

'characters' in the book. I had never thought of a dramatic structure when I wrote; I thought in terms of case-histories... and predication. Yet, to my amazement, this worked.

As I and the other actors read our parts, we became patients and doctor, under John's direction (direction which, at times, seemed to me no less musical than dramatic). I kept having the uncanny sense that my patients, my old patients, were actually coming to life – I had turned them, and their lives, into words; and now the words, miraculously, were turning back into people. I felt, and we all felt, an extraordinary poignancy, sadness, joy: I wanted to reach out and embrace them – 'Hi, Leonard! Rose! Leonard and Rose and Lucy and Miron and Hester and Magda were all incarnated before me; illusion had become reality, they were there, they were alive, they were flesh again. It was not just the individual performances which were so moving; the actors performed as a community, as a troupe, and collectively we became the 'characters' of *Awakenings*, collectively we played it, lived it, made it alive in a new medium.

John Reeves's production, which was broadcast that March, excited a large radio audience in Canada – hundreds of phone calls and letters came in from listeners, who said they had been completely transported, that they felt they knew the patients themselves, had been present and shared their lives, and lived through their 'awakenings.' Many of these listeners had not read the book; many said, indeed, they were not 'readers'; that reality, for them, came through the ear, not the eye. This new intermediary of speech, the human voice, had given the words a physicality, a body, a presentness they lacked on the page. And even though writing is (perhaps) 'written speech,' and 'converted' in the mind of the reader to speech; yet speaking aloud has a directness which no writing has. The radio version of *Awakenings* showed the power of the word, and specifically the power of the spoken word, to represent, to convey, to evoke, a reality. Listeners said they could 'see' Leonard, Rose, and the others, even though the medium of communication was auditory, verbal. This modified my own attitude to *Awakenings*: I continued to hope that people would read it, but I started to feel that other modes were valid, and needed, too.¹⁶⁹

¹⁶⁹ At this point, with Carmel Ross, an actress and producer, I selected parts of *Awakenings* and read these aloud, spoke them, performed them, for an audiocassette version. I had never read aloud before, nor listened much to recorded speech – but now, suddenly, it seemed right, and indispensable.

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In September of 1987, Arnold Aprill, artistic director of Chicago's City Lit Theater Company, which specialises in near-verbatim dramatisations of written works, put on a stage dramatisation of *Awakenings*. I was not quite prepared for what I saw – I had thought this would be a dramatic reading of *Awakenings*, as with the CBC radio production: I did not realise it would be an actual staging.

Listeners to the radio play often wrote that they could 'see' the patients and characters, but this meant 'imagine' or 'in the inward eye.' But here the characters were actually visible. I (perhaps alone in the audience) knew what the patients actually looked like, knew that the real Leonard, or Rose, or Lucy, looked quite different from the stage versions. This discrepancy perturbed me – for all of five minutes – and then ceased to matter, for what I was seeing had great verisimilitude, was truthful, was *also* real, despite the actual and factual differences. That this could be so quite fascinated me: the Chicago Miriam H., a wonderful actress, was a great, busty, gutsy, ebullient black woman – whereas 'my' Miriam H. was an ageing, and somewhat deformed, Ashkenazi-Jewish white woman. None of this mattered – indeed the reverse: Jackie Samuels was an absolutely perfect Miriam, a deeply creative, deeply *right* characterisation such as the original Miriam H., had she been alive, would have delighted in. And Samuels, while sticking closely to the text of *Awakenings*, made Miriam her own, charged her with her own vitality, exuberance, idiosyncrasy. She invented, or created, a Miriam all her own; and yet this Miriam was fundamentally true – it was my Miriam, and the original Miriam, too.

The stage version took liberties which the radio version had not. It invented a certain amount of dialogue (though three-quarters of the dialogue, and the general structure, were still those of the book), and it used a certain amount of invention and dramatic licence in the creation of characters and situations. It was not just a dramatic reading, it was Arnold Aprill's vision or version of the book. It was more of a departure, certainly, than the radio version had been, but a fascinating and creative one which never departed from the truth.

