, and extends this inquiry through burlesque inspired techniques, prosthesis puppetry, and edible jelly breasts, using humour further to dismantle dominant narratives of heroism and sentimentality often associated with breast cancer. Underwood-Lee's work interrogates the cultural framing of illness, considering the scarred body and whether it should remain hidden or be seen and celebrated. These performances offer an alternative mode of translating embodied experience and articulating the ineffable. By intersecting the realism of lived experience with burlesque and absurdity, Underwood-Lee challenges conventional expectations of female sexuality and illness, refusing to conform to

the passive role of the patient. While not participatory in structure, and focused only on Underwood-Lee's experience, their emphasis on lived experience, disruption, and feminist critique informs the dramaturgical and ethical foundations of this thesis, which seeks to explore similarly complex representations of illness on stage.

Interestingly, both Lobel and Underwood-Lee found that the most appropriate way to translate their personal account of such traumatic, life-altering moments was through humour. Just as Kimmings considered music a way to communicate the ineffable, here humour provides a pathway to explore the absurd, to destabilise the audience and engage deeper political issues. Lobal discusses the discomfort often felt at the idea of humour, when about cancer, in his book *Theatre and Cancer* (2019), whilst acknowledging its ability to provide the spectator with a uniquely human perspective. He suggests the audience laugh with a 'palpable discomfort,' unsure whether they should or not. Often, the addition of humour disrupts the audience's expectation. This is important because it could foster connection and identification for those who have lived through the disease, while forcing others to recognise that, amidst trauma, cancer survivors are still human, with multifaceted lives and personalities.

An alternative perspective can often have a deeper impact on those who engage with it, as it challenges the dominant, linear cancer narratives we are so frequently exposed to. The shock of this alternative form can often invite the spectator to think and feel in new ways, prompting new questions. Moreover, such an intense subject often warrants moments of reprieve: spaces where the emotional weight of illness can be held differently. Lobel draws on Jean-François Lyotard's (1984) concept of the 'incommensurable' (Lobel, 2019:28), which refers to experiences that resist dominant cultural frameworks. He uses this idea to argue that lived cancer experiences often defy linear, sentimental storytelling and instead, by their very nature, demand fragmented and disruptive dramaturgies, which Lobel suggests 'that traditional narrative structures' (28) often struggle to present. Lobel explores what is at stake when the artist/patient does not yet possess the language to communicate such traumatic life events (diagnosis, grief, feeling lonely), and how these complex issues can shape theatrical form (Lobel, 2019).

It could be argued that both Lobel and Underwood-Lee allow for multiple ways of exploring, experimenting with, and expressing embodied experience in relation to, and in response to, the body that has undergone illness. When words fail to communicate the depth and fragmented nature of trauma, theatre offers a space to explore new possibilities through varied performance lenses, including humour, movement, installation, documentation, song, and multimedia. Live performance is immediate and responsive, empowering the performer to translate their story and speak back to an audience through whatever theatrical form best serves their experience. Indeed, humour reflects the lived reality of cancer. Having or having had cancer does not negate a person's capacity for silliness, laughter, or joy.

2.4.3.4 A Clean Breast of it, Linda Park- Fuller

Park-Fuller's *A Clean Breast of It* (1995) tells the story of her lived, autobiographical experience with breast cancer. Although I was unable to see the work live, I engaged with a version of the script (as the dialogue was improvised but structured through various techniques, making each performance unique) and Park-Fuller's own written reflections on the piece. Inspired by performances about the lived experience of HIV and AIDS, Park-Fuller recognised the power of personal narrative and felt compelled to share her story- challenging the dominant 'diagnosis-suffering-death' narrative she had previously assumed to be typical. She was driven to seek out others who had lived through and beyond cancer, sharing her experience in church halls, hospitals, universities, and any space that would offer her a platform (Park-Fuller, 1995).

The performance opens with a playful exchange in which Fuller asks for the lights to be turned up so she can see her audience and ensure they are paying attention. She maintains this conversational tone throughout, within a performance space divided into three areas: downstage right represents the doctor's office, hospital bed, and recovery room; centre stage features a table with a tablecloth and flowers, positioned beside an electronic timer and a glass of water; and to the left sits a black chair and a guitar. Her conversational style is interwoven with song and poetry, statistical information, and occasional digressions into politics, treatment options, and breast cancer research.

She recounts her experience with cancer, from diagnosis to the anger she felt

during chemotherapy, and the guilt she experienced upon seeing a small boy enter without complaint. She speaks of infertility, hair loss, and the profound, unexpected grief these caused- grief that, for her, surpassed even the loss of her breast. She also discusses weight gain, loss of identity, and the harrowing reality of her house burning down just as she was beginning to recover. These moments underscore the idea that, despite the linear and all-consuming narrative often portrayed in survivor stories, life does not pause for cancer.

Park-Fuller describes the aesthetic challenges of composing a story that was engaging and informative,while avoiding predictability. Her aim was to find closure through performance. In her essay 'Narration and Narratization of a Cancer Story: Composing and Performing "A Clean Breast of It"' (1995), however, she admits to feeling fear about how the work might affect both herself and her audience, especially in the event of a recurrence. To address this, she chose to improvise rather than write a fixed script, committing instead to a verbal framework that could evolve across performances. This open-ended approach allowed her to remain responsive to her changing experience.

Park-Fuller used questions as a structural device to maintain focus during performance and to connect with her audience. She describes the challenge she faced in the early stages of developing the play, knowing that she would be performing for young adults and teenage students. Her goal was to make relevant what many considered 'an old woman's disease' (217). Park-Fuller recalls asking, 'How do you make love to a woman with one breast?' This question allowed the audience, particularly those who viewed themselves as risk-free, to grasp the profound ways breast cancer can affect every aspect of a person's life. She also found that framing her questions politically, addressing issues such as drug costs and accessibility, encouraged the audience to look beyond her personal story and consider the broader social and economic dimensions of the disease.

One technique which had a profoundly disruptive impact was Park-Fuller's use of a timer, which went off every 13 minutes throughout the performance to signify how often someone died of breast cancer in the U.S. at that time. This device was aesthetically powerful, viscerally reflecting not only the pervasive nature of the disease, by demonstrating its relentless impact, but also the biographical disruption caused by a cancer diagnosis. Park-Fuller reflects that cancer forced

her ‘to stop, reevaluate, and revise’ her life, and so the sounding of the timer compelled her to stop and revise her performance.

Like the timer, cancer is not polite or considerate of what’s happening in your life- it arrives uninvited, amid whatever else is going on. It disrupts not only your daily routine but also your sense of self and the narrative of your life. The timer’s unexpected interruptions mirrored this intrusion: regardless of where Park-Fuller was in the story, each time it sounded, she had to stop, turn it off, and then continue. This act embodied the way cancer disrupts, interrupts, and intrudes; we must confront it and somehow find a way to carry on.

Moreover, the timer served to resist the survivor narrative by placing those who did not survive in the present. Every 13 minutes, the audience was reminded that someone else’s story had ended- someone who would never get the chance to tell it. This disrupted the conventional survivor narrative by representing those who did not survive within the same framework as Park-Fuller’s own story, challenging the linear and triumphant arc often found in traditional cancer narratives.

These techniques helped Park-Fuller become more comfortable with the fluidity of both her lived and performed experience of breast cancer. Rather than framing her story as one of loss or triumph, she positioned it as part of an ongoing healing process. Her concern with being too personal could be seen to contradict the form she adopted. Autobiographical performance, rooted in the second-wave feminist movement, was a means for women to make visible their previously invisible lives, resisting marginalisation and asserting agency through self-representation (Heddon, 2008). Both the structured use of educational questions and the timer, however, served to make visible the political, that is, the contextual, systemic factors that shape and inform lived, first-hand experiences. Furthermore, Park-Fuller’s concern for the audiences’ wellbeing is crucial, as she centres care not only for herself but for her audience. By building a space for reflection and emotional reprieve, Park-Fuller models an ethical approach to autobiographical storytelling. This is a vital consideration for my own practice research: how to engage ethically with my audience, collaborators, and self.

A Clean Breast of It emerged from a drive to educate, provoke thought, and perform as a way of challenging the silence that often surrounds breast cancer. It

aimed to confront medical narratives that prioritise clinical, abstract knowledge over the lived experiences and personal stories of those affected by the disease. Like my own work aims to do, Park-Fuller presented the disruptive experience of the disease and actively resisted the conventional survivor narrative by adopting aesthetic techniques that acknowledged the stories of those who did not survive.

2.4.3.5 Rebel Boob by Angela El-Zeind

Angela El-Zeind's *Rebel Boob* (2022) is a performance that centres the lived experiences of multiple women affected by breast cancer. I had the privilege of attending the performance in person in 2022 and participating in the post-show Q&A session. The piece resonated deeply with me, both as a performance maker and as someone who had recently experienced breast cancer. Drawing on her own encounter with the disease, as well as interviews with women in recovery, El-Zeind developed a performance that explores topics often left unspoken in mainstream discourse (Pink Ribbon Foundation, 2025).

The production was staged in a simple, black box theatre, with a white screen and three cubes used throughout to represent various objects from seating to a dance partner. The performance begins with three white, middle aged female actors on stage, who embody a multitude of women through a collage of verbatim voices. One performer moves to choreographed dance throughout the piece, underscoring the spoken language and intensifying the embodied understanding of the internal feelings that accompanied the stories.

Dressed in black, the performers represent multiple anonymous characters through a collage of stories exploring disruptive themes such as diagnosis, body image and intimacy after cancer, hair loss, blame, the psychological side effects of medication, and the role of support. Fighter metaphors are also challenged, as the women express rage toward such language, asking, 'If I am a fighter, does that mean those women who lost their battle didn't try hard enough?' The piece is fast-paced, with each woman darting around the stage, weaving in and out of a multitude of narratives with varying tones and contexts. The actors become vessels for conveying diverse experiences. A powerful moment sees a woman discuss the challenges in her marriage, her need for intimacy, and her husband's inability to talk about it. The scenes range from humorous to heartbreaking,

including a comical musical number where different names for breasts are projected on the white screen. The collage format effectively conveys both the diversity and universality of the disease.

Rebel Boob introduced me to a post-verbatim 'cancer performance' and prompted me to consider theatrical form itself as a disruptive tool. This shift in thinking aligns with broader methodological and aesthetic frameworks that challenge traditional modes of representation. Norman Denzin's concept of the 'postmodern interview', as outlined in *Interpretive Ethnography* (1997), offers a useful lens for understanding El-Zeind's dramaturgical choices. Denzin attributes this method to Anna Deavere Smith's work, which expands qualitative theatre research through collage, montage, and the disruption of linearity. Duška Radosavljević (2023) further describes the postmodern interview as a dramaturgical approach in which 'points of view and style collide, switch back and forth, [and] commingle' to produce 'an emotional, gestalt effect' (2023: 87).

The emotional, fragmented approach of *Rebel Boob* was demonstrated further in choreographer Katie Dale-Everett's use of movement and dance, which added depth to the performance by expressing what words alone could not. The ongoing staccato-style dance movements created a rhythmic beat, giving the piece a sense of urgency- reflecting the panic and intensity of the cancer experience. These embodied gestures, like her standing behind an actor whilst they described intimacy issues with a partner, shifted the texture of the piece, creating a layered encounter between performer and spectator. Dale-Everett's movements grounded the audience in multiple understandings of that experience. Rhythm and repetition further heightened this effect, allowing the audience not only to observe and hear but also to feel the emotional weight of the narratives. This was particularly effective when a story of treatment burden was accompanied by Dale-Everett's physical expression as well as the beat of the music. These techniques resonate with the post-verbatim ethos, where the emphasis shifts from realism and representation- typical of verbatim theatre- to style and embodiment, using aesthetics to heighten emotional resonance beyond language alone.

The use of multimedia in *Rebel Boob* is another example of the post-verbatim shift that Radosavljević (2023) identifies. The play weaves together sound, movement,

and dialogue to portray the turmoil experienced by the participants represented on stage. At times, these theatrical devices come together and at others, they clash, signifying the internal conflict so prevalent in traumatic experiences. One moment features a soundscape of El-Zeind's oncologist discussing her diagnosis. This sobering addition disrupts the established format: until that point, the play had followed a structure of three actors presenting a collage of words, movement, and music. The introduction of a male, medicalised voice starkly reminds the audience that this is real life. El-Zeind reflects that her decision to use the oncologist's voice only once was intentional, as she did not want to medicalise the performance (El-Zeind, 2021).

Whilst this play shares similarities with the intentions behind my own work, particularly in its participatory nature and use of interviews with lived experience, it differs in the depth of its enquiry. The collage form is powerful in its ability to offer broad engagement with a plethora of narratives, which weave in and out of one another, building momentum as the performance progresses. It can, however, limit the potential to unpack the layers of experience that a character might explore across a whole life. Specific issues are often touched upon briefly, with lines coming and going quickly. And while the gestalt form creates momentum, it doesn't always allow for the depth needed to fully grasp the complexities of each experience.

In contrast, my project seeks to examine the multidimensional and biographical disruption that unfolds through these experiences. For the spectator, who has not lived through illness and treatment, the collage format may suffice- they may not want or need to understand more. However, my work aims to delve deeper into the embodied realities of lived experience through co-created theatre with a participatory group made up of and for those affected by this disease. While I welcome a wider audience, my targeted spectator includes those seeking agency for change in their relationship with the disease, whether they are individuals with lived experience or professionals working in medical and charitable organisations that support them.

While *Rebel Boob* challenges dominant survivor narratives that portray recovery as a linear journey, it was performed by three middlle aged, heterosexual, able-bodied white women (information which was made clear in the post-

performance Q&A). My project seeks to build on this work by presenting more diverse and inclusive cancer narratives that can influence how the disease is understood medically, culturally, and aesthetically. An intersectional approach foregrounds the reality that cancer does not happen in isolation; multiple lenses shape how people's lives are experienced and interpreted. Furthermore, the depth required to explore the complexity of biographical disruption may not be fully achievable through a collage of voices alone. These creative decisions, however, will be made collaboratively with the research participants involved.

