

Chapter 9

Narrating a Return to Work After Spinal Cord Injury

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Since the growth of disability studies and of an advocacy movement for persons with paraplegia and quadriplegia, scholarship on disability and rehabilitation has grown rich with ethnographic accounts of these illness experiences and the narratives that communicate and embody them (Sandahl and Auslander 2005; Rogers and Swadener 2001). Medical ethnographic accounts have contributed to: the recognition of identity (re)formation following traumatic injury or disability (Linton 1998; Shakespeare 1996; Manderson and Peake 2005), an awareness of the need for continuity across the life span (Becker 1998; Manderson and Smith-Morris 2010), and the testing of new identities through embodied and vocalized performances (Mattingly 1998a, b; 1994; Frank 1995; Mattingly and Garro 2000). The narrative is now viewed not as a static, referential form, but as a pregnant and productive tool in rehabilitation and chronic illness, as well as a source of qualitative data for program evaluation and even clinical trials.

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In this chapter, we report on data from the qualitative arm of a clinical trial of supported employment for persons with spinal cord injury (SCI). The trial, a supported employment program investing human and technological resources to help veterans reach their personal employment goals, extended a progressive form of what might be called either “vocational rehabilitation” or “occupational therapy” (Frank et al. 2010). In the qualitative research, we were concerned with the productive task of the illness narrative, what Mattingly and Garro identified as its “perlocutionary functions” (Mattingly 1998a, drawing on Austin 1962; Garro and Mattingly 2000), specifically for persons with SCI. Perlocution is the productive capacity of narrative that allows speakers to imagine, test, and enact new adjustments to illness, in this case to SCI and to new goals for employment.¹ For our informants, rehabilitation is an ongoing process of employment, one that Mattingly says is necessarily social, and which links the past and the future together as “time itself takes on narrative shape. Actions acquire some of the formal and aesthetic qualities of the well-told tale: drama, suspense, risk, adventure, surprise, plot, a sense of the whole, and especially that sense that something significant is afoot” (Mattingly 2000, 181). In short, it is not something limited to the clinical rehabilitation unit. Our informant narratives illustrate not only the overall perlocutionary function of narrative but also several of Mattingly’s features of narrative time, as they intermingle and reconcile both past and future, sometimes more than a decade after our informants’ spinal cord injuries.

The Qualitative Arm of a Clinical Trial

The clinical trial of which our work was a part occurred in facilities of the Veterans Health Administration and was aimed at helping persons with SCI return to employment. Not a traditional ethnography but the qualitative component of a larger trial, our study sought to learn participants’ notions of work and their goals for returning to work after an SCI and to consider critically how interview narratives within the clinical trial might reflect an ongoing experience of illness and healing. The “Spinal Cord Injury Vocational Integration Program (SCI-VIP): Implementations and Outcomes” multicenter project was based at the Dallas Veterans Affairs Medical Center (VAMC) and offered an intensive intervention in supported employment to participants with the expressed desire to return to work. Our qualitative research focused on narrative data that would supplement the trial’s clinical and quantitative outcome results.²

We are careful to point out that, since the clinical trial occurred in a VA Health Administration facilities in the USA, all participants were veterans of the US military branches (e.g., Army, Navy, Air Force, Marines). This institutional context of our study introduced certain similarities in the background of our informants that would not be present in a more random sample. Enrolling only Veterans, whose experience and identities as soldiers involved unquestionably physical competencies and

constitutions, may have produced an extreme or hyper sense of physicality and/or masculinity in our sample. We address this in a limited way in our discussion, but we do not have comparative data that would help isolate the influence of a military experience on narratives of SCI. Further, the vast majority of our informants were male, a characteristic that is likely correlated to their having been veterans ten or more years ago and to their engagement in the activities that led to their SCI. We do not attempt to explain this pattern in our sample, since the gendered nature of both military service (Armor 1996) and even SCI (De Vivo et al. 1999) are already documented. Instead, we acknowledge these two characteristics of our sample – their shared background as military veterans and the predominantly male gender of our informants – as just some of the aspects of their desire to return to work.

Twenty-four informants provided recorded interviews in their homes, some on multiple occasions, and allowed us to attend various community and clinic events with them to observe their daily lives. We observed their high- and low-technology adjustments to life with SCI in their cars, their homes, and their work. In conversation, they shared their psychological and emotional challenges of recovery, both near to the time of their injury and in the years that followed. They also talked about barriers – in health-care institutions, in societal attitudes, and in physical landscapes – that affected their daily activities and goals.