Just a month later, now from Los Angeles, I received the first version of a film script of *Awakenings*. Its producers, Walter Parkes and Larry Lasker, had approached me as far back as 1979; they had visited Mount Carmel the following year, and had met Leonard L. and many

of the patients I had written of in *Awakenings*. There were to be many more visits, and there was much discussion over the years – but Hollywood is slow to move, and I remained unsure if anything would actually happen, until finally, in 1987, a film script came.

The script, written by Steve Zaillian, was very different in structure from the book, concentrating on a single patient (Leonard L.). The background of a whole ward of post-encephalitic patients, and the hospital they were in, was vividly sketched in; all of these patients had their own, individual 'awakenings.' The script centred on the close bond between Leonard L. and his doctor (who bore some relation, but only some relation, to myself?), a bond which gets closer as the film develops, as the doctor himself develops, from being a little academic, a little withdrawn at first, to intensely and humanly concerned for his patients. Many unexpected things occurred – some tender, some violent – and there was a fine dramatic ending which moved me as I read it, even though, factually, it was completely untrue. I was not quite sure how I felt about the script, for while in some ways it aimed at a very close reconstruction of how things had been, it also introduced a plot, several plots, which were entirely new. But I saw that this was necessary, and I liked many of the dramatic inventions (though I had reservations about the creation of a violent psychiatric ward – no such ward ever existed at Mount Carmel – and a certain tendency to portray the institution, and the other doctors, as unimaginative and repressive). What I could respond to, clearly and positively, was the emotional truth of the portrayals, the imagination and depiction of the inner lives of the characters. And what I was especially pleased with, and determined to watch closely, were the neurological portrayals demanded by the script – the portrayals of a profound illness, with innumerable strange forms; of the ways in which the patients endured and coped; and, of course, of their 'awakenings' and thereafter.

Though I was to be intimately involved with this film as a consultant, I had to renounce the notion that it was, in any way, 'my' film – it was not my script, it was not my film, it would be largely out of my hands. It was not entirely easy to say this to myself, and yet it was also a relief. I would be able to advise and consult, to ensure medical and historical accuracy; I would do my best to give the film an authentic point of departure, so that it *could* depart, so that the filmmakers and actors could realise their own creative work.

The following October I met the film's director, Penny Marshall; she too came to Mount Carmel, and we spent days walking round the Botanic Garden just by Mount Carmel, discussing the patients and the film. In June of 1989 I heard that Robert De Niro was to play the patient, and the following month I heard that Robin Williams would play . . . *me*, or at least the doctor character in the film who was, in part, to be based on me.

Bob, Robin, Penny, and Steve were all eager to see as many patients as possible, to get the feel of Mount Carmel, and to get it right. We spent many hours and days visiting various hospitals where I work, talking to patients with Parkinsonism, and to the few remaining post-encephalitics. And the documentary film of *Awakenings* was to be studied in minute detail by all the actors who would play post-encephalitics. This became the primary visual source, the source of images, for the feature film. There were, in addition, miles of Super-8 film and audiotape which I had taken myself in 1969 and 1970. And finally, there was archival film taken at the time of the great epidemic.

Robert De Niro's passion to understand what he is going to portray, to research it in the minutest, most microscopic detail, is legendary among actors; and now I was to see this for myself. I had never before witnessed, much less played any part in, an actor's investigation of his subject – the investigation which would finally culminate (as Tom Conti once said to me) in the actor's *becoming* his subject, knowing him, knowing it, in his own body, from the inside.

Learning that there were still nine post-encephalitic patients remaining at the Highlands Hospital in London – patients who had been admitted there as adolescents, and been there for almost sixty years – Bob felt it important to visit these, so in August of 1989 we went to see them together. He spent many hours talking with these patients, and taping them (he always liked to make research tapes which he could study at length). This was the first time I had actually seen him with patients, and I was impressed and moved at his powers of observation and empathy. He came to them not as a doctor concerned with their medications, not as a scientist concerned with their physiology, but as one human being approaching another. He approached them also as an artist and actor, as someone determined to make an accurate portrait, determined to *become* an accurate portrait. This was fully realised by the patients themselves, who were

intrigued and moved at a sort of attention they had never had before – and one which, curiously, they felt akin only to the best sort of scientific study. 'He really observes you, looks right into you,' one of them said to me the following day. 'Nobody's really done that since old Purdon Martin. *He* tried to understand what was really going on with you – and Mr De Niro, he's a bit like him, he's trying to understand too.'