2.5 Conclusion

This literature review has mapped the cultural terrain of breast cancer narratives since the 1980s, from the shame challenged by Sontag to the dominant discourse of the survivor narrative, which was framed by positivity- and critiqued by Ehrenreich- to the emergence of disruptive, complex counter-narratives. Scholars and artists such as Sontag, Mukherjee, Nielsen, Spence, Lobel, and Park-Fuller have paved the way for resisting the silencing effects of shame and the limitations of positive discourse. Drawing on theoretical frameworks from medical humanities, feminist theory, theatre studies and existing performance, this chapter has positioned theatre, specifically postdramatic and post-verbatim forms, as a powerful site of resistance. These approaches have the potential to engage lived experience, challenge oppressive norms, and create space for collaborative, emotionally complex storytelling.

Drawing on the work of scholars such as Mermikides, Lobel, Shaughnessy, and Barnard, the review has considered how theatrical approaches rooted in autobiographical enquiry and non-linear dramaturgy can challenge dominant narratives and emphasise the essential role of lived experience. These methods not only disrupt conventional representations of illness but also create space for emotional nuance, intersectionality, multiplicity, and embodied storytelling. By situating this thesis within the evolving discourse of medical performance, it seeks to extend existing scholarship into the terrain of breast cancer, proposing a dramaturgical approach that embraces participant-led creative outputs and a polyphonic representation of patient experience.

This project extends Nielsen's *Disrupting Breast Cancer Narratives: Stories of*

Rage and Repair (2019) and Lobel's *Theatre and Cancer* (2019), which both advocate for a political and relational approach to understanding cancer: one that recognises the importance of the representation of diverse, intersectional and multi-cultural backgrounds. By working directly with people affected by the disease to create performance, these narratives will offer a counter-discourse that not only validates lived experience but opens space for public dialogue and systemic change. In doing so, this project fills the gap outlined by Lobel and Neilsen- to contribute to a broader reimagining of cancer storytelling within medical humanities, exploring theatre's potential as a transformative site of agency, empathy, and empowerment. Taking my own experience of breast cancer as a catalyst, this research situates itself within the interdisciplinary field of medical humanities, extending the singular 'auto' into a plural form by inviting others with lived experience onto the stage.

Chapter 3 Methodology

3.1 Introduction

Having contextualised my thesis project within the theoretical landscape of theatre studies and the emerging field of medical humanities, which has enabled me to identify a clear gap in scholarship, in this chapter I turn my attention to research methods utilised. These methods enable me to rigorously address the questions I posed in the previous chapter, namely:

1. How live theatre practice can be interrogated to disrupt normative breast cancer discourse, demonstrating the complexities of both the disruptive, as well as the upbeat, narrative.

2. The challenges of narrative self-representation in the context of serious illness, such as cancer, when both treatment and recovery can be deeply destabilising.

In this chapter, I present a Practice Research (PR) framework shaped by Participatory Action Research (PAR). The chapter is divided into two interrelated sections: the first offers methodological considerations, outlining the values, ethos, and theoretical orientation that underpinned the research; the second details the specific methods used to generate, analyse, and translate collaborative data into performance. This is where I will draw on workshops and relational interviews as methods for developing a verbatim theatre response to breast cancer discourse.

I offer an interdisciplinary PhD which draws on a theatre practice called participatory theatre that itself sits within applied theatre, defined by Prenki and Preston in *The Applied Theatre Reade*r (2009) as:

> ...an umbrella term that is meant to describe a broad set of theatre practices that are simultaneously research methods and pedagogical approaches. They are often participatory and community-based, they foster an awareness of social issues and they exist outside the scope of traditional and mainstream performance theatre.

(Prentki & Preston, 2009:9)

However, in this interdisciplinary space there is an obvious connection to what, in social sciences, is called Participatory Action Research (PAR). Cieri and McCauley (2007:145) define participatory theatre within a Participatory Action Research framework as ‘artists and researchers in collaboration with diverse individuals and groups [to] produce Participatory Theatre (PT) to explore questions of importance to their communities and to initiate a process of dialogue and interaction that can effect change’. My thesis is really a Venn Diagram of these two definitions, as I am working across theatre and social sciences.

Through a multi-modal and inclusive approach, the research seeks to disrupt normative illness narratives by foregrounding the creative agency of lived experience by inviting participants to share their experience of disruption through theatre. By creating data, analysing it, and then drawing it into theatre practice through dramaturgical experimentation and intersectional representation, this project adopts a methodology that produces new knowledge, whilst reimagining engagement with serious illness. In doing so, it reframes ‘methods’ as a site of inquiry, meaning-making, and transformative possibility (Denzin & Lincoln, 2011), which positions creative practice as a representational tool, as well as a transformative and resisting mode of showing alternative meanings, fostering dialogue, and reshaping cultural perceptions.

3.2 Methodological Considerations

Given that this research is concerned with doing- the practices, processes and performance of theatre- it is essential that the methodology is led by practice research and performance. Rather than imposing a rigid framework, this allows the research to emerge iteratively through engagement with live processes, rehearsals, and performative encounters. This methodology highlights the experiential nature of theatre-making, positioning performance as both subject and method of exploration. The following section outlines the theoretical frameworks used to develop, reflect upon, and analyse these performance processes, including modes of observation, practitioner reflection, and contextual analysis. It was clear from the questions arrived at and outlined above, that it was only through the act of doing that they could be answered. It was therefore essential to use theatre practice to uncover the extent of

theatre's impact on these different dynamics.

3.2.1 Practice Research

Nelson (2013) defines Practice Research as a project in which:

> practice is a key method of inquiry and Introduction where, in respect of the arts, a practice (creative writing, dance, musical score/performance, theatre/performance, visual exhibition, film or other cultural practice) is submitted as substantial evidence of a research inquiry.

(Nelson, 2013: 8–9).

Adopting this understanding, creative practice constitutes a central component of my research. Nelson further develops this concept in the 2022 edition of his book, stating that 'practice' in this context 'denotes research undertaken not primarily nor exclusively through the cognitive processes', such as those of 'typical academic research traditions'. But rather through embodied modes of inquiry and 'doing' activities rooted in 'experience, perception, awareness, play (and) crafting, [that] are not devoid of thought' (Nelson, 2022:19). This highlights the distinctive epistemological stance of Practice Research, where knowledge is generated through creative engagement as much as critical reflection.

Practice Research is interdisciplinary by nature. Contrary to Efva Lilija's view in her essay, 'The Pot calling the Kettle Black: An Essay on the State of Artistic Research' (2021), that 'the object of artistic research is art' (2021), Nelson notes that although usually performed in arts contexts, around arts practices, it is not exclusive to the arts, but has value in any research setting that uses a 'being-doing-thinking practice' (Nelson, 2022:4), and in which the findings can be presented through praxis. In *Artistic Research in the Future Academy* (2017), Danny Butt observes that in fact, the arts, and thus theatre practice, will only find a 'full university function in conversation with other disciplines in the humanities and social sciences' (ibid).

As Chapter Two has established, this project sits at the intersection of performance practice, medical humanities and social sciences: challenging socio-

political issues through creative engagement and practice research. It also highlights the broader academic relevance of Practice Research, positioning this work within the 'second wave' of Practice Research discourse (Trimingham 2002). While the project does not seek to validate Practice Research as a methodology, because it is already well established (Trimingham, 2002, Nelson 2013), it contributes to the ongoing development of this field by offering new insights into how Practice Research operates within this research project. By weaving together participatory techniques, relational interviews, and documentary/verbatim theatre, the methodology reflects Practice Research's transformative potential. This is evident, not only in generating inclusive narratives of serious illness, but also in expanding the role of creative practice research within an academic landscape.

In line with Nelson's approach (2022), my PhD Practice Research is composed of multiple modes reflecting a multi-mode research inquiry: the performance of *A Waiting Game,* on the 1st of May 2025; the documentation which informed this practice through feedback; photographs; recorded interviews and workshops with participants; and my critical reflection of the practice. The practice research is contextualised in this chapter, which locates it in a conceptual framework for the research.

3.2.2 Participatory Action Research (PAR)

As discussed in the introduction, the other key method used in this project is Participatory Theatre (PT) through Participatory Action Research (PAR). In *Participatory Action Research Approaches and Methods: Connecting People, Participation, and Place*, Kindon, Pain and Kerby (2007) outline the approach central to this project, defining Participatory Action Research (PAR) as a 'process of research, education and action explicitly oriented towards social transformation' (Kindon, Pain, and Kesby (2007:9), framing it as a politically engaged, collaborative process that seeks to empower participants and challenge dominant structures through co-produced knowledge and action. This project aims to co-create genuine, realistic, and informative outputs, that reflect the disruptive lived experience of breast cancer to empower participants and challenge dominant structures that inform the dominant narratives which have come to surround it. Grounded in collaboration, it engages stakeholders

across theatre, research, healthcare, and cancer charities to help forge relationships with those with lived experience of the disease. My research bridges theatre studies and medical humanities, where Participatory Action Research is widely used. Participatory Theatre, in particular, has strong potential to drive social change. McCauley (Kindon et al, 2007:145-149) highlights how theatre can both conduct and communicate research, reaching beyond academic spaces (ibid). Cieri and McCauley (Kindon et al, 2007) argue that creating and presenting participatory theatre is itself an act of Participatory Action Research, bringing people together to create and reflect. It is important to note, however, that while this method lends itself to Participatory Action Research, Participatory Theatre also exists outside research frameworks. Research has specific characteristics, in that it aims to systematically co-produce knowledge and data. These are not always intrinsic to Participatory Theatre, which can operate independently of formal research paradigms.

This Participatory Action Research project uses performance to generate and explore data created from the lived experiences of breast cancer. As discussed in Chapter 1, dominant narratives often focus on positivity (King, 2010), leaving little space for more complex or disruptive narratives. Yet many patients' stories reveal a pressing need to broaden these narratives (Ehrenreich, King, Brenner, 2010), highlighting how challenging experiences illuminate important dimensions of the illness. Cieri and McCauley (2007) argue that both the creation and presentation of theatre are inherently collaborative acts, bringing bodies together to co-create. Furthermore, they make a compelling case for the aesthetics of Participatory Theatre, noting its potential to 'play a vital role in changing how people think about, and act upon, social and political relationships within their communities' (149). This is central to the aims of this project, which seeks to uncover disruption through the semiotic tools of post-verbatim and participatory theatre. Cieri and McCauley's proposal that the form and aesthetic of Participatory Theatre can shift perspectives on critical political issues suggests it is an ideal method for challenging normative discourse around breast cancer.

Mutual trust is essential in this kind of research, which is why Practice Action Research values action as much as inquiry. In *Rights and Social Justice in Research: Advancing Methodologies for Social Change* (McGarry, Bradley, &

Kirwan, 2024), Participatory Action Research is described as being embedded within a rights-based framework that advocates for inclusive and transformative methodologies. The book showcases how Participatory Action Research can advance social justice through participatory engagement to 'foreground an ethical praxis of trust built through the co production of new knowledge' (McGarry, Bradley, & Kirwan, 2024:142). In his chapter on 'expanding the conceptualisation of engaged research' (Hearne, 2024: 201), Rory Hearne draws on his own experiences to argue that the positionality and role of the academic researcher are critical. He asserts that Participatory Action Research promotes empowerment, social change, human rights, and equality through its methodological approach.

The main output of this Participatory Action Research and Participatory Theatre project is a post-verbatim play. As discussed in Chapter Two and revisited in Chapter Four, both verbatim and post-verbatim theatre fall under the broader category of Applied Theatre. Participatory theatre, introduced earlier in this chapter, is a form of applied theatre that has long been associated with community engagement. Advocates of this practice emphasise its participatory, dialogic, and dialectical qualities as powerful tools for social intervention (Nicholson, 2005). The Central School of Speech and Drama defines applied theatre as involving 'intervention, communication, development, empowerment, and expression when working with individuals or specific communities' (Nicholson, 2005:12). In *Applied Drama: The Gift of Theatre* (2005), Nicholson further explains that applied theatre is characterised by its operation outside conventional theatre institutions, with the explicit aim of engaging and benefiting individuals, communities, and wider society.

Prendergast and Saxton (2009), in *Applied Theatre: International Case Studies and Challenges for Practice,* affirm the value of this method- one that aligns closely with the aims of this PhD project- by asserting that applied theatre works to reassert or challenge socio-political norms, with the intention of creating greater understanding about the world we live in. This dual function, interrogating dominant norms and engaging communities, is what makes Participatory Action Research, through the method of applied theatre, central to this Practice Research in challenging prevailing socio-political understandings of breast cancer discourse.

Community engagement is integral to my participatory project. Peters and Burton's book, *Verbatim Theatre Methodologies for Community-Engaged Practice* (2024), offers up-to-date research-based discussions of an approach to verbatim theatre deeply embedded in community engagement. Their work focuses on collaboration and ethics, exploring the form's historical roots, international case studies, and practical exercises. Verbatim theatre extends the singular account typical of autobiographical performance by inviting the plural voices onto the stage, often within the broader category of documentary theatre. It traditionally places interviews with people with lived experience at the heart of its process. Peters and Burton provide a historical context for participatory, verbatim theatre, whilst emphasising the added value of community engagement, which complements the verbatim approach (Peters & Burton, 2024).

In their article, 'Participatory theatre for transformative social research' (2017), Erel, Reynolds and Kaptani explore the 'transformative potential of participatory theatre methods for democratising social research' (ibid), noting its value in 'highlighting conflicts and the obstacles to effectively claim rights when recognition as equal and entitled is raising questions, and initiating collective reflections'(ibid). As outlined later in this chapter, community engagement is at the heart of this work, realised through extensive community relational interviews, workshops, and attendance at community events necessary for recruitment of participants from the intersection of the breast cancer, lived experience community.