US Veterans have access to medical care through the Veterans Health Administration after they complete their military service.³ Our participants received their health care through the spinal cord injury unit at the Dallas VAMC. Participants were an average of 48.3 years of age and had sustained their SCI on average 12.4 years prior to the research. Most of our informants had a high school degree but little college credit prior to injury (on average, the project sample had 13.4 years of schooling prior to injury). Most did not sustain their injury during active military duty but after discharge from service, and most had been living civilian lives for quite some time. These veterans were not recently returned from Iraq or Afghanistan (as was the case for Messinger 2010). Instead, our informants' experience of SCI was already long term and not acute. And so while the most substantial adjustments to newly lost functioning may have occurred many years ago, our informants were able to talk about the long-term adjustments or "chronicity" that an SCI engenders (Manderson and Smith-Morris 2010). As new technologies and medical interventions become available, the illness experience of SCI also changes. For persons with chronic illness or disability, the entire continuum of health and disability are thrown into new light, such that only the period of diagnosis is truly acute, whereas a lifetime is viewed as a constant series of adjustments and adaptations (*ibid.*).

The degree of disability and causes of injury in our sample varied. Over one third of the spinal cord injuries was caused by a motor vehicle accident (39.1%), followed by a gunshot wound (16.3%), or a fall (14.9%). Almost half had paraplegia (47.3%), while the others had either high (C1–4) (34.3%) or low (C5–8) (16.4%) tetraplegia. Hence, what informants had in common was a history of military service and an expressed interest in returning to paid employment. Each had volunteered to participate in this multicenter clinical trial for supported employment, made available through

the medical center's spinal cord injury unit. Since participants were chronically injured and chronically unemployed, more than half had not participated in paid employment in the past 5 years. Yet given the opportunity, they were still interested in going back to work. Invited to participate by their own clinician or a hospital employee, the SCI-VIP program gave many of them the extra "push," or encouragement, they needed to return to the job market.

As a clinical trial, the SCI-VIP was designed to improve veterans' occupational outcomes by measures of competitive employment⁴ and psychosocial functioning. In the trial, veterans were randomly assigned to either a supported employment program (SE) or to the standard care group. Participants in the standard care group were free to use whatever vocational services were available at their VAMC including referrals to outside agencies (e.g., state vocational rehabilitation services). Veterans in the SE condition received the treatment, namely, supported employment services from a specialized vocational rehabilitation (VR) counselor with training in SCI.⁵

The VR counselor spent many hours with each participant, assessing their needs, strengths, and goals; collaborating with their clinical care providers; and conducting job searches that targeted participants' interests and qualifications. Much of the VR counselor's work was conducted in the participants' homes or on the phone. She would help the participant construct resumes and applications and occasionally make preliminary phone calls to employers, drawing these resources from the local newspapers, internet employment advertisements, job ads within the VAMC itself, and contacts she had through her own years of work as a VR counselor in the area. The VR counselor might also provide rides and assistance at job interviews or other related appointments, including clinical appointments. In sum, the VR counselor's support was extensive and individually tailored, and the program of supported employment much more intensive than other (e.g., state) vocational services that were available to veterans (Ottomanelli et al. 2009, 2011; Smith-Morris et al. n.d.).

In summary, the SCI-VIP was a large and complex clinical trial, and we report here on just one ethnographic set of data from one of its sites. Our approach to ethnography within a clinical trial deserves a brief explanation, so we offer one final comment of introduction about these data, how and why these interview narratives were produced, and what their meaning may be. As anthropologists working within a clinical trial, we viewed our interviews as having both therapeutic and anthropological purposes. Patient narratives were one vehicle by which treatment for SCI recovery and adjustment occurred, but they were also an important communicative device by which informants expressed having reached their goals or having been satisfied with their care. Thus, narratives not only reflected veterans' adjustments and ideas about life and work with an SCI but also gave them an arena – the interview – in which to actively craft and formulate new adjustments. Clearly, we rely heavily on Mattingly's theorization of narrative emplotment in our work and the discussion below not only for what this model teaches about therapeutic narratives but also for how essential the narrative has become to the anthropological project (Garro and Mattingly 2000).

Narratives Within a Trial of Supported Employment

In formulating our research, and in the analysis of our data, the concept of perlocution (Mattingly 1998a; Mattingly and Garro 2000) figures prominently. That is, illness narratives are not “just talk” (Myerhoff 1986) but actions that prompt specific effects in the listener, shape conduct, and bring experience to conscious awareness.⁶ Narrating the story of one’s injury is an essential, and constitutive, act of rehabilitation (Mattingly 1994; Becker and Kaufman 1995; Warren and Manderson 2008). The narration changes according to audience, to stage or sense of recovery, and to severity or type of disability in order to help the speakers craft and verbally test out new visions of themselves. The responses to and results of each narration either act to support the given vision or promote alterations. This is Mattingly’s (1994, 1998a) framework; it allows us to analyze the narrative as a *productive* tool in rehabilitation and also as a vehicle for expression of continuity.

Our discussion also relies on models from medical anthropology for understanding chronic illness through narrative (Manderson and Smith-Morris 2010; Becker and Kaufman 1995; Becker 1998). Mattingly’s own work – which gave us therapeutic emplotment – emerged from research with informants with chronic illness or disability, and so the utility of this method for our own subjects with SCI is neither surprising nor particularly new.