By the time we returned to New York, Robin Williams had arrived, and now I was to meet the man who was to be me. This was not entirely easy, at first, for either of us: I had seen with what precision Bob had observed and studied the Highlands patients, and now, I feared, I was to be observed and studied in equal detail. But Robin wanted chiefly to see me in action, to see me in my own role as explorer and physician – and, equally, to see the sorts of patients I had worked and lived with in *Awakenings*. So, with Penny, we went off to the Little Sisters of the Poor, where I had two post-encephalitic patients I had followed for fifteen years. Here, as with Bob, I was fascinated to see how immediately at ease Robin seemed to be in a situation which was wholly new to him; how open and easy he was with the patients; and how his spontaneity put them at ease. He is very different from Bob, clearly, as a person and an actor – gregarious and outgoing, where Bob is brooding and intense – yet they share the same intensity, yet tact, of care; the passion, the minuteness of observation.

This hit me explosively a few days afterwards, when Robin, Bob, and Penny all came along with me to Bronx State Hospital. We had spent a few minutes in a very disturbed geriatric ward, where several of the patients were shouting and talking bizarrely, at one point at least six of them together. Later, as we all drove away, Robin suddenly exploded with an incredible playback of the ward, imitating everyone's voice and style to perfection. It was incredible to hear this: I felt that he must have taken in everything which went on, all the different voices and conversations together, and held them in his mind with total recall – and now he was reproducing them, or, almost, being possessed by them. This instant power of apprehension and playback, a power for which 'mimicry' is too feeble a word (for they were funny imitations, feeling ones, and full of creativity), was developed to an enormous degree in Robin. It constituted, I came to think, the first step in his actorial investigation; the one

which provided an intense and minute sensory and motor corporeal image, which he could then scan internally and analyse, and then finally imbue with himself, deepen, subjectivise.¹⁷⁰

The three of them – Bob, Robin, and Penny – went to Mount Carmel several times, to get the atmosphere and mood of the place, and most especially to see patients and staff who remembered the 'awakenings' of twenty years before. One evening especially moving to me (and to many of us) personally was a gathering together of all of us – doctors, nurses, therapists, social workers – who had been at Mount Carmel in 1969, all of us who had seen, and participated, in the 'awakenings.' Some of us had long since left the hospital, and some of us had not seen each other for years; but that evening in September, we swapped memories of the patients until early the next morning, each person's memories triggering others. We realised again how overwhelming, how historic that summer had been, and equally how funny, how human its events. It was an evening of laughter and tears, nostalgia and sobriety, as we looked at each other, at our twenty-years-later faces, and realised the many years that had passed – and, most sadly of all, that almost all of the patients were now dead.

All, that is, save one – Lillian Tighe, who had left Mount Carmel in 1975 to go to another chronic care hospital nearby, and who showed such eloquence in the 1973 documentary film. Lillian was, is, the only survivor, the only "Awakenings" patient still left. In September we visited her – Bob, Robin, Penny, and I – and we all marvelled at her toughness, her humour, her lack of self-pity, her realness. She has retained, despite advancing disease, and unpredictable reactions to L-DOPA, all of her humour, her love of life, her spunkiness. Bob, Robin, and Penny, although they had lived for months now with the reality of book and script, were overwhelmed

¹⁷⁰ I was soon to find this in regard to myself. After our first meeting, Robin 'had,' or mirrored, some of my mannerisms, my postures, my gait, my speech; all sorts of things of which I had been hitherto unconscious. It was uncanny, and disconcerting, at first, to see myself in this living mirror. We would talk – and the way we stood, and our cadences, our gestures, were the same: it was like suddenly acquiring an identical twin. But then this too-explicit mimesis gave way to a much profounder, much more subjectivised, actor's portrait of me – or rather of a being half-Robin, half-me, one created by his imagination and feelings, no less than by his observation of me; and finally, to a new character, neither Robin nor me, but one with a life and personality of its own.