In Social Sciences, the notion of 'community' shapes who is involved in a project, how knowledge is co-produced, and what kinds of changes are pursued. Robert M. MacIver in: 'Community: A Sociological Study' (2022) defines it as:

> the term which best expresses the object which social science as such endeavours to study; it is in community, the common life, that the interests represented by the specific social sciences are bound together, made integral, and thus amenable to a more comprehensive science.

(MacIver, 2022:6)

I should also note here the distinction between communities of interest and communities of place. Margaret Ledwith & Jane Springett, in *Participatory*

Practice, Community-based Action for Transformative Change (2010), define a community of place by ’geographical boundaries- people living in a particular locality’, whereas a community of interest is ‘formed around shared concerns, identities or values, regardless of where members live’ (Lethwith & Springett, 2010: 91). In this project, the community I refer to is one of interest.

3.2.3 Ethics

In her book, *Creating Verbatim Theatre from Oral Histories*, Claire Summerskill (2021) discusses the ethical challenges around creating Verbatim Theatre that represents vulnerable or marginalised participants. She reflects on her own experience of writing and producing *Hearing Voices*, a verbatim play about her experience on a secure psychiatric ward. Summerskill interviewed some of the people she had interacted with as part of the process and considers the dynamics of the group and ethical decisions that had to be made. She asserts the importance of assessing power dynamics and made it clear to the reader that all participants were no longer in active treatment.

It was crucial to pay ethical consideration to these power dynamics when creating *A Waiting Game* (2025), as all participants had lived experience of breast cancer. In this instance, all participants were fully finished treatment and had full agency over their level of engagement and participation. Sue Wilkinson and Celia Kitzinger consider from a feminist perspective that representing ‘the other’ presents an ‘ethical dilemma’, suggesting that instead of ‘speaking for others’, we would be better placed by maintaining ‘respectful silence’ to focus on creating a social and political environment where people feel empowered to speak for themselves (Summerskill, 2012). However, sharing stories in collaboration with those who tell them, can empower others to speak up. Heddon (2008) argues for the empowerment that autobiographical theatre holds as the ‘ideal medium to publicise’ (89) marginalised communities, where there is often oppression. People can lack the resources, education, and ability to access platforms which enable them to have their voices heard. (Auto)biography and Verbatim Theatre provide platforms through which to empower marginalised groups to speak out, to educate others on their experience and with that education comes the agency to provoke change.

Perhaps considering the complex ethical concerns regarding the representation of others on stage, acknowledgement of its theatricality is also appropriate. Heddon suggests for instance, that 'intercutting the "real" with the "theatrically represented" does potentially serve to make transparent that what we are witnessing is a theatrical representation' (Heddon, 2008:133). Using meta theatrical devices such as the disclosure of processes, inclusion of original documentation and the recorded voice, which underpins this work and that of post-verbatim, gives it a transparency, disrupting theatrical illusions to include narratives that might not conform to those which are prominent in dominant discourse. And it is a powerful reminder that outside the theatre the real world exists, whilst acknowledging that this creative product is not reality but a representation of it.

During the interview stages of this project, it was clear that many of the participants felt comfortable and relieved by the opportunity to discuss freely their frustration around their disruptive experience. Many participants expressed the empowerment they felt when the group was brought together. There was never any doubt, therefore, that the stories collated as part of this project should be told, but it was essential to prioritise the ethical practice around that process. Being in a university setting with a robust and tested ethical approval system was a privileged position as all ethical approval was considered fully before each step of the process.

The research paradigms discussed in this section have informed the overall framework of this study. This section outlined the approach adopted to conduct the research, highlighting the values, ethos, and theoretical orientation underpinning the Practice Research and Participatory Action Research methodology. Building on these foundations, the following section will present the research design and detail the specific methodological processes undertaken to achieve the objectives of this project. I now offer a chronologically linear explanation of the different methods used in developing this Practice Research (PR) and Participatory Action Research (PAR)-namely workshops, interviews, and production- through the methodological design section.

3.3 Methodological Design

This study employs Practice Research and Participatory Action Research which are qualitative methods. The research design will explore the participatory theatre methods used to disrupt dominant breast cancer discourse. Grounded in the methodological considerations outlined in the preceding section, the approach was selected to capture the depth and complexity of participants' experiences and perspectives. The research process was guided by participatory methods, informed by the theoretical frameworks of both social sciences and theatre studies, ensuring that the methods aligned with the study's ethical commitments of integrity, respect and confidentiality through its participatory epistemological stance.

The process was split into three sections: the first was taster workshops, the second was one-to-one relational interviews, and the third was in-person workshops. These will be outlined further in sections 3.3.2- 3.4, following the recruitment methods section which I turn to now.

3.3.1 Recruitment Methods

It is important to note that, despite measures being taken to reach as many prospective participants as possible, the nature of the work and of illness itself meant that there were fundamental challenges in attaining inclusivity. The difficulties arise through the very nature of participation, in that those who volunteer are likely to be empowered and have the resources and ability to participate. This highlights further the challenges in reaching more marginalised groups for research purposes. I recruited participants in various ways. I contacted cancer-related stakeholders such as Macmillan, Cancer Research UK (CRUK) and Maggie's to collaborate on offering taster workshops as an introduction to the project. Macmillan were involved heavily in the beginning, and CRUK sent out an advertisement to their network for recruitment, though the response was minimal. Macmillan were particularly helpful and facilitated

two introductory taster workshops, each with 5 participants. These are discussed in more detail below. I also posted an advertisement through the online social media platform, Twitter (now X), which received 70 responses worldwide. This

proved instrumental in finding international participants, which was important in considering different cultural barriers and limitations to different socio-political environments. It became clear, however, that X was not necessarily going to broaden that reach, or attract the inclusive sample needed.

Despite the number of responses received, gaps in representation quickly emerged and it was clear that the project was not engaging the diverse groups essential to its aims of platforming minoritised and marginalised experiences, whilst being attentive to intersectional lived experiences. This posed a significant challenge, as inclusivity was a core value of the research. Although the project attracted considerable interest, initial interactions revealed that participants were predominantly middle-class, middle-aged, white women: individuals with the time, resources and confidence to engage. While their stories were valuable, diverse, and often fraught by disruption, there remained a wide intersection of society whose experiences were absent.

There was limited visibility of participants from minoritised communities, along with the cultural specificities and complexities their stories might bring. Similarly, voices from those living in communities experiencing socio-economic deprivation, where health inequalities are more pronounced and healthcare priorities may differ, were notably missing. In addition, there was very little representation from older individuals, who may be less likely to encounter the project due to generational differences, such as computer proficiency, limited internet access and preconceived ideas around sharing their experiences openly. At this stage, it became essential to revise the recruitment strategy to actively target seldom-heard groups. This led to a collaboration with Susan Grant, Community Engagement Coordinator for the School of Health and Wellbeing at the University of Glasgow.

We attended community networking breakfasts to engage third-sector organisations with potential to assist in breaking down the barriers in reaching specific groups. I gave talks at the Speaker’s Corner at the Community Networking Breakfast in Possilpark and Govan, run by a North Glasgow Housing Association, Ng Homes. These events are designed as a chance for individuals working or volunteering in the community to connect, share information and build partnerships (nghomes, 2025). Many local representatives were present,

providing the opportunity to explain the research objectives. Consequently, I was introduced to *The Bike Shed* charity who introduced me to one of their volunteers, Sarah. Sarah, a local GP with lived experience of breast cancer, introduced me to four women from diverse backgrounds, who became part of the project. We collaborated with Macmillan Libraries drop-ins through these groups. This is a free, confidential drop-in service offered by the charity at different libraries across the country. I attended the Tuesday Mitchell library session and gave two talks. One of these led to an opportunity to present my project to an asylum seeker's *Mother's Day* event group in Possilpark. Through these talks, women and men shared information about the project within their networks and I was put in contact with a South Asian woman who was diagnosed with breast cancer in her late 20s. Through her networks, I was introduced to two further contacts, one with an Asian background and one with an African background. These additional groups and networks had a huge impact on the research, supporting the generation of a broader range of stories, and representation from a more diverse, and international group of people. This aligned more with the project aims and put me in a position to move forward with the practice research.

Now, I turn my attention to the Taster Workshops, offering a description of the process.

3.3.2 Taster Workshops

The Taster Workshops were structured around introducing the project and giving the participants the opportunity to consider their experience of disruption, within their experience of breast cancer. The aims of these workshops were centred around question two: the challenges of narrative self-representation in the context of serious illness, such as cancer, when both treatment and recovery can be deeply destabilising. The aims of these workshops were as follows:

- To introduce the project.
- To establish how the survivor narrative made them feel, and what they felt would have been better.
- To discuss disruption and how that can manifest in breast cancer experience.

- How breast cancer affected their lives and their sense of self.

There were four taster workshops, which took place on the online platform Zoom; each workshop lasted 1.5 hours with five people present. All participants were women in the UK or America, whose first language was English.

The workshops opened with a creative icebreaker adapted from participatory workshop practices, inspired by *The Back of the Napkin Method* (Roam, 2009). Participants each traced their hand and listed five personal attributes they associated with themselves before their cancer diagnosis, then reflected on how these attributes may have changed. They were invited to draw around their hand, put their name and time away from treatment in the middle, and then list on each finger an attribute of their character which is not associated with their experience of breast cancer. We then went around the group, and each participant introduced themselves, using their drawing to relate these five characteristics. They were then asked if they thought these attributes had changed or been affected by breast cancer. This task was not only designed as an introduction to the group and project itself, but to ascertain the level of disruption each felt to their sense of self through illness. As each participant started to speak it became clear how the complexity of illness has a profound impact on the human condition and confidence one feels within oneself.

As part of the workshop process, we introduced a task called *Object/Photo Elicitation* (Kindon et al., 2007), which is a visual method rooted in qualitative research and designed to evoke deeper emotional and cognitive responses than verbal interviews alone. Participants had been invited beforehand to bring to the workshop an image or object from their cancer treatment and share with the group how it made them feel. Each participant presented their item to the group and explained what it was and why it carried such meaning. This activity created space for reflection and storytelling, allowing participants to anchor their narratives in a specific moment, emotion, or association. Collier first introduced photo elicitation in the 1950s, demonstrating its power to stimulate memory and enrich dialogue (Collier, 1957) with Harper later defining it as ‘the simple idea of inserting a photograph into a research interview’, suggesting that images can access layers of consciousness that words cannot (Harper, 2002:13). This approach aligns with participatory and reflexive methodologies, encouraging

participants to shape the direction of the conversation through personally meaningful visual prompts.

The session concluded with each participant being invited to share how they experienced disruption during their breast cancer journey- a theme that would later inform the script development. This final task was a catalyst for group discussion, followed by a brief explanation by me about how the word disruptive relates to both biographical disruption and the disruption they may experience in comparison to the dominant narrative of breast cancer. The discussion took up the largest part of the workshop. This was not by design, but because, by this point, the participants seemed comfortable enough to share openly and were motivated to discuss their disruptive experiences.

The first two of these four workshops were set up through a collaboration with Macmillan Cancer Support and the National Book Trust project, Digital Stories (Scottishbooktrust, 2025). This is a project which works with people with cancer experience to create a digital film about their experience of the disease. They work as a group, whilst also having six one-to-one sessions with a mentor who helps them create their film. The next two were arranged independently through the methods discussed in the recruitment methods section. The women involved in the first two workshop had all been participants in the digital stories project and therefore had some experience of talking about their experience of breast cancer in that format. This was valuable as it encouraged people to share more readily.

The workshops were effective because they brought a group of people together to talk about their experiences and the tasks were used to stimulate conversation and encourage participants to think about things from different perspectives. Hearing another's version of events can propel one to come forward with similar or indeed opposing views. For example, in the first Macmillan group there were five participants: Nicola, Aileen, Jan and Andrea[1], as well as Chris Leslie, MacMillan Digital stories Programme leader. The workshop ran smoothly, but there were some initial teething problems that had to be

[1] Pseudonyms are used here.

reassessed for the subsequent workshops. There was one participant, for example, who wanted to talk a lot about her own experience, interrupting frequently to assert that she had 'a really positive experience'. Every time someone tried to express their disruptive experience, Aileen would come in straight away to contradict them by saying how positive that particular aspect had been for her. Here are examples of two different occasions when this happened with Andrea, who was eager to talk about the disruption she encountered:

> Andrea- I did not feel supported at all and felt like there was an expectation to just get over it and move on.
>
> Aileen- See that's funny, because I never experienced that. For me I had a really positive experience. Everyone was great and I found that because I am a very positive person, that I found the positivity a good thing.

Here, Aileen not only talks over Andrea, but by asserting that because she is a positive person then she enjoyed the positivity, she is inferring that Andrea and others who do not enjoy that positivity are negative people. This happened again later in the workshop when Andrea expressed her difficulty with her nurses:

> Andrea- I had a terrible **experience** with my nurses, constantly being told to be positive. The only person that was any good was the oncologist to oversee the radiotherapy, and the people I met through that. You were always waiting for like three hours for your two-minute appointment. I was advised not to have chemo. It was like you are not having it. This is your number; this is your type, and you are not having it. Same with surgery. The surgeon comes in and goes, I am going to do is this. There were no explanations.
>
> Aileen- Oh, I just need to butt in here and say that I cannot believe that, I feel really bad because I had a wonderful experience with the NHS. I cannot fault any of them and nobody spoke to me like that. Everybody explained what I wanted them to explain and more. She just showed me the picture and said this is your cancer and explained everything. But oh my goodness, honestly, it's just making me, y'know. The thing is well, I am very grateful for what the NHS have done for me.