What we do suggest to be provocative and new are the subject matter and the timing of our interviews. First, these are narratives of a return to work by informants with an SCI and who have received not only traditional rehabilitation but now also an intensive program of supported employment.⁷ And so, the disruption of the SCI is paired with another disruption, the difficult and disruptive process of winning and keeping a paid job. Second, the timing of these SCI narratives is quite late relative to our informants’ initial injuries, indicating the chronicity of these adjustments. We met our informants on average 12.4 years after injury. Narrative efforts for a return to work, notably after many years of disability-related unemployment, produce and perhaps compel a distinctive looking-back by our informants, and a linking of some long-distant past to an emerging future. And so we consider a longer time depth in these narratives than is common.

Without perlocution and narrative emplotment, our data would be flatly referential and could have been collected more economically through a closed survey method. Instead, Mattingly has illustrated the productive capacity of storytelling in her own vivid ethnography of the occupational therapy sessions she captured on video (Mattingly 2000).⁸ Key to her analysis were the imaginary and dramatic performances that she witnessed, each mutually crafted by therapist and patient through reliance on shared cultural tropes and roles. In just one example, a 9-year-old patient proposes to transform her regular therapy session into a playful dramatization of Olympic sport competition. With the help of her therapist (and the ethnographer camerawoman), a plot developed, “one in which the child is not a disabled patient undergoing treatment but a brilliant athlete performing her breathtaking feats for an admiring audience” (Mattingly 2000: 191). In short, therapeutic emplotment is not just playacting but a healing event.

While we did not seek out episodes of dramatized employment so much as narrations of life plots, we found ample evidence of productivity and action. Viewed through Mattingly's (1998a, b) prism, the clinical trial in which these veterans were enrolled was an intensive opportunity for narrative recasting of the past and for the subjunctive, as-if work of future planning. When we asked informants to talk to us about their goals for work and what they considered a good or rewarding job, we were setting the stage for a performance, inviting them to narrate the back-to-work plot that they (and their VR counselor) had envisioned for themselves or to revise it for us in this new performance for a fresh audience. We expected, and to a large extent heard, narratives about societal assumptions of physicality, about the centrality of work to US images of productivity. In the USA, where individualism, wealth, and self-sufficiency are all highly valorized in the productive adult, the states of poverty and dependency that a catastrophic SCI can engender are as traumatic socially as they are physically and emotionally (Hanson et al. 1993; Linton 1998; Yoshida 1993).

In the sections that follow, we discuss the following: first, that adjusting to SCI required ongoing adjustments in relationships and self-sufficiency, not only upon initial injury but with each new event or change as when, for example, persons with SCI attempt a return to work; and second, that the need for continuity in one's life narrative survives across many years. Our informants narrated their strained relationship between physicality and identity and evoked memories of physically hard labor and constant mobility and activity in their past. We explore how these historic physicalities would carry forward and how memories of these abilities would help shape veterans' new goals for work.

SCI Over the Long Term: Relationships, Dependency, and Physicality

Adjustment to the increased dependency on others after a spinal cord injury is a significant aspect of rehabilitation and recovery (Yoshida 1993; Hanson et al. 1993). These difficult adjustments impact old relationships, of course, but also each new relationship for the rest of one's life. As our informants discussed the process by which relationships adjusted or dissolved, they made clear how strong their negotiation skills had to be and how complex their support networks had become. Independence had to be renegotiated with existing family and friends, possibly with new caregivers and often a new social circle, involving not only different people but more people. And veterans had varying degrees of success in this effort.

Forty-three percent of the SCI-VIP participants were divorced; 26.7% were married; 11.4% were either separated, widowed, or cohabitating; and 19.3% were never married when we first met them. All veterans described relationships that went through adjustments – and sometimes dissolved – after the injury, including different romantic, familial, social, professional, and more distant relationships. Among some of their new relationships were those that supported them in the once mundane

physical aspects of living including physical caregivers, staff in the wheelchair repair office, and the SCI-VIP staff themselves. The narratives reflect on themes such as humility, patience, and courage as they negotiated these new relationships and the loss of self-sufficiency and independence that they represented.

Family members – spouse, parents, children, and siblings – were the first line of support for most informants. The veteran's rehabilitation and increased dependency led some families to stronger ties and reignited relationships:

My family was there. They support and help in all that, in every way they could. There was really nothing they could really do but come and visit me and everything. I'm sure the doctor probably told them that he would be in bed for the rest of his life. But of course, they were encouraging, you know. That's about all that I had at the time, was family.

One participant described his mother learned all over again how to care for him when he was sent home: "when I needed all that medical care, well my mom, she learned what she could do to help me to get better. And she did it." Another stated that "well, I would guess I would have to say it brought me closer [to my family], because I wasn't living in this state. And physically I am closer because I live with my mom now, and so I do see all my family more." The narrator uses his authority over the narrative to ignore any complexities behind this story and close the story with its positive lesson: "it brought me closer".