(as Bob had been earlier at Highlands) by the reality of flesh and blood, by the mixture of terrible disease with gay, laughing transcendence. Indeed, Lillian was to remain a powerful inspiration and presence throughout the actual shooting of the film, visiting the set several times and even playing a part in a scene with Bob.

This careful research did not stop with pre-production but continued into the months of filming in the fall and winter of 1989. Particularly important was another person with firsthand knowledge of the disease, Ed W., a brilliant man in his forties, exactly Bob's age, who has a youthful form of Parkinson's disease and spectacular reactions to L-DOPA. Ed could describe eloquently – and even more importantly, *demonstrate*, in his own person – many of the phenomena Bob, and the other actor-patients, would have to show: he could show, and describe, exactly what it is like to be frozen in one's chair, or bed, for hours, unable to leave it; how it felt to be 'high' on L-DOPA; and how it felt to have, at times, a 'chemical personality' not one's own. Bob spent a great deal of time with Ed, sometimes spending whole days with him on weekends, in his apartment, or walking outside, or travelling – continually taking in more and more of what such a disease, such a changing neurological state, such a life, is actually like.¹⁷¹

¹⁷¹ The question of how a dramatic representation compares with reality – the clinical reality of my patients – always comes to my mind, perhaps even when it shouldn't. I once went with a cousin, Carmel Ross, to see the play *Wings* (in which one character is supposed to be aphasic). I was disappointed by the performance, and said to my cousin: 'But this is nothing like aphasia – it isn't real.' She replied: 'Stop talking about "real"! Can't you forget you're a neurologist? Can't you appreciate it as a wonderful performance – *emotionally* true? But I remained unconvinced.

On another occasion I went with her to see Tom Conti acting the role of a quadriplegic in *Whose Life Is It, Anyway?* This struck me, besides everything else, as being full of verisimilitude, as being clinically real. I spoke to Tom Conti at length about this later: I was fascinated to learn how he had spent hundreds of hours amid quadriplegic patients, and how he himself would spend hours daily imagining himself to be quadriplegic, at least imagining how, say, he could get his hair out of his eyes, if he happened to be paralysed from the neck down. 'You're an investigator,' he said to me. 'But acting is investigation too. We investigate from the inside, we investigate by *becoming*.'

On yet another occasion I saw Peter Barnes's short play, *Drummer*, based on my case-history of a Tourette drummer, *Witty Ticky Ray*. I went along with a Tourette friend. The actor playing the 'drummer' himself, I learned later, as he was waiting in the wings, was very taken aback at hearing a *real* Tourette in the audience, and thought, 'How will this appear to *him*? Will he think it's convinc-

There were, besides Bob, fifteen other actors playing post-encephalitic patients in the film, and I had to show them what Parkinsonism, and other symptoms, looked like and felt like. These were intriguing classes, oddly similar, in a way, to my classes for medical students – and then again, of course, completely different. For the medical students needed to gain a medical and physiological knowledge, to gain a general picture of Parkinsonism, a picture from the outside. Whereas the actors needed a concrete picture of Parkinsonism from the inside, so clear and concrete, so motorically precise, that they would be able to simulate, and in a sense *become*, Parkinsonian.

I showed them how Parkinsonian patients sat – immobile, with masked face and unblinking eyes; the head perhaps pulled backwards, or torqued to one side; the mouth tending to hang open, with spittle drooling from the lips (drooling was felt to be difficult, and perhaps too ugly, for the film, so we did not insist on this). I showed them common dystonic postures of hands and feet. I showed them tremors, and tics. (I found, interestingly, that the actors naturally divided themselves into 'shakers' and 'jerkers,' those who found it easier to tremor and shake, and those who found it easier to jerk and tic; I could not help wondering if there was some physiological disposition behind these different mimetic faculties.)