Once again, Andrea is trying to express the lack of control one finds when entering cancer treatment. Suddenly, one can go from being very autonomous in life, to being told by a professional what is happening. Aileen, however, did not allow

Andrea the space to fully explain herself. Instead, she held onto one part of it and almost accuses Andrea of not being grateful to the NHS. Whether Andrea is grateful or not for the NHS is not the concern of this thesis. Whilst not wanting to silence Aileen, because her experiences of breast cancer are just as important and valid as Andrea's are, my invitation to participants was to share their experiences of the challenges they faced. It seemed like Aileen was missing the point, which Andrea was trying to communicate: mainly the lack of control she felt. This project sought to uncover and give space to disruptive narratives that don't fit the dominant, overly positive discourse. When this participant repeatedly interrupted others to emphasise her 'positive experience', it silenced other voices. Feedback from Andrea later confirmed that she felt 'diminished' because she was being talked over by another participant. This part of the workshop, intended as a safe space, ended up echoing the very dynamic it aimed to challenge: the minimising of difficult, nuanced stories. This highlighted the need for ground rules to protect participants' voices and keep the space focused and open.

Feedback from that first taster workshop session helped reshape the three remaining ones. We began with co-created ground rules, which improved clarity around boundaries and encouraged diverse perspectives. At each subsequent workshop, participants were asked at the outset if they would like to set any ground rules to ensure everyone felt valued and seen. In each case it was decided that everyone should remain muted, and that if anyone had a comment or feedback, they should write it down so that they would not forget, and then raise their hand after whoever was speaking had finished. Participants shared a wide range of biographical disruptions: experiences with breast reconstruction, infertility, dating, sex, employment, and cultural pressures. One woman reflected on society's discomfort with her choice not to have reconstruction, noting how it clashed with expected norms. Another participant spoke of feeling invisible as a 65-year-old woman, and how her illness added to that. Sontag (1978) described illness as entering the 'land of the sick', a taboo space that the dominant survivor narratives urge us to move through quickly. The workshops revealed that many women still live with significant physical and emotional effects long after treatment ends. Far from survivorship being a return to normal, there is a clear liminality here: this state of still being in the land of the sick but society seeing

something different. Little et al suggest in their article 'Liminality: a major category of the experience of cancer illness' (1998), that 'the state into which the survivor of serious illness, or the person with chronic illness, enters is one of *liminality*, and that this state persists in some form or other for the rest of the patient's life' (Little et al,1998). During treatment, the participants recalled that they felt seen, monitored, and supported. Whereas afterwards, many felt abandoned in their ongoing struggle. These stories underscore the importance of highlighting disruption and creating space for reflection- something dominant narratives around breast cancer often fail to accommodate. The taster sessions fulfilled the aims outlined in the introduction to this section and helped clarify which themes felt most disruptive and least discussed in existing discourse. At the end of each session, I invited participants who were interested in continuing the conversation through the relational interview stage to contact me via email. Some participants had particularly disruptive experiences that could not be adequately explored within the limited timeframe of the taster workshops. I now turn to the relational interview stage.

3.3.3 Relational Interviews

The relational interviews were one hour long and were also on the online platform, Zoom, following the completion of the four taster workshops. In her book, *Interviewing in Social Science Research: a relational approach* (2017), Fujii notes that '[i]n relational interviewing, the data emerges from interaction, rather than interrogation. Research-related knowledge is generated in that interaction'(Fujii,2017:8). The relational interview model was, therefore, appropriate in this instance, so that the participants did not feel obligated or pressured, but rather a safe space was created where they felt free to express themselves. This ensured ethical practice.

In total, twenty-two participants were interviewed, spanning various geographical locations including Scotland, England, Ireland, Canada, and the United States. The sample included 19 women and 3 men, aged between 26 and 75 years. All participants gave their approval by completing a UofG ethics consent form, outlining, explicitly, the nature of their involvement (**see appendice, Ethics Ref No: 100210172**). The aims of the relational interviews mainly related to question 2: the challenges of narrative self-representation in the context of serious illness,

such as cancer, when both treatment and recovery can be deeply destabilising. But they were also informed by question 1, which considers how theatre practice can be interrogated to disrupt normative breast cancer discourse, demonstrating the complexities of both the disruptive, as well as the upbeat, narrative since the data from the interviews were always intended to inform the development of performance outcomes. The aims were as follows:

- To provide a platform for stories that do not conform to the traditional survivor narrative.
- To explore the multifaceted nature of breast cancer, recognising that it does not occur in isolation.
- To gather deeper insights from individuals who either lacked sufficient time to share the breadth of their experience during the workshop, preferred one-on-one conversations, or were unable to attend the taster sessions.
- To understand how breast cancer has affected participants' lives and theirsense of self.
- To identify disruptive narratives for inclusion in the play.

Given the sensitive and personal nature of the research, particular attention was paid to the positionality of both myself as researcher and each participant. As someone with lived experience of breast cancer, I recognised that my presence and openness often fostered a sense of ease and mutual understanding. This was evident in moments of shared vulnerability; when, for example, I disclosed feelings of shame around my vanity about hair loss and weight gain during chemotherapy, one participant, Brigit, responded with visible relief: 'Oh my god, absolutely. I felt so guilty'.

At its core, relational interviewing is underpinned with a 'heightened ethical sensibility' (Fujii, 2018:5). It demands treating participants with respect and dignity, understanding that we are all 'experts' of our own lives. It is therefore essential to consider issues such as 'positionality' and 'reflexivity' throughout to help alert us to any practices that could potentially exploit or harm participants. Reflexivity relates to accountability of the ethical merit of the project, ensuring that everyone is treated with the same dignity and respect. Positionality relates

to the researcher's awareness of their own standing in relation to potential structural inequalities, such as social, political or economic conditions which could potentially put any participant at a disadvantage (Fujii, 2018). The purpose of relational interviewing is not to extract information from participants, but rather to learn how they make sense of the world by engaging them in dialogue. The data is generated from interaction as opposed to interrogation.

In *Interviewing for Qualitative Inquiry: A Relational Approach* (2013), Josselson suggests that relational interviewing centres on building trust and co-constructing meaning, however it can still benefit from a flexible topic guide. She suggests using, as I did, prompts to initiate dialogue while allowing the conversation to evolve organically based on the participant's responses. This topic guide approach allowed participants to guide the substance of the interview, often leading to deeper and more authentic reflections, while allowing me to direct the 'topic' to make sure the interview covered the necessary ground and ensured that it followed a relevant course within the one-hour time frame. Relational context is imperative to fully understand the richness and complexity experienced through real life situations (Rubin and Rubin, 2004). It lends itself well to creative documentary projects such as this, as it helps us understand how people construct meaning from lived experiences. Fujii asserts that '[r]elational interviewing is well-suited for exploring how and why people identify themselves or others in a certain way' (Rubin and Rubin, 2004:72), while effectively uncovering how people 'explain processes of change or transformation' (ibids), such as how one navigates the constraints of illness.

Each interview began with an introduction to the project. For participants who had not attended the workshops, I provided a general overview; for those who had, I offered a more detailed contextualisation. Five participants took part in both the workshops and the relational interviews. Their inclusion raised important considerations around the depth and continuity of engagement. These individuals had previously expressed particularly disruptive experiences, and their dual participation was intended to allow for further exploration of those narratives.

The interview structure was designed to explore the lived experience of breast cancer through the lens of biographical disruption (Bury, 1982) and liminality (Turner, 1969; Pilnick, 2016). Participants were first invited to describe their

experience of diagnosis, treatment, and recovery, with an emphasis on moments of disruption. They were then asked to reflect on how these experiences had affected their sense of self and life trajectory. Finally, each interview concluded with a question about humour: what, if anything, they found funny about their experience. This final prompt often revealed unexpected insights and moments of lightness within otherwise difficult narratives. Overall, the interviews were well received by participants. They engaged openly and thoughtfully, responding to questions that functioned more as prompts than directives. The relational nature of the interviews, grounded in shared experience and mutual respect, was key to the depth and quality of the data collected. As already mentioned, both the interviews and earlier taster workshops had taken place via Zoom, and I created transcripts from the recorded sessions, editing them for clarity and readability within a participatory workshop context, which I will now discuss in the next section.

3.4 Participant workshops

Before commencing the participant workshop, I conducted an initial analysis of the data created and collected thus far. This early analysis involved identifying and filtering stories that reflected experiences of disruption, given this was the primary focus of the research. While this process may raise questions about the participatory nature of the work, given that it happened outside of the participatory workshop setting, it was necessary to manage the volume of data and ensure that the material selected would, at the outset, support the research aims. As someone with lived experience of breast cancer however, these decisions were still made through an autobiographical lens. It was also important to consider the emotional and creative experience of the participants, ensuring that the workshops remained engaging and meaningful. Furthermore, given that the final output was intended to be a theatrical performance, I felt that it was crucial to curate the data in a way that would resonate with an audience. Drawing on my experience of making theatre, I selected material that would serve the research aims of the project, focusing on experiences rarely discussed in dominant discourse. I also considered the dramaturgical potential of a theatrical production which would be shared with an invited audience and recorded for wider dissemination.

The participant workshops which took place in spring 2023 involved a smaller group of invited co-participants based in the Glasgow area. The reason for the geographical decision was due to costs and budget limitations (workshop spaces were provided through the University of Glasgow) and my personal need to remain local. I extended an invite to all participants who had been involved until this point who lived within travelling distance of the location of the workshops (Gilmorehill Halls). Five participants accepted my invitation. We worked with the curated data from the transcripts of the introductory workshops and the relational interviews to begin shaping ideas for a theatre piece. These drama-based participatory sessions focused on devising and discussing, co-creating fragments of performance material that would feed into the final creative output.

The in-person workshops were initially planned as a 12-week engagement with fortnightly workshops (6 in total), but in practice extended to span the full duration of the project with frequent consultations and meet ups right up until production. This flexible timeline allowed for deeper participant involvement and iterative development of the research themes. While there were no additional workshops, participants acted as collaborators in script readthroughs and later as part of the production itself. The extended involvement was at the participants' request. Their ongoing involvement informed the co-creation of the verbatim script and had a significant impact on the development, rehearsals, and aesthetic choices in the final performance. The multi-phase approach, moving from embodied expression to analytical reflection and creative production, reflects a commitment to participatory, arts-based inquiry. It also aligns with Boal's principle that theatre should be a 'rehearsal for reality', empowering participants to reflect on and recreate their lived experiences (Boal, 2002:19).

Developed in the early 1970s, Boal's Theatre of the Oppressed aimed to democratise performance by transforming passive spectators into active 'spect-actors' who could intervene in staged scenarios to explore the alternative outcome to challenge oppression (Boal, 1985; Boal, 2002). Forum Theatre explores short scenes presenting social conflict, inviting audience members to step into the performance if they so wish to propose alternative actions. Image Theatre, meanwhile, uses body poses sculpted like a photograph to explore emotional and social dynamics, enabling participants to express complex experiences

nonverbally (Boal, 1985; Boal, 2002).

Ali Campbell claims in his book, *The Theatre of the Oppressed in Practice Today: An Introduction to the Work and Principles of Augusto Boal* (2019), that Boal's techniques encourage participants to 'claim agency, through personal intervention' informed by the 'social model of disability' and moving toward 'equity and social justice'

(Campbell, 2019:115).

Drawing on these principles, I adapted Boal's Forum Theatre as a tool for devising and script development. As the participants were not trained actors and did not have theatre experience, it was important to develop a process that felt accessible and minimised feelings of exposure. The first workshop therefore incorporated trust-building exercises, such as Boal's mirroring activity, along with Image Theatre exercises that enabled participants to explore experiences of disruption through embodied and non verbal forms of expression. These activities helped establish connection and trust within the group, creating a foundation for the more participatory work that followed.

Building on this work, Forum Theatre was then adapted to support the engagement of participants' experiences within the context of this work. Rather than devising scenes entirely from personal experiences, we worked with excerpts and monologues drawn from the interview transcripts. These texts provided a degree of distance that made engagement feel less exposing, while still allowing participants to connect the material to their own lived experience of breast cancer, if they wished. Working within a modified Forum Theatre framework, participants were able to participate in, extend, and redirect narratives emerging from the transcripts, while also drawing upon their autobiographical experiences to challenge, complicate, or deepen the stories being presented.

This adapted approach proved particularly valuable when engaging with illness, as it allowed participants to engage with potentially sensitive experiences without feeling pressured to disclose personal information directly. By giving participants control over how much they contributed and by grounding the work

in shared research data, the workshops created a space where vulnerability could be negotiated safely. As trust was developed, participants increasingly connected the transcript material to their own experiences, fostering a process of collective reflection and support.

The first three workshops centred on drama based devising tasks using the collected data alongside Forum Theatre and Image Theatre. Through the early image-based work, followed by the development of a modified Forum Theatre process, recurring themes and points of tension began to emerge from the data. As the workshops progressed, we devised short scenes based on disruptive experiences identified within the transcripts and participants were invited to intervene in these scenes by proposing alternative actions, perspectives, or outcomes. The scenes were then further developed through group discussion and experimentation. This process enabled participants to interrogate emerging themes, consider perspectives beyond their own, and collaboratively develop ideas for material for the verbatim script.

The themes were identified as: infertility; racialised experience and culture; male experience of breast cancer; Covid-19; LGBT and gender issues; mental health and addiction; sexual intimate relationships; and, social class. The final workshop focused on further thematic analysis, storytelling, and writing. Participants created a storyboard based on what they felt were the most disruptive, and least represented themes, within dominant survivor narratives, as outlined above.

Drawing from the documentation from the participant workshops, I began working on the script. During these workshops it was decided that characters were instrumental, in order to understand the full intersectional impact of breast cancer on a life. We therefore decided to amalgamate characters and themes to create composite characters, a technique expanded on in Chapter Four. The play was written by myself, using the transcripts and data and there were two readthroughs with participants, where they offered feedback that shaped further revisions. We also discussed and agreed collectively on the nature of the participants' involvement in the rehearsal and performance process, as outlined in Chapter Four.