Here is another informant who narrates a successful ending to his story of adjustment with parents, who had been too willing to do things for their son:

My parents, at first, were... kind of coddling but after talking to the doctors, were told, "don't baby him", you know? Which helped a lot, you know? I gotta make it through this.

The story begins with an ending in mind – an ending in which the veteran makes it through his adjustment to SCI. In narrative time, our informant can organize and control the storyline so that the beginning links swiftly and clearly to the ending he narrates. First, his parents were overindulgent and "coddling," then the doctor intervenes, and finally, he makes it through. The listener suspects, however, that the transition was an emotional and painful adjustment for all those involved and no simple matter for the doctor to address.

Unreliable support made the transition more difficult and lonely. Veterans' priorities for their close relationships sometimes changed, so that relationships that existed prior to the injury did not necessarily continue afterward. This included some romantic relationships and marriages, as well as some platonic friendships and more distant, casual relationships. Some reported that the effects of the SCI proved an insurmountable barrier to the relationship (i.e., either physically, emotionally, or logistically), while others explained that they just didn't have as much free time for relationships as they used to have. For example, Randall's marriage ended after the SCI and he explained:

My wife didn't seem to give me any understanding in regards to this limitation. I was expected to do everything as if I was an AB [able-bodied] which frustrated the tar out of me. I just said, "Can you please cut me some slack?" You know, I don't like to say, "because I'm in a wheelchair." You know, I didn't feel like I had to remind my wife every day that I'm in a wheelchair. How can you expect me to do all those things that I could do if I was AB? It ain't gonna happen.

Randall made clear that it was the new limitations related to being “in a wheelchair” that caused his marital strain, and through his narrative authority, he is able to project tremendous clarity onto a marriage breakup that was likely more complicated: “I didn’t feel like I had to remind my wife...” For others, the impact of the new SCI on already strained relationships was not so clear:

I had a wife in the past [but she left me for another man]; in order to justify what she did, she would tell people that [she left me] because I was in a wheelchair. But that wasn’t true. It just makes it [so] she doesn’t have to explain what it was she did. So she used that as an excuse.

Here again, narrative authority allows this informant to contain the chaos of this relationship by ending the story with a clear and unambiguous assertion: “she used that as an excuse.” He also asserts and reestablishes his societal legitimacy as a man and a husband, by negating the impact of his wheelchair and squarely placing responsibility on his ex-wife’s behavior (“what it was she did”).

The sometimes difficult negotiations with family and friends initiated a new period of social integration for veterans post-SCI. Although their experiences were varied, and their reactions and coping abilities equally diverse, the problem of stereotypes and norms of physicality was nearly universal. In general, social norms promoted an assumption and expectation of bipedalism, and the use of a wheelchair signified dependency and incapacity. “I’ve learned firsthand, that when you have a traumatic [injury] and you’re in a wheelchair or an electric wheelchair that... you are discriminated against.” Paul is a veteran who had limited mobility in his legs and used a wheelchair for most (but not all) of his mobility. When he was seen out of his chair, others sometimes assumed that Paul was faking an injury, expecting him to function “normally.” He told us, “one thing I learned about my condition is, I’ve been accused of constantly, I call it visual discrimination. You might judge me as being able to do something that I am not able to do.”

Another veteran explained how he was patronized when going out to restaurants. Some social interactions felt confrontational or demeaning: “If I go to a restaurant with somebody, instead of somebody asking me what I want to order, they will ask somebody that’s with me. And I will immediately snap and tell them, ‘I’m the one you need to ask’.” Another suggested, “I just think people are uncomfortable with being around people in a wheelchair. There’s this stereotype. Every time you see them in Hollywood, they’re all assholes, you know?”

We do not offer an in-depth analysis of social discrimination but it was a common experience among our informants, and it took many forms. For one female informant, a social worker’s ignorance of her capabilities prevented a successful adoption application process:

Yeah, well we were starting to go through the process of being foster and adoptive parents. And we went through their training classes and they asked, “well, who is going to take care of the kids if something happened to your husband?”, and things of that nature.... We got to the point where the social worker was more worried about my disability than me being a parent. And we thought, if that’s going to be the attitude of the social workers with the foster care department, then we don’t want any part of it. So, we backed off from that. Maybe someday in the future, but I doubt it.

The narrative is brief, and again the narrator's authority allows her to conclude the story with her own assertion which is both logical and moral. She leaves open the possibility of another attempt in the future, but the narrative has established her as a proud and moral person despite the ignorant assumptions of her adoption social worker.