I showed the actors how Parkinsonian patients stood, or tried to stand; how they walked, often bent over, sometimes accelerating and festinating; how they might come to a halt, freeze, and be unable to go on. I showed them different sorts of Parkinsonian voices, and noises; Parkinsonian handwriting; Parkinsonian *everything*. I counselled them to imagine themselves locked in small spaces, or to imagine themselves stuck in glue ('It's like being in a vat of peanut butter,' said Ed, graphically).

We practised *kinetia paradoxa* – the sudden release of Parkinsonism into normality. We practised the release of Parkinsonism by music; and by spontaneous responses, such as catching a ball (the actors loved practising this with Robin, whom we felt might make a great ballplayer were he not committed to acting). We practised catatonia, and post-encephalitic card games: four patients completely frozen, clutching hands of cards, until someone (perhaps a nurse)

ing?' as well as 'Will he think this decent – or will he see it as a cruel take-off, an exploitation of his condition?' But my Tourette friend was impressed, and delighted, with the performance and play.

made a first move, and how this precipitated a tremendous flurry of movement – the game, first paralysed, now finishing itself within seconds (I had seen and captured this on Super-8 film in 1969, and now it was to become a scene in the feature film).

Sometimes special tricks are invaluable in allowing actors to simulate Parkinsonian symptoms which, otherwise, they could not have done. I have described how Miriam H. was able to talk at 500 words a minute *without fudging or missing a single syllable* – something which no 'normal' person can ordinarily do. But Jackie Samuels, who played Miriam in the stage adaptation, found that she could do this if she thought of Miriam's words as *music*, as musical phrases, operatic arias, recitations to be conceived (though not actually sung) in musical terms, as a series of musical impulses, rather than a series of words or sentences (perhaps auctioneers use a similar trick).

These singular, almost Zen-like exercises – becoming immobile, emptying oneself, or accelerating oneself, perhaps for hours on end – were both fascinating and frightening to the actors. They started to feel in their own persons, and with frightful vividness, what it might be like to be actually stuck in this way.

The one thing I could no longer directly show the actors was the impulsive, witty, ticky, 'hyper' states so many of the post-encephalitics had been in when young – the 'enkieness' they had shown before their Parkinsonism closed in on them, and which so many of them were to show, extravagantly, when they got over-excited by L-DOPA. To show them this I brought a number of young people with Tourette's syndrome to the set – for this was the nearest thing to the enkieness I could no longer show them. I had described enkieness and Touretishness to the actors, but description is pallid; they needed to be *seen*. One of the Touretters, Shane F., in particular, showed the sort of 'motor genius,' zaniness, and acceleration of thought which had been so characteristic of many enkies (p. 24), as well as explosive gusts of joking, mimicry, ticcing. All of this amazed, delighted, and above all, taught the actors, as no verbal descriptions or films could possibly do.

But perhaps none of them came to know Parkinsonism in as much depth and detail as Robert De Niro did, in his intensive playing of Leonard L. Can a neurological syndrome be acted? Can an actor with, presumably, a normally-functioning nervous system and physiology 'become' someone with a profoundly abnormal nervous sys-

tem, experience, and behaviour? Can he have the experience – psychological, or indeed, physiological – which would enable him to do this? There can, obviously, be a sort of imitation or mimesis – but this is not acting, this is not the level at which Bob works. He himself had said, right at the beginning, 'It's never just a method, just a technique – it's a *feeling*. You have to feel what's right, feel it out of your own experience and self-knowledge.'

Ed W. told Bob that sometimes he might be completely frozen for hours, completely unable to get out of his chair or bed. Bob told me that he would sit and think of being frozen like this, of not being able to get out of bed – he would think about this intensely, almost hypnotically, for hours; he would imagine the inner quality of frozenness, at such times. Bob also had to imagine what Ed described as 'the challenge of not being able to do anything directly, the need to break it down into a series, a task.' One of the greatest, and most paradoxical, challenges of all was imagining *nothingness*, which Leonard L. himself, and many other post-encephalitics, would often experience. Bob and I spent hours talking about nothingness, and the different sorts of nothingness patients might experience (see Rose R., n. 54, p. 75); this was a challenge Bob took very seriously – he quoted Becker to me once: 'Nothing is more real than nothing.'