3.5 Conclusion

This chapter has outlined a Practice Research framework informed by Participatory Action Research, employing workshops and interviews as key methodologies in the development of a verbatim theatre response to breast cancer discourse. Through both the methodological considerations and the methodological design sections, I hope to have effectively demonstrated not only the value of Participatory Action Research (PAR) as a qualitative method for generating impactful creative outputs, through Participatory Theatre (TP), but also that the framework has been clearly articulated.

This multi-modal process has enabled the development of artistic outputs that challenge normative breast cancer narratives whilst demonstrating the creative potential of lived experience within participatory creative research practice. By exploring the performative possibilities of theatre, this work proposes a methodology that not only produces new knowledge but reimagines how we engage with serious illness. In doing so, it reframes ‘methods’ as a site of inquiry, meaning-making, and transformative possibility. Furthermore, it positions creative practice research as a resisting and transformative mode of expressing alternative meanings, to reshape cultural perceptions. These methods impart meaning beyond the textual, demonstrating creative research practices’ ability to expand the scope of academic inquiry and contribute to a larger cultural conversation around illness.

Chapter 4 Critical Reflection on Practice Research

4.1 Introduction

This chapter critically reflects on the staged performance of *A Waiting Game* (2025). Retaining the understanding of dramaturgy as the 'underpinning principles of theatrical construction' (Turner, 2015: 2), here I conduct a dramaturgical analysis of aesthetic design within my Practice Research (PR). Where relevant I will direct the reader to time stamps of recorded scenes from the performance. I examine the different modes of sensory engagement, ensemble and character to consider their effectiveness in fulfilling the project's main aim, to disrupt dominant breast cancer narratives and discourse through a multiplicity of diverse experiences. I also provide an analysis of the rehearsal process and performance output to demonstrate the value of post-verbatim as a model in the sphere of disrupting discourse. I will then consider the feedback collated after the event, as well as that of the participants involved in different stages of the project, to demonstrate the impact of the work for both the spectators and the participants.

A Waiting Game is a post-verbatim play that explores the alternative lived experiences of individuals affected by breast cancer, which are often overlooked in dominant discourse. Moving beyond the dominant 'pink ribbon' symbolism and survivor narratives, this multimedia play challenges prevailing discourse by centring personal testimonies of themes rarely spoken about (time stamp 11.30-13.30, 28.50) and voices that have historically been marginalised in breast cancer discourse.

In the play there are eight characters on stage, seven of which seek to represent a plurality of disruptive themes. This is achieved through the amalgamation of different interviewee voices/experiences into these seven amalgamated characters. This process of character creation, rather than representing separate interviewees, reflects my choice of 'post-verbatim' as the term to describe the practice I developed here (addressed further in the next section). The eighth character, Linda, represents the dominant survivor narrative and so is not drawn from interviewees alone, but rather the wider cancer discourse. The audience observes Linda's process as she is exposed to the diverse experience of others, empowering her to gradually open up about her own disruption and enabling her,

in turn, to also disrupt the dominant narrative. The post-verbatim, multi-sensory aesthetic of *A Waiting Game* highlights the profound disruptions breast cancer causes in every aspect of life and simultaneously disrupts dominant breast cancer discourse.

There was a constant ethical tension around the responsibility to honour the participants who had given of their stories and the aesthetic challenges of telling their stories in an engaging way. Their words, independently, were powerful. Whilst the research aimed to highlight how theatrical techniques can be used to magnify disruption, it was crucial to ensure that these accounts remained honest and not misrepresented. Careful attention was given to balancing the impact of their words with the additional meaning created through embodied theatre devices such as sound, movement, and character portrayal.

4.2 Verbatim/ Post- Verbatim Theatre

Verbatim theatre (Paget, 1987) is based on real-life stories. There is no doubt that the traditional verbatim theatre format of interview, recording, transcript, and editing into a script is a powerful way of capturing lived experience on stage. I have elected to use the term post-verbatim to describe the theatre practice research developed for this thesis. Post-verbatim builds on verbatim scholarship. The blurred lines when considering the practice of verbatim theatre is in the assumption that verbatim represents a truth that the writer simply stumbled upon, much like the assumption that the fly on the wall documentary is not creatively set up for entertainment (Heddon, 2008). The playwright or director typically instigates a verbatim project, then orchestrates the process. As Heddon notes, interviews are never accidental (2008); they are set up by the practitioner as part of the creative process. The author decides what the topic of focus is, who they interview, attempts to recruit, and are responsible for the questions they ask and edit according to the material they (as the writer) think is important to shape the text and make the points that they want to make. They will potentially interview a range of people, then edit, structure, and rehearse the play to refine it for the spectating eye. Thus, the veracity of the form is in question, and often the audience are not aware of the extensive creative process that has taken place before they are presented with ‘the truth’ of what happened (Heddon, 2008).

For *A Waiting* Game I interviewed 37 people, generating thousands of words of transcript, aiming for a 45-minute play- a duration I decided was appropriate for the project's purpose, and a practical window, allowing for a lunchtime sharing, which was accessible to more people. I decided to work further with a group of 5 local participants with lived experience of breast cancer, to determine collectively which themes and narratives were appropriate to carry the message that was consistently communicated as important and underrepresented in the research. Whilst inviting and acknowledging the invaluable input of the participants, I also acknowledge here that, as the doctoral researcher driving this project and its practice research outcome, I chose to retain creative control of the project, shaping the story to ensure the aims of the doctoral research remained centred. I also chose to co-direct the final creative output so that, although I actively sought multiple perspectives, I remained responsible for the final outcome as both writer and co-director.

It is, however, important to note here the distinction between a writer who is completely removed from the community they are representing and one who is part of that community. As someone with lived experience of breast cancer I take as catalyst my autobiographical story, which is underpinned by the isolation and frustration felt in the process of undergoing treatment, and navigating recovery and the discrepancy in the narratives predominantly circulating and shared, compared to the reality of living with the disease. I then invited others to share their own experience, with these presented by professional actors. It was creatively shaped in the way that I, as writer, felt was most powerful to demonstrate disruptive experiences of breast cancer. When considering the veracity of the representation then, it could be argued that my work presents the multiplicity that it aims to, as not only does it represent the stories engaged with through the data, but my editorial role is an (auto)biographical one, shaped through my experience of breast cancer.

The extensive work with a group of local participants with lived experience, as discussed in the preceding chapter, allowed us to workshop the play and identify, collectively, the themes, narratives/transcripts which were conducive to the research aims. This was essential to maintain a dynamic perspective in the editing and structuring process. Heddon (2008) observes that, often, verbatim plays share a dramaturgical structure, whereby multiple opinions or experiences are used in

a collage of voices to represent a vast array of people interviewed. Whilst I see the benefit in this classic structure, especially considering the aim of multiple perspectives, as I explain later, it was important that this project used more fully rounded characters, some of which were amalgamated out of the different interviews, to represent the stories. Clare Summerskill refers to this approach in her book, *Creating Verbatim Theatre from Oral Histories* (Summerskill, 2021), as creating 'composite characters' (326). I elaborate on this decision later in the chapter when I talk about character in more detail.

4.2.1 Toward the post-verbatim

In her book, *Aural/oral dramaturgies: Theatre in the Digital Age* (2023), Duška Radosavljević contemplates the limitations of using just language, suggesting that alternative theatrical modes can be more effective in heightening the audience experience. As touched on in Chapter Two, Radosavljević suggests a paradigm shift around the retelling of experience, moving toward the post-verbatim, describing it as an 'epistemologically significant' turn to the 'artist-led transformation of practice' (79). Inspired by playwright Anna Deavere Smith's methodology and recognition of the limitations of language, it gives autonomy to other meaning-making tools of theatre and allows the audience space to 'widen and reflect on their own modes of perception and observation' (Radosavljević, 2023:85).

Radosavljević considers post-verbatim as 'the inextricability of text from performance' (6) which characterises the basis of an aural/oral dramaturgy and more specifically aligns with that of post dramatic dramaturgy: as frequently mentioned by Hans-Thies Lehmann as 'sound spaces' and the 'materiality of sound' in *Post Dramatic Theatre* (2006:91-93). In what follows, I consider the semiotic elements of *A Waiting Game,* which constitute the multi-sensational experience that foregrounds the post-verbatim as a style.

4.2.2 Character

The characters within *A Waiting Game* served a crucial function. The project sought to convey not only the ways in which cancer permeates all aspects of life but also how the complexities of life itself shape the cancer experience, as

discussed in the previous two chapters in relation to ‘biographical disruption’ (Bury, 1982). Indeed, language alone may be insufficient to capture such a nuanced and liminal experience. This reinforces the importance of composite characters, sound and movement as integral components of the performance, allowing for the communication of elements beyond verbal articulation. It was essential for these stories to demonstrate the disruptive impact of breast cancer on a whole life, on a human level: composite characters offered a way to explore the multiplicity of the disease in the depth needed to fully translate the embodied experience. Whilst it is not linear, it is a complex experience that a collage cannot fully represent. The collage approach does not present full characters, but for the play to meet the research aims, the spectator needs to see the whole. The collage structure is, in itself, disruptive in that it is fragmented. Thus, it is only through representing whole, three-dimensional people, that the disruption can then be witnessed.

There are, however, limitations to this method of characterisation. A key impetus was to have a plurality of perspectives to ensure an intersectional and multidimensional representation on stage. As discussed in Chapter Three, it was difficult to recruit black and ethnic minority participants into the project. There are cultural barriers that meant that although some were willing to talk informally, they did not want to attend workshops or be recorded. Some of those who had arranged interviews pulled out at the last minute. I did interview three South Asian women and so did have a composite character drawing on those experiences (time stamp 11.30- 13.26, 19.00- 20.57). However, the risk then was that one character ‘stands in’ for an entire community, having to do a lot of work and risks the representation presenting as stereotypical. The further challenge with only managing to speak with three people who all had similar experiences is that there are still untold stories. In a future version of the play, with more time, beyond the capacities of this thesis, there would need to be dedicated time to making sure that one character does not represent just one aspect of a racialised experience.

Interestingly, at the time of completing this thesis, a new project was developed by Gilead Sciences in partnership with Black Women Rising, part of the Leanne Pero Foundation (Association of the British Pharmaceutical Industry (ABPI), 2026), called *Unseen Unheard, the untold breast cancer stories of black women*.

The project focuses on black women and how they are disproportionately affected by certain breast cancers, and their voices and experiences are rarely reflected in medical or patient materials. This leads to isolation, mistrust, and, in some communities, ongoing stigma, which contribute to widening disparities in outcomes. Black Women Rising collaborated with playwrights to create work based on real patient experiences. Set in a support group, the play explores the emotional and practical realities of diagnosis, treatment, and survivorship while challenging cultural taboos and systemic inequalities. Whilst deeply relevant, an analysis of this performance lies outside of this thesis, due to time constraints.

The male narrative was also pivotal in representing a diverse and disruptive experience of the disease. The character Mike is an amalgamation of a few different stories and highlights how men often feel emasculated and excluded from any support or events (time stamp 28.50-30.32). This again gives only a limited view of the experience of men, because it is based on such a small group of people. Yet, the issues raised (feelings of exclusion, ridicule, and diminished masculinity) are precisely the barriers that have historically stopped men from speaking out. Thus, only a small number of men came forward. However, this does demonstrate further the complexities of addressing the lack of such narratives, because these stories do exist, but there are social and cultural barriers which prevent those with lived experience from wanting to talk openly about it.

Those themes covered needed to remain as true a reflection of the experience as was possible. Jenn Stephenson's description of theatre of the real in *Insecurity: Perils and Products of Theatres of the Real* (2019) as 'theatrical performances, in general, that tap into an international documentary tradition- staging real people, real words, real places- to connect their audiences with that reality' (24) accurately describes my intention. She suggests that theatre of the real strives to capture unmediated realness (Stephenson, 2019). Theatre by its very nature is always mediated in some way and therefore cannot ever be completely 'real'. However, as a verbatim theatre maker, I can strive to prioritise an honest reflection of the story I am aiming to represent. The participants' words have been carefully extracted where it was crucial, to tell their disruptive experience, in the most efficient way in the time available on stage.

The characters in *A Waiting Game* do not interact with one another and so remain in their own isolated story. This separation emphasises their isolation, as well as making clear that they are not present in the same time and place, whilst simultaneously identifying the disruptive realities of breast cancer that brings them together. This was crucial to highlight the universality of the experience, whilst also bringing forward the differences in cultures and individual circumstances which are so often left unseen. It felt pivotal to have eight characters represented on stage, ensuring the coverage of the multiplicity of stories interacted with in the development of the play.

4.2.3 Aesthetics

Theatre offers what narrative alone cannot, through the embodied, intimate encounter between the spectator and performer, which has the potential to resonate at a visceral level. The unique temporality of the theatre, its here-and-nowness, can bring to the fore the complex reality of someone else's experiences. A decision was made early in the process to adopt a post-verbatim approach (Radosavljević, 2023) to achieve as much of an embodied, sensory experience as possible. From discussions in the workshops with participants, it was clear that much of the biographical disruption encountered from lived experience could never be fully explained through words alone; a notion which, as discussed in Chapter Two, seems ubiquitous.

I started to explore the notion of the ensemble to further articulate the universal experiences of the disease and as a symbolic gesture to demonstrate the force of well-established traditions within cancer frameworks such as treatment pathways and early diagnosis measures. In her book, *Performing Ensemble Practices, Theatre, and Social Change* (2025), Carmen Pellegrinelli explores the dynamics and processes involved in ensemble theatre, referring to John Britton's (2013) view of ensemble in the performance space as that which denotes a 'complex organism, a collective body where each subject, behaves like an organ with a distinct role within the system' (Pellegrini, 2025:10). I decided to juxtapose the strong presence of these characters on stage with that of them becoming the ensemble in the transitions between the scenes; to convey the constant contradiction of being part of such a well-practiced tradition and collective structural framework like cancer, to feeling entirely alone. This is evident at time

stamp 08.46, when the characters become the ensemble of the chemotherapy ward.