In addition to discrimination in public spaces, veterans mentioned discrimination in professional environments like the workplace. When sharing his experience with finding employment, Ben stated:

Forget about the physical challenges, you've got to overcome people's opinion. Because the first thing they see, especially an employer, [is someone in a wheelchair]. When people walk through the door on an interview for employment, people are going to pass a personal judgment. Whether it is right, wrong or indifferent, it's going to happen. And when they see an individual come through the door in a wheelchair, some of the first things that go through their mind is, "are they going to be any good to me", and "is this a medical insurance liability?"

Participants' frustration with these forms of discrimination, like their changes in work and career goals, is evidence of the tension between the pre-injury and post-injury selves. As experiences trigger memories of (or contrast with) the pre-injury self, another disruption is created of the kind that Becker suggested is universal and a lifelong occurrence (Becker 1998). Adjustment to increased dependency on others was a significant aspect of veterans' integration into post-injury life, but a variety of new disruptions could trigger both similar and new needs for adjustment and reestablishment of a sense of order, purpose, and meaning. Narratives not only reference and report this restructuring of both close and socially distant relationships but also contributed in a real way to our informants' reestablishment of order through the perlocutionary aspect of performance. It became more orderly because they were able to assert that order to us, their audience. Had our information gathering been in a closed format, assessing only current or former facts or statuses, then these veterans would not have been able to cast their narrative summaries or to assert the closure on their stories that placed them in their correct moral and social light.

Our second realm of narratives mirrors our first, in presenting narratives that are active and assertive, and which develop plots or storylines that suggest the narrator's hindsight-informed perspective on the whole thing. In this second set of narratives, physicality remains central to both their past as an uninjured and active person, and to their present, so full of possibilities.

The Physicality of Work, Yesterday and Today

In treating our interviews as emergent narratives, we viewed the veterans' stories not so much as being told but tested. In the emergent narrative, again drawing on Mattingly, "time itself takes on narrative shape" (Mattingly 2000: 181), and the story gives the illusion of chronology (Barthes 1975) and a coherence that may not have existed in the original sequence of events.⁹ One key feature of narrative time on which we will dwell is that it is not linear or chronological but centered around a given action or motive.¹⁰

We began by asking veterans how they defined the term “work,” and what it meant to their lives and identities. Although the SCI-VIP aimed to place participants in paid employment, and not volunteer or subsidized employment,¹¹ our informants sometimes chose a payment-based definition, but other times defined “work” more broadly and often with reference to physical activity. Asked simply, what does “work” mean to you? Veterans gave characteristic responses such as:

For me, the concept of work means doing something physical, like farm work, ranch work, building, construction. Because... there were a lot of opportunities for kids to earn money when I was growing up. It doesn't seem to be there now. I had a paper route when I was 11 years old. [I] sold greeting cards, I did all kind of things. Mowed yards, stuff like that, anything to earn money. For me, yeah, work back then was something physical.

Work takes on a new connotation, you know? You can work at a computer, which isn't very physical but has its own stress points: repetition, tennis elbow, whatever. You know, there's things that could happen to people that do that all the time ... I've learned to appreciate all of it. Fact is, everybody's job is important. There's just some jobs that I would prefer over others. But you know, doing ranch work requires more AB [able-bodied] ability than I have... There's things I've done. It's like when I had to repair my fence. I figured out a way to do it. And, of course, it's physical labor so I enjoyed the heck out of it. Because I had, our dogs were tearing the fences down, so I had to repair them all.

Being able to repair a fence from his position in a wheelchair was an example of the type of work Rich might have done before his injury. It was the type of physical labor that he “enjoyed the heck out of” but not the type of work he normally does now. Rohe and Athelstan's (1982) work also illustrated how men who preferred action-oriented, performance-oriented occupations prior to their SCI preferred this type of work after their SCI.

However, not all veterans defined despite national discourse. Several of our informants referenced broader ideas of purpose and productivity and of being paid as essential elements of “real” work:

I know we need purpose. And I know that I like the - I like feeling useful, [and] not just to myself. I like to feel that I'm useful to society, to the country, that I can contribute in some small way. It's all of us working together to make the whole thing work. And of course, I feel useful. And I guess you could say, since I can't do all the real physical things that I like to do, being around kids really makes me feel useful.

I wouldn't consider [going to school] a 'job'. You pay to go to school, you don't get paid. I did volunteer work for the paralyzed Veterans for about 15 years and they didn't pay me... Mowing the grass, rake the leaves and put them in the bag and stuff, yeah that's work. But I don't get paid for it. But it's still work. If I was doing it for somebody else I would probably get paid for it.

So payment helped differentiate the notion of “work” from volunteer jobs or the work of daily life.

What we find noteworthy is the fact that, as informants began to elaborate on their notions of work, they began to tell stories. They shifted from simple, referential talk into narrative talk, suspending time so that historic moments could help explain contemporary ideas and meanings. This veteran's reference to volunteer jobs for which he was not paid emphasized the difference between “real” work and nonwork, namely, that “real work” is not altruistic and that one is paid for it. In the

narrative, the “gap” or “place of desire” (Mattingly 1998a: 85) is volunteer or altruistic work; the resolution (and it is not entirely resolved, but the goal is clear) is to achieve paid work.