Bob's method, as far as I could see, was to take in everything he learned about Parkinsonism, absorb it silently, without any external sign; let the images he had taken in sink down into his unconscious, and there ferment, unite with his own experiences, powers, imagination, feelings – and only then would they return, become visible, so deeply infused with his own character and subjectivity as to be, now, an integral part, an expression of, himself. (So it was with Harold Pinter; the processes of creation seemed very similar, whether within the writer's or the actor's mind.) This process, it was clear, could not be hurried. Sometimes there was, it seemed to me, a tension between the brisk timetable of the shooting schedule and the slow, unhurried pace of the creative process. And yet, through incessant inner work and rehearsal (and I had the impression that Bob was occupied with these, consciously or unconsciously, almost 24 hours a day), he would always come up with the needed image, the matured performance, on time.

One morning, when everyone was busy in another building filming a scene, I caught sight of Bob, alone in a corner of the set, with

a look of rage on his face; he looked extremely formidable. A few seconds later this gave way to a look of suspicion, a look of the most terrible, deepest, almost paranoid distrust. And then, the look of rage once again. When I first saw him I thought he *was* beside himself with rage, and then with suspicion. Now, I realised, he was *playing* with expressions of rage and suspicion, rehearsing privately for a coming scene. He clearly thought himself unobserved, so I hushed my breath and tiptoed away. It was amazing to see this; it was like overhearing a man *thinking* – but thinking with his body, experimenting, thinking in action. Thinking is not normally visible, but for the actor, for Bob certainly, it may be. Jerome Bruner (1966) speaks about three sorts of representation: iconic, symbolic, and enactive. The actor represents *enactively*, though in a very special, uniquely sophisticated sense. ('I learned to make of my body,' said Gielgud, 'a vessel to receive the text.')¹⁷²

On one occasion Bob and Robin were depicting a scene in which the doctor is testing Leonard's postural reflexes (which can be severely impaired, or absent, in Parkinsonism). I took Robin's place for a moment, to show how one tested these – one stands behind the patient and, very lightly, pushes or pulls him off balance backward (a normal person would accommodate to this, but a Parkinsonian or post-encephalitic might fall backward like a ninepin). As I demonstrated this on Bob, he fell backward, completely inert and passive, with no hint of any reflexive reaction. Startled, I pushed him gently forward to the upright position – but now he started to topple, incontinently, forwards; I could not balance him. I did not know what to do; I had a sense of bewilderment admixed with panic. In that moment I forgot he was an actor; I thought he *had* suddenly lost all his postural reflexes, that there had suddenly been a neurological catastrophe. And then I remembered, and said to myself: 'Don't be silly, he is only acting.' But even when I bore this in mind, I still found it uncanny, I still thought he had somehow managed to override all his postural reflexes. At this point I started to wonder how

¹⁷² A couple of years ago, I had a visit from Dustin Hoffman, who was then researching for the film *Rain Man*. We had visited an autistic patient of mine in hospital, and were now strolling outside in the Botanic Garden. I was chatting with his director, and he was walking by himself a few yards behind. Suddenly I thought I heard my patient. I was extremely startled, and turned round – and saw it was Dustin thinking to himself, but thinking with his body, thinking enactively, thinking of the young autistic man he had just seen.

deep, with Bob, acting might go. I knew how deeply he might identify with the characters he portrayed, but I had to wonder now how *neurologically* deep he might go – whether he might actually, in his acting, *become* Parkinsonian, or at least (in an astoundingly controlled fashion) somehow duplicate the neurological state of the patient. Does acting like this, I wondered, actually alter the nervous system?