This is further emphasised by the addition of soundscapes to the movement to create an embodied experience for the audience and performer, so that as the ensemble strives to move as one, it is perpetuated by the heightened sensory overload of sound (time stamp 08.46-10.32). As part of his work around the musicalisation of theatre-making, David Roesner's article, 'The politics of polyphony of performance: the musicalisation in contemporary German Theatre ' (2008) considers a strategy of 'de-hierarchisation' in theatre with particular interest in how German speaking directors, Heiner Goebbels and Christoph Marthaler, employ musicalisation and the use of polyphony as a way of 'freeing the work from logocentrism', and 'the hegemony of text and character, and the semiotic compulsion' (2008). Roesner is a composer, writing from the perspective of a musician, but it is relevant to the 'musicalisation' referred to by Lehmann in *Postdamatic Theatre* (1999) and indeed the soundscape in *A Waiting Game*. The musical essence of these sounds is the equivalent of Rosiner's composition. During this process, like Roesner, I wanted to foreground other semiotic tools, as much as the spoken word, to assist the audience in reflecting on and developing their own ways of understanding and observing this narrative (2008), which they may or may not have had direct experience of.

Roesner suggests that utilising these multi-sensory techniques engages a 'playful multiplicity of conjunctions and confrontations' (2008: 51). This is an interesting concept to consider in relation to my practice to harness an embodied interaction with the spectator. It was essential that the audience had a multisensorial experience without necessarily feeling an obligation to understand what it means: but to provoke self-reflection.

Thus, theatre's ability to unsettle and destabilise perception can harness a sensory understanding of the liminal and complex realties of breast cancer, rather than words alone, which is rarely witnessed in dominant discourse. We focused primarily on sound and movement as an ensemble to emphasise the human experience which I will now discuss through three key transitions in the play.

4.2.4 Sound and Movement through Ensemble

Throughout my research, patterns emerged in the way people would explain their experience. Some phrases and images would come up repeatedly. Sound has always been an important part of my creative practice, but it became central during my own experience of breast cancer. Participants often expressed their struggle to articulate this life altering, existential period in their lives which Lobel described as, 'happening to (him) but not to everyone else' (Lobel, 2019: 20). The social fragments of life can be disrupted, and people are often unsure where they fit into this new narrative. As an autobiographical artist, it felt natural to take photographs and record sounds and reflections as my treatment progressed. Using documentation to create soundscapes and movement fostered a deeper connection in the processing of the trauma. As noted in the Introduction to this thesis, during my Masters project I created an autobiographical installation representing the embodied experience of chemotherapy; and it was apparent that others with lived experience were equally compelled by the embodied enactment of sound and images as a way to remember. I therefore built on some of the documentation from my Master's and developed it further, in conjunction with the research participant's own documentation and recorded interviews, for this project. The images were developed into movements, from photographs, and from that which was described through transcripts. Sound and ensemble movement were therefore an important aesthetic contribution to the production of *A Waiting Game*.

The soundscapes provided an opportunity to explore the multiplicity of the illness in more depth. Whilst I could not represent every single experience of breast cancer on stage, the use of sound gave a sense of the universality of the disease. Sound underpinned the whole production, aiming to give one the sense not only that these stories exist but also an infinity of others, moving through time and space, existing among multiple lenses, within experiences which are disruptive on multiple levels. The soundscapes were fragmented and intentionally overlapped, often lacking clear coherence, to reflect the non-linear path of illness. Whilst in the throes of cancer treatment, there is so much to process that memories are disjointed and fragmented, as is often characteristic of trauma (Lindsay and Walsh, 2012). These soundscapes, accompanied by movement, were delicately interwoven throughout the performance, and served as pivotal transitional

devices.

All soundscapes were created from autobiographical experiences of the disease, drawing on documentation, interviews, and workshops. This further reinforces the autobiographical nature of the play on multiple levels. Not only is the verbatim material drawn directly from lived experience, but it is also shaped through the autobiographical lens of my own interaction with the disease. However, the complexity of autobiography in this context is multi-layered: it emerges not only from my personal experience and that of the participants, but also through biography, as I am editing and reworking others' autobiographical narratives.

Yet biography alone does not fully capture the depth of this process. Unlike the scenes in between, where character stories are amalgamated to form composite characters, these transitions- though still verbatim and autobiographical in language- are curated to form a collage of voices. Sound plays a crucial role in intensifying this understanding, transforming how the audience perceives the material. These soundscapes, also rooted in lived experience, reinforce the autobiographical, biographical, and post-verbatim dimensions of the work. The intention was for the audience to engage with multiple experiences on a visceral level simultaneously. This was further enhanced through movement, which added additional layers to the complexity of perception. I now turn my attention to three specific transitional scenes to explore where these ensemble movement and sound pieces came together, to demonstrate their heightened impact.

4.2.4.1 Waiting Room

The play opened with a movement piece which represented that of the clinical waiting room (time stamp 0.11-2.52), but which was also symbolic of the overall experience of cancer and the waiting that accompanies so much of the experience of the disease. The waiting room is symbolic of the timeless mundanity of cancer treatment as well as the liminality so prevalent in the experience. It reflects this space in between, where someone may never fully move on but is simultaneously entirely different to what they were before. This draws on both liminality and biographical disruption, which are interesting and under-researched characterisations of cancer survival. It also nods to the historical and medical institution of cancer treatment. I wanted to communicate a sense of

timelessness where the bodies in the space represented a plurality of people, representing shadows of all of those who have come before and who have yet to enter the 'waiting room' of cancer treatment.

The soundscape was designed from my recording of the first chemotherapy appointment where I had to wait 1 hour and 40 mins past my appointment time. It was overlapped with another participant's recordings of walking to the Beatson for her chemotherapy treatment and with the added integration of a ticking clock. This emphasis on waiting further highlights the helplessness that one feels in that task-based ritual, that rhythmic waiting. Perhaps in my own experience, the only way I could feel agency over my own time and body was to record the scene for future documentation for my practice. Trying to navigate a world which is alien, autobiographical performance can be a tool to process this pivotal existential moment in one's life. Linda Park- Fuller referred to her experience of creating work around breast cancer as:

> an attempt to break out of the prescribed, marginalised role of 'patient-victim', and exercise socio-political agency in the world. That exercise of agency, in turn, circles back to transform and constitute me as actor agent-as survivor.

(Park- Fuller,2003: 215).

In exploring illness as a 'site of narrative authority' (Park-Fuller, 2003:169), creative practice can exercise agency around illness, escaping the marginalised role of 'patient-victim' that Park-Fuller describes. As Heddon states in *Autobiography and Performance* (2008) 'performance can be a transformative act, contributing to a network of political activity' (Heddon, 2008:2).

The movement in the waiting room (time stamp 0.11-2.52) was cocreated with participants and actors in the rehearsal space. We devised it in a workshop where we used choreography to pick three different moves that one would associate with waiting. Then, using the soundscapes referenced above, we explored these gestures at different speeds, taking up different amounts of space and with different intentions. We ended up with a movement piece which for the cast felt uncomfortably long, but which was meant to be slightly unsettling for the spectator, just as it is when you are waiting in this setting.

4.2.4.2 Chemo corridor

The transition between scene one and two was that of the chemo corridor which was a movement piece that was reflective of the experience of chemotherapy treatment and the sickness that accompanies it (time stamp 8.36.). There were rows of people attached to imaginary drips paired with a soundscape which was co-created with sound designer, Jen Athan.

We used a combination of home video footage and sound recordings of participants talking about their experiences to create the embodied sound of sickness. This was played over the choreography with fragmented words which describe the experience. During the research process, an image that came up repeatedly was a comparison of chemotherapy treatment to a conveyer belt in a factory setting. Whilst exploring documentation in preparation for my practice, I came across a video of myself explaining how treatment 'had a rhythm to, like a beat to it' (time stamp, 9.59). It felt natural that this involuntary, rhythmic cycle of treatment which was both traumatic and mundane could be accurately conveyed in an embodied way through a choral piece on stage.

These movement sequences would see the cast leave their autonomous characters to become the ensemble, symbolic of the embodied clinical experience of the illness. Chemotherapy happens on a rotation over a period of time. Every time you are treated there is a process; a pattern of recovery which takes weeks. The body is injected with the drug, which it initially resists, then gradually recovers from. The first phase brings sickness, lasting a few days, followed by a week of medical appointments, then the cycle begins again. As treatments progress, recovery takes longer; the body weakens, both physically and mentally. It was crucial to emphasise the sterile, clinical setting and how the mind starts to adapt to its surroundings with this numbing normalisation of a very abnormal situation.

For this transition, it was important that the audience got a sense of the cold, clinical, task-based experience. We developed it through improvisation, adding the participant's own sounds and movements to demonstrate the added layer of their experience of sickness. This was crucial to demonstrate that as much as it feels very uniform when everyone receives their concoction, everyone's experience is different, and these people are autonomous with their own

individual experience.

4.2.4.3 Breast check dance

Among the documentation gathered from lived experience during the research period, there was a pink leaflet with images to demonstrate the process of checking your breasts for signs of breast cancer. This led to reflection on the potential preventative impact such knowledge might have had, had there been more exposure to it as a young woman. It spoke to the perception of breast cancer as an older woman's disease. Notably, it was explicitly directed toward the female body. When I enquired about equivalent materials for men, I was informed that there were not any, but that the nurse assumed it was the same process. Whilst going through treatment, a friend and I joked about the movements resembling that of the dance routines one might have seen in teenage magazines in the 90s.

We therefore developed a movement piece using these movements (time stamp, 31.12- 32.04). We combined it with the upbeat, distorted, dance soundscape, co-created using participant interviews and video footage. The soundscape was designed to denote the stage of treatment participants described as they started feeling better, as steroids kick in and they began overcompensating by trying to be everything that is not possible in the throes of sickness. We paired this soundscape with movement to create a high energy dance routine to simultaneously demonstrate the overwhelm and sensory overload one endures whilst monotonously taking part in the task-based rhythmic performativity of patienthood. This can destabilise identity and impact on the feeling of agency over one's body with one lived experience participant suggesting she felt like 'a performing monkey'.

Drawing again on Judith Butler's concept of performativity, patienthood is not simply a passive state, but a socially constructed identity shaped by repeated interactions, behaviours, and institutional expectations (Butler, 1990). The patient performs their role by adopting expected emotional responses, and engaging in prescribed routines such as waiting, undergoing examinations, and expressing gratitude toward the NHS. Thus, the characters in *A Waiting Game* perform their dance with smiles on their faces. Ultimately, this clinical,

impersonal framework can engender a sense of helplessness, wherein individuals perceive themselves as mere instruments within a predetermined system, stripped of autonomy and compelled to adhere to its prescribed trajectory.

4.3 Participant Involvement

From the beginning, participant involvement was crucial to the success of this project. To accurately reflect the realities of living with breast cancer, it was essential to involve an inclusive and diverse group of people. As previously outlined, a three-stage process guided the project, supported by creative engagement with charities, medical professionals, and lived experience participants. This approach aided the recruitment of participants who were both willing and able to share their experiences of disruption.

As we moved into the production phase, the local participants, who had been involved since the project's inception, were given the option to contribute further. I was committed to allowing participants to define the nature of their involvement. It was collectively agreed that professional actors would portray the main characters, while the participants would join them in the ensemble. This strategy was an effective way of the participants keeping their sense of agency over the work, as well as allowing them to enter the rehearsal process at a later stage. At the same time, having the participants present in the rehearsal space was invaluable, particularly in offering insight into the aesthetic direction of the piece. Notably, two sections of the play, which I will now explore in more depth, underwent significant changes during this period, shaped directly by their feedback.

4.3.1 The Bell: Resisting the Survivor Narrative

Originally, I had planned to include video footage of myself ringing a bell. The bell has become a tradition within the cancer treatment process: usually when a patient finishes treatment, they get to ring a bell to signal its completion, and thus the end of their cancer experience. On stage, the character Linda would then appear with a bell of her own, ringing it until the sound naturally faded, despite her efforts to keep it going (time stamp 28.10-28.22). This was intended to serve as a symbolic gesture reflecting the tension between the excitement of finishing

treatment and the uncertainty of recurrence. I proposed that two participants with lived experience might also then join this scene to ring bells.

However, both women declined. They explained that they had never rung the bell themselves and felt strongly about their reasons. One had lost loved ones who never had the chance to ring the bell, and the other had met people who would need to go through chemotherapy indefinitely. They also believed that the ritual felt 'jinksy.' To them, the bell embodied the 'survivor narrative,' which didn't reflect their realities.

We therefore decided to cut that scene. Instead, the participants created their own way to express why they chose not to ring the bell with both women walking on stage silently, holding placards with their personal reasons why (28.22-28.47). Semiotically, this became a powerful act of resistance. Their silence and refusal to use the bell challenged the dominant focus on survivorship and highlighted the pressure that narrative can place on patients. The bell, in this context, disrupted the assumption that ringing it signals a happy ending, when in reality, there are no guarantees.

4.3.2 The Ending: Changed through Lived Experience

Another significant development stemming from lived experience input involved the restructuring of the play's ending. The character Linda was initially inspired by a participant who had been very upbeat and 'positive' during earlier phases of the research. This participant was discussed in chapter three under the pseudonym Aileen. While her positivity offered an important perspective, it occasionally overshadowed other participants who were attempting to share more complex or disruptive experiences. Over time, however, this woman disclosed more vulnerable aspects of her own experience (notably the disruption of her hair never returning after treatment). At the first rehearsal she attended for the play, she confided in the small group of lived experience participants, and myself, that she had been diagnosed with a new form of cancer. She expressed a desire to include this development in the production, pointing out that narratives around recurrence and managing cancer long term were underrepresented. Her insight reinforced a central theme of the work, that cancer changes life as we know it and that survivorship is neither linear nor conclusive.