These narrative turns to an historic self or to experience were nearly ubiquitous in our discussions of work. Veterans relied on memories to illustrate a productive past and to narratively link these to their desires for an active and productive future. Corroborating other research from the realm of rehabilitation, veterans’ narratives of progress become essential to therapeutic goal-setting and evaluations (Warren and Manderson 2008; Mattingly 1994). As for Warren and Manderson’s informants (2008), whose functional assessments offered benchmarks by which a therapeutic trajectory might be measured, these participants in a trial of supported employment had embraced the goal of finding and keeping paid employment. So narratives of progress or employment were not so surprising. What we did not expect was the consistency with which historic references (including references to hyperactive and physical selves) would structure their narrative about work.¹² Veterans many times referred to the productivity of their past:

Before [my injury] I was pretty well active. I had 3 or 4 jobs at that time.

[When] I was in high school, I worked in farming... I would go to football practice, and then I’d go straight out in the field [farm] for a neighbor or whatever until 1 to 2 o’clock in the morning. [Then I’d] come in, and sleep a little bit, get to school. Then, when the farming kind of went down, I went to work in the oil field, you know? And I always worked.

One man stated: “I used to like to work out, lift weights... I usually worked out about three times a week.” Another said, “before I was injured I still ran, I still exercised even though I worked. I was considering going into competition with full contact karate... I [also] did weight lifting.” The importance of physicality to this man’s identity was clear. Another informant proudly reported, “I was always running, always healthy and in fact, when I first broke my back, the doctor in the San Antonio VA said, ‘other than your back,’ he said, ‘you’re healthier than I am’.”

Still other veterans described another type of productivity, like a pre-injury career that had been entrepreneurial and on the rise prior to their injury. Dexter offered, “before my injury I was working on getting my journeymen license in heat and air. If I didn’t get injured, I would have those licenses.” Another individual, Shawn, was in the carpeting business and, in mentioning how good business was prior to his injury, said:

Well, I was working towards the goal of growing my carpet store big enough to where all I was in was in sales... I was busy doing installs, and checking on my crews, and running around, and I was hoping for all of that to grow.

These narratives of activity, productivity, and pre-injury successes are, we argue, an important part of narrative time for persons with chronic illness. Without the ability to draw on historic actions and accomplishments, narrators have greater difficulty justifying or giving a morally defensible explanation for their current goals. As if the SCI were not justification enough for a revised physicality, narrators seek to establish their historic physical abilities and independence (core cultural values) as evidence of their credibility as full participants and members of society.

The actual types of work to which participants returned varied as widely as the pool of participants but included paid work in computer programming, mechanics, and phone support for different types of businesses. The physicality of work today was managed through a combination of therapy, accommodations, and technological modifications, either to their practices and behaviors or to their surroundings and supports. Some environmental modifications and technologies (made possible through the supported employment program) made a surprising level of physical activity possible. Examples such as joystick operation of wheelchairs, robotized work stations, and advances in prosthetic devices made it possible for some informants to drive cars, live alone, and even return to their former jobs. One Veteran and his wife, who also has SCI, are both members of a Paralympics team and compete in cycling. In addition, Jackson is part of a bowling league for people who are in wheelchairs. Similarly, Bill described his continued enjoyment of basketball by joining a league for people who use wheelchairs. He joked that the wheelchair league is much more vicious and dangerous than that in which he played before the injury. In fact, Bill said that he has never enjoyed the sport as much as he does now and feels lucky to be able to move his arms.

Of course, accommodations were neither perfect nor always reliable, and informants struggled with new physical dispositions that left them frustrated and immobile:

My biggest and worst, just greatest, difficulty is throughway. I don't even have a throughway [i.e., physical access, especially involving doorways] wherever I go. Most of the places I go, there is always an add-on, a flip-on, or something that I have got to always concern myself with.

As with the social discrimination we discussed earlier, physical barriers – not being able to maneuver through sidewalks, stores, restaurants, or in other homes – were a constant concern to this veteran. Another could perform tasks but was frustrated with the additional time it takes to finish:

We have a garden, me and my wife, and [my injury] limits me to how long I can spend in there planting or tilling or anything. [It] used to be, I could go out there and till the whole thing in [about] 2–3 hours. And now it takes me 2 or 3 days, because I do a little bit and I have to quit and come back to it later. It just takes me more time. And I hate it.