The next day I was talking with him in his dressing room before the day's shooting began – and, as we talked, I noticed that his right foot was turned in, turned in with precisely the dystonic curvature it was held in when he portrayed Leonard L. on the set. I commented on this, and now Bob seemed rather startled. 'I didn't realise,' he said. 'I guess it's unconscious.' I knew that Bob sometimes stayed in character for hours or days – he might make comments at dinner which belonged to Leonard, not himself, as if 'residues' of the 'Leonard' mind and character were still adhering to him – but I had not realised that this might include the sustained holding, unconsciously, of *neurological* characteristics, such as this persistent, dystonia-like, inward turning of the foot. (I observed this sort of thing also with some of the other actors playing 'enki's,' especially those who had to maintain a very abnormal and fixed head or eye posture for hours; some of them seemed to be getting a wry-neck even off the set.)

There was one *grand* and (neurologically) climactic week in January when Bob portrayed two sorts of post-encephalitic crisis – an oculogyric and a respiratory crisis. He studied for these with extreme care, reading and rereading the descriptions in *Awakenings*, going over and over bits of film and tape, and questioning me endlessly as to what they were like. But when he actually did them, entered them, it was with a power and a conviction that seemed to exceed representation: he gasped, he stiffened, his eyes rolled torturedly upwards, he turned such a color I feared he would pass out. And here again – all of us watching him were appalled and spell-bound – it seemed to us that he was no longer 'acting,' that he was *actually* in the throes of a terrible crisis. I thought, 'He is actually having an oculogyric crisis,' and wondered what altered state his nervous system was now in; I wanted, half-seriously, to get an EEG, an electroencephalogram, on him at this time, wondering whether it might not be (as it tends to be in an actual crisis) grossly slowed, or perhaps convulsively abnormal. And his respiratory crisis, for me,

at least, was deeply moving and nostalgic. I had not seen a respiratory crisis for twenty years, not since the stormiest days, the tribulations, of 1969. I was delighted to see one once again – I thought, 'You dear old thing'; it was like seeing an old and missed friend. And so real, so real, it made me *think* about respiratory crises, which I had not had occasion to do for twenty years (ever since I had published a short paper in the *Lancet* about them); it made me look through my tapes again, reread the classic papers of Turner and Critchley, and then write a new footnote for this edition of the book (p. 46). Here, then, the flow was reversed: it was not I teaching the actors neurology, but the actors beginning to teach me – at least making me *see* it, see the nervous system, in an unusual and fresh way.¹⁷³

But there were many revelations for me in the film – it was not merely, for example, that I was made to think about neurology and acting in a new way; I saw whole events anew from the perspective of their portrayal in the film. One such event – a very central one – sticks in my mind. The enkies, the post-encephalitics, have all 'awakened' one night (for dramatic reasons this was condensed, although in real life some of the patients had come to at different times, over the course of several weeks), and the next day are seen, all awake, in the dayroom. It is a complex scene, for there are fifteen patients there, and each of them has awakened, indeed, *to a world of his own*. They do not, at this point, form a community, in the least – every patient is still alone, almost autistic, in his own singularity. There are fifteen Rip van Winkles, fifteen intense egos, each totally absorbed with the wonder, and the problems, of their own, individual, and totally separate 'awakenings'. All of them have their own, completely different needs and demands. The staff is rushing from one to the other, answering a score of questions at once, dealing with a dozen and more completely different lives – intensely excited, intensely individual, intensely importunate new lives.

This is an amazing scene, in every way – it is, as a start, one of enormous physical complexity, for so many people are moving and doing different things at the same time. Penny has many special gifts,

¹⁷³ Jonathan Miller, who is both a theatre director and a neurologically trained doctor, has often made comparisons of patients and actors, how both have an implicit, unconscious knowledge of neurology – not in the formal, medical sense of 'savoir,' but in the intimate, personal knowledge of 'connaissance.'

but her choreographic gift – her power of directing twenty people doing twenty things simultaneously, of visualising and directing all their movements like a ballet – this choreographic power reached its height in this scene; all was movement, all was confusion, and yet everywhere, at the same time, all was focus, all was sense. But what was overwhelming for me was the *truth* of this scene. Steve Zaillian had invented it, but he had invented it right. For one reason and another (some of this to do with the form of the book, my presenting individual patients one by one, rather than the evolution of a social situation, as a whole), I had never described such a scene as now unfolded before me. But Steve, with his strong dramatic sense, had seen that such a scene must have occurred, and in this he was joined by Penny's strong dramatic sense too. They created this scene, then, with nothing to go on – nothing, that is, except their sense of what was dramatically necessary and right. And they were right, they had imagined absolutely correctly – there had been such a scene, several such scenes. I recollected this, as soon as I saw *their* scene. 'Damn it!' I thought, 'They've got it – that's what happened. That's just like the truth.'