We therefore decided that the lived experience performer would embody Linda's character toward the end of the piece (time stamp,39.01-42.38). She would initially come on in the last scene to mirror the actor who plays Linda (time frame, 39.58), before stepping forward alone to conclude the monologue, by breaking the performative boundary and revealing herself as the 'real' Linda (timeframe, 40.46). This dramaturgical shift emphasises the continuity between narrative and reality, offering the audience a more nuanced and authentic encounter with the lived experience of illness.

4.4 Feedback

The intended audience for the play included key stakeholders from cancer charities, medical professionals, researchers, and those with lived experience of the disease. This engagement aimed to maximise the impact of the work, fostering dialogue and instigating change within the cancer landscape to enhance patient experiences. It was performed on the 1st of May 2025, in the James Arnott Theatre, University of Glasgow. The play took place at 1.30pm, it was ticketed but free to attend, and 50 people attended. It was also recorded. As part of the practice research presentation, audience feedback was gathered through written evaluations and an interactive question/ answer session.

Following the performance, Gillian Hailstones, CEO of Beatson Cancer Charity, provided the following reflection:

> Coming along today, having worked in Oncology all my life and having had my own breast cancer experience, I was interested in seeing how you approached this conversation and if it would feel new. I was incredibly moved by the honesty and rawness of how you opened up the dialogue and allowed the spoken word to give a platform to the lived experience. An amazing and powerful piece of work, thank you.

(Hailstones, 2025)

Hailstones is a significant stakeholder due to her leadership role within a major charity but also as a medical professional and someone personally affected by the disease. She acknowledged her initial scepticism regarding the novelty of the play's approach, which perhaps reflects the familiarity with dominant cancer narratives within society. However, she ultimately found the raw and candid

nature of the portrayal to be ‘incredibly powerful’ (Hailstones, 2025).

Audience feedback further underscored the impact of the performance, particularly among the medical professionals present. Among the self-identified 18 healthcare practitioners in attendance, numerous responses highlighted the significance of the work in influencing clinical practice. One general practitioner noted: ‘This work must be shared. As a GP, I have many patients who need to see this, who feel lost. I will be mindful of the effects on sex.’

Another attendee remarked:

> I found today so powerful. It really unearthed the breadth of impact and diversity of experiences, highlighting aspects I had never considered within my clinical practice. It was so cleverly designed-an amazing way to hear so many voices and themes.

(Anonymous, 2025)

Such responses affirm the role of the performance in shaping professional perspectives and encouraging discourse on overlooked aspects of patient experience. The feedback suggests that engaging medical professionals and stakeholders in this form of artistic inquiry can facilitate critical engagement with prevailing narratives, to encourage a more holistic and multidisciplinary approach to breast cancer discourse.

In addition, audience members with lived experience of cancer provided compelling reflections on the work’s emotional and thematic resonance. One individual remarked, ‘Living with breast cancer myself, this show is so true to my experience of this horrible disease.’ Another commented, ‘It has given me a feeling of comfort. I am not alone in my perception.’ Perhaps the most indicative response regarding the research’s aims came from someone who expressed a renewed empowerment after the performance, stating, ‘this work has renewed my anger and my empathy, which is a good thing. I had become complacent’. This feedback served as critical validation of the work’s ability to provoke change, through reflection and emotional engagement. It reinforces the necessity for continued exploration of patient experience within breast cancer narratives. The response also resonated with my own experience, reminding me

of the impetus five years ago to assert personal agency in navigating my own encounter with the disease.

Indeed, the play's capacity to disrupt conventional narratives was further emphasised through reflections on its diversity. One spectator highlighted the significance of incorporating a range of perspectives, stating 'It was powerful to hear diverse voices included, especially men and queer narratives, as well as lived experience performers.' Several audience members reported shifts in their perspectives over the course of the performance, with one individual noting their initial association of breast cancer with 'survivors, pink ribbons, and marathon running,' only to conclude that it was 'an incredibly complex social and political issue.'

These insights align with Lobel's (2019) work *Theatre and Cancer*, which advocates for a political and relational model of understanding cancer, wherein a multiplicity of narratives, encompassing differences in race, class, and national origin, are central to meaningful discourse. By challenging dominant frameworks and amplifying patient voices, the play fosters critical dialogue among stakeholders, paving the way for transformative shifts within cancer discourse.

4.4.1 Participant Feedback

Following the performance, a further gathering took place to acknowledge and thank the lived experience participants for their contributions. Eight women attended: four were directly involved in the performance, while the remaining four had participated earlier in the process, through workshops or interviews. They had then attended the production as audience members. During this informal session, each participant was invited to reflect on their experience of involvement and of witnessing the final work. Seven described the experience as empowering. One participant described feeling angry, but clarified that the anger felt constructive, giving her a sense of purpose and motivation for change.

This concluding session was significant. It reinforced that the process was just as much about the participants as it was about the audience. Although I had hoped more of them could have remained involved throughout, and that more who were involved could have made this event, this discussion, alongside audience

feedback, provided valuable insight into the emotional and transformative impact of the work. This feedback demonstrates that despite the post-verbatim fictionalisation- through the creation of compositive characters- participants felt that the production represented their experiences, which suggests the validity of the work. People could see their experiences represented, even if they could not specifically see themselves on stage.

4.5 Conclusion

This chapter has reflected on *A Waiting Game* through a dramaturgical analysis of its aesthetic design within the context of practice research. By examining modes of sensory engagement, ensemble dynamics, and character representation, I have considered their effectiveness in advancing the project's aims: to challenge dominant breast cancer narratives by centring a multiplicity of lived experiences; to explore how live theatre practice can be interrogated to disrupt normative breast cancer discourse to demonstrate both disruptive and upbeat narratives; to examine the challenges of narrative self-representation in the context of serious illness, where both treatment and recovery can be deeply destabilising; and to develop auto/biographical methods that represent more intersectional and inclusive approaches to cancer narratives.

As discussed in Chapter Three, community engagement through recruitment, interviews, collaboration with stakeholders and workshops were crucial stages in the development of theatre which represents intersectional and inclusive approaches to cancer narratives. However, the implementation of post-verbatim was fundamental to the creation of an embodied encounter that represents a multi-sensory approach to cancer narratives which are complex, disruptive, and often traumatic. The analysis of both process and performance demonstrates the critical value of the post-verbatim model as a tool for disruption.

Feedback from audience members and participants across various stages of involvement further underscores its impact, affirming post-verbatim practice as a powerful method for amplifying marginalised voices and unsettling reductive assumptions about culture-specific norms, values and practices.

Chapter 5 Conclusion of Thesis

5.1 Opening Statement

In bringing this thesis to a close, I reflect on the central questions that have guided the research and the insights that have emerged as a result. By examining how narratives surrounding breast cancer are represented and contested through performance, this study has demonstrated the capacity of post-verbatim theatre to challenge dominant discourses and reframe lived experiences of illness. The practice-based methodology, grounded in Practice Research (PR) and Participatory Action Research (PAR), has exposed the limitations of the prevailing 'survivor' narrative while highlighting the potential of collaborative participatory performance to generate more inclusive, ethically grounded, and socially resonant representations. This conclusion, therefore, considers the broader implications of these findings, situating them within cultural, medical, and socio-political contexts, whilst outlining their contribution to both scholarship and practice. Although the research speaks to wider cultural and healthcare debates, its primary contribution lies in demonstrating the unique possibilities of theatre and performance as sites of representation, intervention, and dialogue.

5.2 Summary of Key Findings

The project set out to explore three central research questions:

- How have cancer narratives been represented in performance?
- How can live theatre practice disrupt normative breast cancer discourse, revealing the complexities of biographical disruption and the dominant survivor narrative?

- How can the challenges of narrative self-representation in the context of serious illness be addressed through collaborative performance practice, when both treatment and recovery are deeply destabilising?

These questions are grounded in my lived experience of breast cancer and my professional background as a theatre maker. The research emerged from a desire

to challenge the limitations of dominant cancer narratives, particularly the reductive and commodified 'survivor' discourse, to explore how creative practice might offer more inclusive, complex, and embodied representations of illness. The Practice Research developed a post-verbatim theatre approach that centres lived experience, vulnerability, and co-creation. The primary research output of the project and my thesis is a new play, *A Waiting Game*. This is accompanied by five written chapters. The play and the chapters taken together represent the thesis. The thesis offers a multidimensional inquiry into how theatre can serve as a vital mode of expression, capable of articulating experiences that often exceed the limitations of language.

- Chapter One introduces the thesis.
- Chapter Two mapped the historical and cultural trajectory of breast cancer narratives in performance and discourse. It demonstrated how the survivor narrative, while once empowering, has become a limiting and commercialised framework that often silences more difficult, diverse, and intersectional realities of breast cancer.

- Chapter Three outlined a participatory, ethically grounded methodology that positions creative practice as both a site of inquiry and a mode of resistance. Through workshops and relational interviews, participants were empowered to reclaim narrative agency and explore their experiences in ways that challenged prescriptive cultural scripts.

- Chapter Four critically reflected on *A Waiting Game*, a post-verbatim play co-created with participants. The play disrupted normative representations by centering marginalised voices and exploring themes rarely addressed in mainstream discourse. Audience and participant feedback demonstrated the emotional and social impact of the work, highlighting the value of theatre as a space for connection, reflection, and healing.

- Chapter Five- The Conclusion of the thesis.
- The play, *A Waiting Game*- explores seldom heard voices of individuals affected by breast cancer, through an

> intersectional, multidimensional lens. Moving beyond the dominant 'pink ribbon' symbolism and survivor narratives, this multimedia, post-verbatim play, challenges prevailing discourse by centring personal testimonies of themes rarely spoken about and voices that have historically been marginalised in breast cancer discourse.

Feedback from medical professionals and individuals with lived experience suggests that the work has potential as a training resource for clinicians and support networks, as well as offering space for complex experiences to be shared differently.

5.3 Contributions to Knowledge

By drawing together the research questions, creative practice, and critical analysis, this thesis argues for the value of post-verbatim theatre as a transformative model for representing illness. Its originality lies in the development of post-verbatim as a distinct dramaturgical approach and its application within a context where individuals often feel silenced by dominant cultural scripts. By documenting and reflecting on the embodied nature of this process- which extends beyond spoken language in the face of trauma- the thesis contributes new knowledge to performance studies, medical humanities, and participatory practices. It offers a compelling case for theatre's capacity to amplify lived experience and foster ethical, creative engagement with serious illness. Ultimately, this thesis affirms the transformative potential of collaborative performance to reshape how cancer is represented, shared, and understood, offering an alternative to dominant narratives by embracing complexity, co-authorship, and embodied storytelling.

Grounded in a Practice Research framework informed by Participatory Action Research (PAR), the project used workshops and interviews to develop a post-verbatim theatre response to breast cancer discourse. This process proved deeply empowering for participants. Cancer often affects confidence, and the act of retelling one's story can help individuals reflect, process, and recognise how far they have come. It also offers a means of reclaiming narrative ownership, countering the rigid and depersonalised nature of traditional cancer treatment, which can leave patients feeling powerless.

This multimodal research approach enabled the creation of an artistic output that challenges normative breast cancer narratives while demonstrating the creative potential of lived experience within participatory research. By exploring the performative possibilities of theatre, this work proposes a methodology that not only generates new knowledge but also reimagines how we engage with serious illness. In doing so, it reframes research methods as sites of inquiry, meaning-making, and transformative possibility. It positions creative practice as a resistant and transformative mode of expression, capable of reshaping cultural perceptions. These methods convey meaning beyond the textual, highlighting the capacity of creative research to expand academic inquiry and contribute to broader cultural conversations around illness.

As discussed in Chapters Two and Four, both verbatim and post-verbatim theatre fall within the broader field of applied theatre. And participatory theatre, as discussed in Chapter Three, is a form of applied theatre long associated with community engagement. Advocates of this practice emphasise its participatory, dialogic, and dialectical qualities as powerful tools for social intervention (Nicholson, 2005).

5.4 Limitations of the Study

Despite efforts to reach a wide range of participants, achieving inclusivity proved challenging. The nature of the project, and of illness itself, meant that those who volunteered were often individuals with the time, confidence, and resources to participate. This highlighted the difficulty of engaging more marginalised groups, which was a central aim of the research.

Initial recruitment through organisations such as Macmillan and CRUK, alongside social media outreach, generated interest but revealed a lack of diversity. Most participants were middle-class, middle-aged white women. While their contributions were valuable, the absence of voices from minoritised communities, socio-economically disadvantaged areas, and older individuals limited the breadth of representation.

To address this, I revised the recruitment strategy in collaboration with community engagement professionals. Through local events and partnerships with

grassroots organisations, a more diverse group of participants was reached, including women from South Asian and African backgrounds. These new connections significantly enriched the project and aligned more closely with its inclusive aims.

The collage structure of the play was designed to reflect the fragmented nature of illness narratives. However, to achieve the project's goals, it was essential to portray full, complex characters. While the inclusion of underrepresented voices was a priority, limitations remained. Some participants were hesitant to be recorded or attend workshops, and the small number of contributors from certain groups risked oversimplifying or stereotyping their experiences. For example, the male character in the play was based on a few stories and highlighted how men often feel excluded from cancer discourse. Yet, the limited number of male participants reflects broader social barriers that discourage men from sharing their experiences. These challenges underscore the importance of continued efforts to engage marginalised voices in creative research. While this project made meaningful progress, future work would benefit from more time and resources dedicated to building trust and access within underrepresented communities.

5.5 Closing Statement

This research demonstrates that post-verbatim theatre can effectively disrupt dominant breast cancer discourse, challenging dominant narratives and opening space for alternative voices. Feedback from medical practitioners, individuals with lived experience, and charities in attendance at the performance, underscores the depth of this impact, revealing how the performance resonated across professional, personal, and organisational perspectives. Importantly, the format offers a replicable model that can be applied not only to breast cancer but to other forms of cancer, extending its reach into broader medical and cultural contexts.