Having to go back indoors because of sensitivity to sun exposure or because of a decline in physical stamina limits this veteran's ability to be fully engaged in the household chores he once completed in minimal time. The simplest of daily activities like showering or putting on clothing were among the most difficult to relearn:

Dealing with simple things that were, what you would call 'simple' if you're AB (able bodied), it's a simple thing. It's like putting on your pants in the morning. Does it take a minute to put on your pants? It doesn't even take that long really. You pick them up, you put one leg out, you stick it in, you stick [the other one] in. It's like 30 seconds, you've got your pants on. Well, for me it becomes a project. It don't work that easy. It's like that for a lot of things. It's like taking shower. Before I got hurt, 5 minutes, I could be done and ready to go out; in 15 minutes tops. Well, it don't work that way anymore. It takes me considerably longer and I think sometimes I get frustrated by that. And then when I get frustrated, I get angry because it just – I have to do it day in and day out.

For most, jobs requiring full or even partial-body physical strength were a thing of the past. These veterans defined their future productivity in terms of mental acuity or specialized knowledge. As Steve commented: “I think trying to help people get, like I said: when you have a disability, the more education you have the better ability you have to get a job.” Since, most of our informants were middle-aged men who had lived with disability for several years, finding a career that would provide both economic stability and emotional well-being had been a struggle. But this brings us to another nuance particular to our sample of veterans. Many veterans have federal benefits (e.g., disability pensions or social security payments) that were contingent upon their not working more than a limited number of hours per month. That is, although they may have wanted to work for psychological and social reasons, any threat to their (sometimes substantial) disability income might outweigh their desire to return to work. Thus, these competing sources of income mitigated their freedom to pursue paid employment. The cost-benefit analysis for informants in the SCI-VIP was facilitated specialized benefits counseling by an independent professional. In short, gainful employment did not necessarily mean earning more than being unemployed:

My military pension won't disappear but, after a certain period of time [in employment], my social security - whew it's gone. Right? So, I'm talking about, [you] do the math! Why should I go back working for \$6.00 an hour when I'm already making more than that [in federal benefits]? ... I said [to the social worker], “I ain't doing it now. Yeah, I want to work, but I don't want to work that bad!”

These men had debts and obligations that depended on their existing income. For some veterans, it did not make financial sense to return to paid employment – no matter what the emotional or social benefit such a return might offer. For these participants, the VR counselor typically advised them about part-time jobs and other ways to reach their goals for activity and productivity.

Regardless of the type of work they pursued, veterans' talk about work and their goals was rich with the features of narrative drama and time. That is, they narrated in such a way as to draw on stories, not just offer referential facts and opinions. These stories included authoritative assertions by the narrator about moral behavior in relationships and about the value of work (whether paid or not, whether physical or not). And through references to pre-injury experiences, their narratives take on the temporality about which Mattingly theorized (Mattingly 1998a) where past, present, and future become more coherent and organized.

Discussion

These narratives of a return to work after SCI take two different forms. Many of them are referential and direct, answering our questions with facts or opinions that reflect experience and knowledge. The other form is the story, where narratives have a perlocutionary function, suspended temporality, and a narrator's organizing

authority, all parts of what Mattingly theorized as narrative employment. Both forms are necessary in anthropological research, and they work collaboratively to provide a deeper description of our informants' experience of SCI.

We've attempted to show how narratives communicate the most difficult adjustments that informants had to make following and since their SCI and particularly those associated with a return to work. Relationships were transformed, new forms of dependency had to be explored and resolved, and definitions of "work" would now incorporate more mental and intellectual abilities, social and relationship skills, or returning to school for specialized knowledge. Technological resources and environmental modifications helped reaffirm our informants' long-existing sense of productivity and capability, thereby establishing continuity with important aspects of their historic selves.

As a person recovers from traumatic injury or disruption (Becker 1998), one grapples with both current and historical meanings from society that impinge upon that recovery. Individuals reproduce the meanings of their society about what is masculine (Manderson and Peake 2005), what is feminine (Parker 1986), or what constitutes a whole person (Messinger 2010). Veterans' capacity for memory, including both personal and social memories, was central to their ideas about physical dependency and about work. When their SCI caused severe disruption, veterans defragmented the pre- and post-injury pieces of their identities by drawing and focusing upon specific continuities such as an interest in physical labor or the continuity of certain relationships (Smith-Morris 2010).

The idea that memories project themselves forward in time, through the vehicle of narrative, is what Mattingly theorized as the timelessness of the narrative. Through storytelling, yesterdays become more accessible, more present in our todays, and give us familiar landmarks with which to navigate into the future. This capacity for timelessness is particularly relevant to persons who experience such severe disruption that their pasts seem entirely unrelated to any future they can imagine. These narrators find much-needed mechanisms for continuity in their storytelling and can counteract some of the trauma and breakage that their severe illness or injury created.

As veterans face post-injury challenges and obstacles – either in their desire to return to paid employment or in adjustments to relationships – they face both constructive and negating forces: the force of unconscious ideas or assumptions that inform their ideas of work, productivity, and identity, social pressures and influences and the force of institutional barriers both past and present. We found that a reconsideration of the historical self, what continues and what does not continue into the present, also helped with the social negotiation of illness. Just as narratives of physicality help legitimize revisions in one's work goals, so too do narratives help establish and stabilize one's social legitimacy (e.g., as a romantic partner or family member).