By February, we were tired – there had been four months of filming, to say nothing of the months of research that preceded this. We were all tired, dog-tired, until an event that galvanized everybody into life. I made notes in my journal:

Thursday morning: Arrival of Lillian T. – the only living survivor of *Awakenings*. She has come to the set, where she will play (*be*) herself in a scene with De Niro . . . What will *she* think of the would-be 'enkies', the film post-encephalitics, around her? And what will they feel about her, the last survivor, the real one among them? As she enters there is a feeling of awe – everyone recognises her from the documentary – and a sudden, almost frightening sense of reality – not that anything was unreal before, but it was the reality of stage, of script and book, these *constructed* realities. But now Lillian enters, the aboriginal reality – like Caesar entering a set of *Julius Caesar*, like someone stepping out of the pages of a history book . . .

However much the actors immerse themselves, identify, they are merely playing the part of enkies; Lillian has to be one, is one, for the rest of her life. They can slip out of their roles, she cannot. How does she feel about this? (How do I feel about Robin playing me? A temporary role for him, but lifelong for me.)

As Bob is wheeled in, and takes up the frozen, dystonic posture of Leonard L., Lillian T., herself frozen, cocks an alert and critical eye. How does Bob, acting frozen, feel about Lillian, scarcely a yard away, actually so? And how does she, actually so, feel about him, acting so? She has just given me a wink, and a barely perceptible thumbs-up sign, meaning, 'He's okay - he's *got* it! He really knows what it's like.' . . .

Everyone has been in to see Lillian, or talk to her. The entire set, steeped in make-belief, is moved to the depths. She shines with reality, in this make-believe world. People come in and touch her, grounding themselves, touching the rock.

Past and present had come together, model and representation had come together, to produce an extraordinary sense of reality, of completeness. The film - or at least the filming, the moral act of filming - needed Lillian's actual presence to culminate and complete it. We all had a feeling, now, that the circle was completed.

GLOSSARY

A book such as this necessarily uses a number of unfamiliar words referring to its special subject matter. In general, I have tried to indicate the meanings of these, by context, as they occur. The following short glossary is designed as a reader's companion, to help him visualize the peculiar disorders of movement, posture, will, appetite, sleep, etc., which constitute a major part of the subject matter of this book. Such terms are analogous to the much more familiar words with which we discuss emotional and neurotic disorders. The following words merge and overlap in meaning, as do the disorders they denote.

ABOULIA. Lack of will or initiative. Especially favoured, at one time, in descriptions of neurotic 'paralyses of the will,' true aboulia is perhaps only seen with organic disease or damage to the brain - as in *encephalitis lethargica*, following extensive leucotomy, etc. It is often, but not necessarily, associated with profound apathy. The opposite of aboulia is *hyperboulia* - excess of will, wilfulness, urgency, apertency.

AGRYPNIA. Total inability to sleep, absolute resistance to sedation - the acme of insomnia. This disorder, fatal if it lasts much longer than a week, is also only seen in diseases and intoxications - especially *encephalitis lethargica* and ergot-poisoning.

AKATHISIA. Inability to keep still; intense urge to move; restlessness or fidgets in their most extreme degree.

AKINESIA. Total lack of movement, or inability to make voluntary movements, for any reason whatever - seen in its most profound degree in post-encephalitic illness. One speaks, similarly, of *apboria* (inability to make sounds), *amimia*, *apbrenia* (stoppage of thought), etc.

ALGOLAGNIA. Lust for inflicting or suffering pain.