The multimodal, participatory methodology was central to the co-creation and development of the performance, ensuring that agency was returned to those most affected by the disease, while also engaging stakeholders and medical professionals in meaningful dialogue. In doing so, this approach demonstrates

how artistic practice can intersect with healthcare to reshape socio-political and cultural terrains, influencing the narratives that surround illness and, ultimately, the patient experience. Taken together, these findings highlight the transformative potential of post-verbatim theatre as both a research method and a cultural intervention. While the significance of this work extends into healthcare and the medical humanities, its primary contribution lies in demonstrating the unique capacity of theatre and performance to generate knowledge, challenge dominant narratives, and facilitate meaningful social dialogue.

By disrupting dominant discourses, amplifying marginalised voices, and fostering collaborative engagement, this work not only contributes to the evolving field of medical humanities but also points toward a future in which performance becomes a vital tool for reimagining how society understands and responds to cancer. Thus, the project closes by affirming that the stories we tell- and the ways we choose to tell them- have profound consequences for care, community, and change.

Appendices

A Waiting Game Performance- Media File
A Waiting Game Full Script
Ethics Consent Forms
Documentation
-Examples of transcript Excerpts
-Workshop Structure Example
-Relational Interview Topic Guide Example

Bibliography

Association of the British Pharmaceutical Industry (ABPI) (n.d.) *Unseen Unheard: The untold breast cancer stories of Black women in the UK*. Available at: **https://www.abpi.org.uk/partnerships/patient-involvement/charity-industry-partnership-case-study-library/unseen-unheard-the-untold-breast-cancer-stories-of-black-women-in-the-uk/** (Accessed 27 January 2026).

Auslander, P., 1997. From Acting to Performance: Essays in Modernism and Postmodernism. London: Routledge.

Boal, A., 1985. *Theatre of the Oppressed*. Translated by C.A. McBride. London: Pluto Press.

Boal, A., 2002. *Games for Actors and Non-Actors*. 2nd ed. Translated by A. Jackson. London: Routledge.

Bortolotti, L. & Antrobus, M. (2015) 'Costs and benefits of realism and optimism', *Current Opinion in Psychiatry*

Brenner, B., 2016. *So Much to Be Done: The Writings of Breast Cancer Activist Barbara Brenner*. Edited by B. Sjoholm. Minneapolis: University of Minnesota Press.

Breast Cancer.org, 2025. Available at: https://www.breastcancer.org [Accessed 17 Sep 2025].

Bury, M., 1982. Chronic illness as biographical disruption. *Sociology of Health and Illness*, 4(2), pp.167–182.

Butt, D., 2017. *Artistic Research in the Future Academy*. Bristol: Intellect Ltd.

Butler, J., 1990. *Gender Trouble: Feminism and the Subversion of Identity*. New York: Routledge.

Campbell, A., 2019. *Theatre of the Oppressed in Practice Today*. London: Bloomsbury Academic.

Cancer Research UK, n.d. *Homepage*. [online] Available at: https://www.cancerresearchuk.org [Accessed 25 Sep. 2025].

Clow, B., 2001. Who's Afraid of Susan Sontag? Or, the Myths and Metaphors of Cancer Reconsidered. *Social History of Medicine*, 14(2), pp.293–312.

Collier, J., 1957. *Photography in Anthropology: A Report on Two Experiments*. New York: American Anthropological Association.

Cooke, J.E., 2020. The living mirror theory of consciousness. *Journal of Consciousness Studies*, 27(9–10), pp.127–147.

Denzin, N.K., 1997. *Interpretive Ethnography: Ethnographic Practices for the 21st Century*. Thousand Oaks, CA: SAGE Publications.

Digital Storytelling: Macmillan Cancer Support, n.d. *Scottish Book Trust*. [online] Available at: https://www.scottishbooktrust.com/reading-and-stories/digital-storytelling-landing/macmillan-cancer-support [Accessed 24 Apr. 2023].

Ehrenreich, B., 2001. Welcome to Cancerland: A mammogram leads to a cult of pink kitsch. *Harper's Magazine*, 303(1818), pp.43–53.

Ehrenreich, B., 2009. *Bright-sided: How the Relentless Promotion of Positive Thinking Has Undermined America*. New York: Metropolitan Books.

Fujii, L.A., 2017. *Interviewing in Social Science Research: A Relational Approach*. Abingdon: Routledge.

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

Garson, C. (2021) Beyond documentary realism: Aesthetic transgressions in British verbatim theatre. Berlin: Walter de Gruyter GmbH.

Gamestorming, 2023. *The Back of the Napkin Method*. [online] Available at: https://gamestorming.com [Accessed 25 Sep. 2025].

Gygax, F., 2009. *Narrative Desire and the Book of Ruth*. Sheffield: Sheffield Phoenix Press.

Harper, D., 2002. Talking about pictures: A case for photo elicitation. *Visual Studies*, 17(1), pp.13–26.

Hearne, R., 2024. *Housing Shock: The Irish Housing Crisis and How to Solve It*. Dublin: Policy Press.

Heddon, D., 2008. *Autobiography and Performance*. Basingstoke: Palgrave Macmillan.

Heyl, B.S., 2007. Ethnographic interviewing. In: P. Atkinson et al., eds. *Handbook of Ethnography*. London: SAGE Publications.

Kafer, A., 2013. *Feminist, Queer, Crip*. Bloomington: Indiana University Press.

King, S., 2006. *Pink Ribbons, Inc.: Breast Cancer and the Politics of Philanthropy*. Minneapolis: University of Minnesota Press.

Kindon, S., Pain, R. and Kesby, M., 2007. *Participatory Action Research Approaches and Methods: Connecting People, Participation, and Place*. London: Routledge.

King, S. and Poole, L., 2010. *Pink Ribbons Inc.* [Film]. National Film Board of Canada.

Kimmings, B., 2017. *A Pacifist's Guide to the War on Cancer* [Theatre Production].

Kuppers, P., 2007. *The Scar of Visibility: Medical Performances and Contemporary Art*. Minneapolis: University of Minnesota Press.

Lehmann, H.-T., 2006. *Postdramatic Theatre*. Translated by K. Jürs-Munby. London: Routledge.

Lethwith, T. and Spring, M., 2010. Participatory practice: Community-based action for transformative change. *Community Development Journal*, 45(3), pp.345–360.

Lilja, E., 2021. The pot calling the kettle black: An essay on the state of artistic research. In: A. Huber, D. Ingrisch, T. Kaufmann, J. Kretz, G. Schröder and T. Zembylas, eds. *Knowing in Performing: Artistic Research in Music and the Performing Arts*. Bielefeld: transcript Verlag, pp.27–34

Lindsay, J. and Walsh, H., 2012. Gobsmacked: Getting speechless in performance.

Contemporary Theatre Review, 22(1), pp.161–166.

Little, M., Jordens, C.F.C., Paul, K., Montgomery, K. and Philipson, B., 1998. Liminality:

A major category of the experience of cancer illness. *Social Science & Medicine*, 47(10), pp.1485–1494.

Lobel, B., 2008. BALL: Introduction. In: A.G. Carr and L. Sally, eds. *Sex on Stage: Performing the Body Politic*. London: Routledge.

Lobel, B., 2019. *Theatre & Cancer*. London: Methuen Drama. Lorde, A., 1980. *The Cancer Journals*. San Francisco: Spinsters Ink.

Lyotard, J.-F., 1984. *The Postmodern Condition: A Report on Knowledge*. Minneapolis: University of Minnesota Press.

MacIver, R.M., 2022. *Community: A Sociological Study*. Reprint of 1917 edition. London: Routledge.

Malacrida, C., 2004. Medicalization, ambivalence and social control: Mothers' descriptions of educators and ADD/ADHD. *Health*, 8(1), pp.61–80.

McGarry, A., Bradley, H. and Kirwan, S., 2024. *Rights and Social Justice in Research*. Abingdon: Routledge.

Mermikides, A., 2020. *Performance, Medicine and the Human*. London: Bloomsbury Academic.

National Book Trust, n.d. *Homepage*. [online] Available at: https://www.nationalbooktrust.org.uk [Accessed 25 Sep. 2025].

National Theatre, 2022. *National Theatre Website*.Available at: https://www.nationaltheatre.org.uk [Accessed 17 Sep. 2025].

Nelson, R., 2013. *Practice as Research in the Arts: Principles, Protocols, Pedagogies, Resistances*. London: Palgrave Macmillan.

Nelson, R., 2022. *Practice as Research in the Arts: Principles, Protocols, Pedagogies, Resistances*. 2nd ed. London: Routledge.

Nicholson, H., 2005. *Applied Drama*. Basingstoke: Palgrave Macmillan.

Nielsen, E., 2018. *Disrupting Breast Cancer Narratives*. Toronto: Universit y of Toronto Press.

Ng Homes, 2025. *Homepage*. [online] Available at: https://www.nghomes.net [Accessed 25 Sep. 2025].

Oakley, A., 2017. *Women, Peace and Welfare: A Suppressed History of Social Reform, 1880–1920*. Bristol: Policy Press.

Park-Fuller, L.M., 1995. Narration and narratization of a cancer story: Composing and performing A Clean Breast of It. *Text and Performance Quarterly*, 15(1), pp.60–67.

Park-Fuller, L.M., 2008. How to Tell a True Cancer Story. *Text and Performance Quarterly*, 28(1–2), pp.178–182.

Participatory Theatre for Transformative Social Research, 2017. [online] Availa Available at: https://www.springer.com [Accessed 25 Sep. 2025]

Patterson, J., 1987. *The Thomas Berryman Number*. Boston: Little, Brown and Company.

Performing Ensemble Practices, Theatre, and Social Change (2025), Carmen Pellegrinelli

Peters, S. and Burton, D., 2024. *Verbatim Theatre Methodologies for Community Engaged Practice: Perspectives from Australian Theatre*. Abingdon, Oxon: Routledge.

Pilnick, A., Trusson, D. and Roy, S., 2016. A new normal?: Women's experiences of biographical disruption and liminality following treatment for early stage breast cancer. *Social Science & Medicine*, 151, pp.121–129.

Pink Ribbon Foundation, 2025. *Homepage*. Available at:

https://www.pinkribbonfoundation.org.uk [Accessed 17 Sep. 2025].

Prendergast, M. and Saxton, J., 2009. *Applied Theatre*. Basingstoke: Palgrave Macmillan.

Radosavljević, D., 2023. *aural/oral: Theatre in the Digital Age*. Abingdon: Routledge.

Rebel Boob, 2021. *Speak Up! Act Out!* [Performance]. Brighton Fringe.

Risko, E.F. & Gilbert, S.J. (2016) 'Cognitive offloading', *Trends in Cognitive Sciences*,

Roam, D. (2009). *The back of the napkin: Solving problems and selling ideas with pictures*. New York: Portfolio.

Roesner, D. (2008) 'The politics of the polyphony of performance: Musicalization in contemporary German theatre1', Contemporary Theatre Review, 18(1), pp. 44–

55. doi:10.1080/10486800701749587.

Rubin, H.J. and Rubin, I.S., 2004. *Qualitative Interviewing: The Art of Hearing Data*. 2nd ed. Thousand Oaks, CA: SAGE Publications.

Risko, E.F. & Gilbert, S.J. (2016) 'Cognitive offloading', *Trends in Cognitive Sciences*,

Sedgwick, E.K., 1993. *Tendencies*. Durham: Duke University Press.

Shaughnessy, N. and Barnard, P., eds., 2019. *Performing Psychologies: Imagination, Creativity and Dramas of the Mind*. London: Methuen Drama.

Sontag, S., 1978. *Illness as Metaphor*. New York: Farrar, Straus and Giroux.

Spence, J., 1988. *Putting Myself in the Picture: A Political, Personal and Photographic Autobiography*. London: Camden Press.

Spence, J. and Coward, R., 1986. *Images of Women*. London: Pandora Press.

Spradley, J.P., 1979. *The Ethnographic Interview*. New York: Holt, Rinehart and Winston.

SpringerLink, 2023. *Participatory Research Resources*. [online] Available at: https://link.springer.com [Accessed 25 Sep. 2025].

Stacey, J., 1999. Breast Cancer and the Gendered Politics of Knowledge. In: M. Maynard and J. Purvis, eds. *Feminism and Science*. Oxford: Oxford University Press, pp.147–163.

Steinberg, D.L., 2015. *Breast Cancer Narratives: Stories of Disruption and Continuity*. Basingstoke: Palgrave Macmillan.

Stepehnson, J. (2019) Insecurity: Perils and products of theatres of the real.

Toronto: University of Toronto Press.

Sulik, G., 2011. *Pink Ribbon Blues: How Breast Cancer Culture Undermines Women's Health*. Oxford: Oxford University Press.

Summerskill, C. (2021) Creating verbatim theatre from oral histories. New York, NY: Routledge.

Trimingham, M., 2002. A methodology for practice as research. In: E. Barrett and

B. Bolt, eds. *Practice as Research: Approaches to Creative Arts Enquiry*. London:

I.B. Tauris, pp.54–63.

Trusson, D., Pilnick, A. and Roy, S., 2016. A new normal?: Women's experiences of biographical disruption and liminality following treatment for early stage breast cancer. *Social Science & Medicine*, 151, pp.121–129.

Turner, V., 1969. *The Ritual Process: Structure and Anti-Structure*. Chicago: Aldine Publishing.

Turner, C. (2015) *Dramaturgy and Architecture: Theatre, utopia and the built environment*. Houndmills, Basingstoke, Hampshire: Palgrave Macmillan.

Underwood-Lee, E., 2010. *Patience* [Performance]. University of South Wales.
Underwood-Lee, E, 2025. *Tittillation*

Underwood-Lee, E, 2025. *Tittillation Grade 3*

Williams, R. and Solbraekke, K.N., 2018. *Breast Cancer: The Emotional Work of Preserving the Self*. London: Palgrave Macmillan.

Woods, A. and Whitehead, A., eds., 2016. *The Edinburgh Companion to the Critical Medical Humanities*. Edinburgh: Edinburgh University Press.