Narratives not only reflect the adjustments and ideas of veteran speakers but also give them an arena – the interview – in which to actively craft and formulate these

(continuing) adjustments. Veterans' efforts to assert narratively and sustain continuity are crucial to their self-conceptualizations. In short, wholly new self-identities are never found. While independent, bipedal mobility and physical strength may be gone, our informants' self-sufficiency, productivity, and activity are still valuable characteristics that they claim and project into the future. These aspects of their self-identities are continuous and adaptive.

The timing of the research vis-à-vis their injury warrants a final comment. These veterans were not in the first weeks or even months of recovery from their spinal cord injury. Most had lived years adjusting to this new physicality, and so when their narratives harkened back to pre-injury selves, they drew on more remote and distant memories. The effort they made to recall and reference aspects of their pre-injury selves revealed their chronic injuries to be neither a disease process nor a static, onetime event; they are complex injuries that evoke lifelong adjustment (Smith-Morris 2010; Manderson and Smith-Morris 2010). And for this purpose, narrative temporality was key.

The SCI-VIP study introduced a supported employment program that encouraged and supported this creativity with human and technological support, but it was the veterans who had to renegotiate the meaning of "work" in their lives, sometimes redefining "productivity" if not also such basic physical ideas as "strength" and "stamina." Their narratives provided a valuable tool for creating continuity across a disrupted life span. Our presentation of these narratives weaves together threads of striving, perseverance, continuity, and change. Veterans sought not only understanding and validation in these interviews but also a narrative that best characterized their evolving conceptualizations of both past and future. New definitions of work and productivity must rely more upon nonphysical qualities, including intellect, social ability, or specialized knowledge. With certain supports and accommodations, there is a great deal of physical activity and strength that may be possible.

Notes

1. Mattingly's own work focused on the perlocutionary function of narrative between patient and biomedical health-care provider, particularly the performance and dramatized aspects of certain narratives through which "emplotment" can occur. Our application of this model is an example of how the testing and performance of new possibilities can occur in narratives produced for an anthropological interview as well as clinical ones (Garro and Mattingly 2000).
2. We discuss in detail the strengths and disadvantages of conducting ethnography as part of a clinical trial in Smith-Morris and colleagues (under review 2011).
3. The cost of these health-care benefits vary according to when the injury occurred (i.e., whether during active duty or not), the extent of disability, and the services available.
4. Competitive employment includes both full- and part-time jobs paid at the going rate in the open market.
5. The treatment and the supported employment model are described more fully elsewhere (Smith-Morris et al. n.d.).

6. As for Mattingly, Myerhoff's words here about dramatic performances express our sense of the narratives we collected. Our data source is neither therapeutic scenarios nor ritual dramas, but anthropological interviews which achieve some of the same ends: bringing experience into conscious awareness and calling up certain experiences in order to make sense of the problem at hand – namely, the goal of going back to work after years with SCI and unemployed.
7. Supported employment is a therapeutic model of intensive vocational support and case management that is carefully integrated with medical care to ensure maximum information sharing and problem prevention and resolution for patients attempting a return to work. This clinical trial was the first test of the supported employment model for persons with SCI. Supported employment is also a model of treatment that touches upon related disciplines of vocational rehabilitation and occupational therapy, which have been the subject of important medical anthropological attention. According to Frank and colleagues (2010), occupational therapy has a “pragmatist orientation toward experience, time, and action” (2010: 237):

The pragmatist conception of emergence recognizes that the reality of the present *differs* from the past from which it develops... Ethnographic approaches should add not only greater theoretical acuity to occupational therapy studies, but also a more powerful appreciation of context – that is, how environments are shaped by *physical*, geographical, *social*, cultural, political, ethno-racial, gender, economic, and class-based systems of enablement and oppression (2010: 237).

8. The study of clinical narratives has a distinctive history within the profession of occupational therapy. It was pioneered by Mattingly and summarized more recently with an historical analysis by Frank and colleagues (2010).
9. Mattingly sought the “improvisational and embodied stories... [in which] actors may seek to turn their actions into a definable and vivid form that has its own temporal unity, a dramatic coherence that cannot be reduced to sequence without loss of meaning” (Mattingly 2000).
10. Mattingly's (1998a, b) earlier explication of narrative time outlines six key features of narrative time including the following: (a) narrative time is configured and constructed by the narrator, (b) action and motive are key structuring devices, (c) it is organized around a problem or “place of desire,” (d) narratives show how things (and people) change over time, (e) narrative time is dramatic and so includes a conflict and movement toward resolution, and (f) endings are uncertain.
11. For a brief summary of these alternatives, see Montrey (2000).
12. Our informant narratives were similar to those of active duty soldiers recovering from traumatic injury (Messinger 2010).

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