

THINKING WITH STORIES
STORY AND EXPERIENCE IN A CLINICAL PRACTICE

by

CHERYL FAY MATTINGLY

B.A., English Literature
Atlantic Union College, Lancaster, Massachusetts
(1973)

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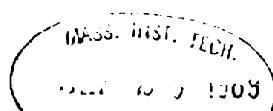
Donald Schon
Ford Professor of Urban Studies and Education
Thesis Supervisor

Accepted by _____

Langley Keyes, Chairman
Department of Urban Studies & Planning

Accepted by _____

James Howe, Chairman
Anthropology/Archeology Program



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ABSTRACT

This thesis is about thinking with stories. It is based on a two year ethnographic study of clinical reasoning among occupational therapists at an acute care hospital in Boston. I examined narrative as an organizing framework for making sense of experience, one which also served as a practical guide for doing things, for altering experience.

I studied two kinds of relationships between story and experience as they arose in the practice of the occupational therapists. One was narrative as an everyday form of discourse therapists used for reflecting on and reasoning about clinical experiences. The other was the implicit use of narrative as a vehicle for actively configuring experience.

For the occupational therapists who were studied, narrative was one of two dominant sense-making modes and therapists called upon it variably, depending on how they interpreted the clinical problem they were treating. Therapists sometimes reasoned in a mode which was a recognizable version of the medical model and of the medical framing of clinical reasoning as an applied physical science concerned with the diagnosis (and treatment) of a physiological disease state. At other times, therapists also addressed disability from a "meaning-centered" perspective, as a matter of illness experience which held personal and culturally defined meaning for the patient. When therapists described their clinical work as the treatment of illness experience they told stories. Narratives offered a mimetic discourse which allowed therapists to reflect on their experiences by "imitating them" through the telling of a story. Narratives provided an imitatively organized reflection on experience, a reflection which explored why something happened and the significance of its happening by showing how it happened. The imitation of action in a story -- "showing-how" -- provided therapists implicit explanations and evaluations of their practice.

The stories therapists told portrayed disability from an actor-centered point of view. They were personal, even individualistic, built on the structure of actors acting. Their stories explained the meaning of disability intentionally. Disability itself shifted from a

physiological event to a personally meaningful one, to an illness experience. General physiological conditions were shadowed as background context. What was brought to center stage were the ways that particular actors, with their own motivations and commitments, had done things for which they could be praised or blamed.

In addition to telling stories about past clinical events, stories guided the creation of clinical experience. The clinical experiences therapists tried to generate were often guided by "prospective stories." These prospective stories, derived from past particular experiences and stereotypical (collectivized) scenarios, were projected onto new clinical situations in order to help therapists make sense of what story they were in and where they might "go" with particular patients. Therapists then attempted to enact their projected stories in these new clinical situations, working improvisationally to build on whatever happened in a clinical session so that it added to the story's plotline. Therapists "saw" a possible story which they recognized as clinically meaningful and they tried to make that story come true by taking the individual episodes of their clinical encounters and treating them as parts of a larger, narratively unfolding whole.

In this study of occupational therapists, I began to examine the way a practice influences the stories that are told and, in reverse direction, how stories influence practice. In my exploration of how therapists try to create stories out of their clinical interactions, turning sequence into plot, I have worked to move beyond those theorists (most notably, Alisdair MacIntyre, David Carr, Frederick Olafson, and Paul Ricoeur) who have argued that actors structure experience narratively. My primary extension of this theoretical work has been a focus on confrontation, on how therapists develop prospective stories which provide them narrative expectations that run into trouble as their experience of working with a patient progresses. Perhaps it would be most accurate to say that their prospective story becomes confronted by the story they would tell about what was actually going on as the clinical encounter unfolds. When this confrontation becomes acute enough, and at those times when therapists allow themselves to be open to it -- to "feel" the acuteness of the misfit -- they may then have an experience in the hermeneutic sense Gadamer and Heidegger reserve for moments when our anticipations and judgments are thrown into radical doubt.

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PREFACE

This thesis has been a long time in the making. There are many people to thank. I have had a great deal of support and intellectual help in considering stories specifically in the context of occupational therapy but my thesis work really began much earlier than my acquaintance with the occupational therapists. Although I have written a dissertation about storytelling and storymaking in occupational therapy, this study is more broadly (or more personally) an elaboration and revision of a set of obsessively considered puzzles about stories which are part of my particular intellectual history.

The history of this exploration began well over a decade ago. In 1977 I took a graduate course from Jeanne Bamberger and Donald Schon in metaphorical thinking in MIT's now defunct Division for Study and Research in Education. Sometime during the course of that seminar it struck me that I could fashion a whole graduate career, perhaps an entire life, out of investigating why people were telling and listening to stories when they wanted to understand their experiences.

From a readerly point of view, I had already wondered at the power of stories to compel a passionate personal reflection. I grew up reading novels; stories were a familiar form of entertainment. As a child I had mostly read novels to escape but I was willing to read even the

good ones for that purpose and as I got older, I noticed the uncanny way that predicaments of unknown characters kept feeling familiar, and conversely, how my own ordinary experiences could take on a peculiar shape when held up to the light of a story. I knew the seduction of stories which could land you before you knew it in the middle of someone else's life. Through a mysterious process of following complete strangers around, stories had the power to offer a way to resee the world. Launched in graduate school by that first metaphor seminar, I decided to investigate these strange properties of stories and to do so in the context of the ordinary stories people told as part of getting through their days.

Once I realized that examining stories could be couched as a research task, for which one could eventually acquire a Ph.D, I began paying special attention to stories around me, the casual narrations of friends, family, MIT undergraduates, fellow Boston redline commuters, and the like. My husband Glenn and I spent innumerable hours recounting and dissecting these stories and it is probably from all that eavesdropping into other people's tales that many of my most enduring intuitions developed. I supplemented this haphazard investigation with graduate school research projects that allowed me to collect and analyze stories. I studied storytelling among Irish and Black schoolchildren in Dorchester, undergraduate MIT students, and air traffic controllers. I listened to

stories told for the fun of it, for making friends, for making a point. I favored those stories people told not for the sake of the story but while trying to do something else, like understand why they hated college physics when they'd once actually read physics textbooks for pleasure, or why they could never get their lover to pay any attention. My coursework in anthropology, particularly the study of ritual, symbol, and myth, and the growing body of work in interpretive anthropology with its hermeneutic metaphor of reader and text, gave me other vantage points for considering ordinary stories.

Conceptually, it was an easy migration from the stories I heard around me to stories professionals told about their work. Striking air traffic controllers in the Boston area gave me hours of time telling me stories about guiding planes and fighting managers. In 1983 the World Bank funded a study which supported me financially and allowed me to examine storytelling among World Bank project officers and their managers. I learned a great deal about how we use stories to shape our thinking through the three years I spent there. But it was in 1986 when I began my research on occupational therapists that I had the chance to really examine the intricate interplay between storytelling and action, to see the configuring force of stories in guiding interventions but also to see the constraints on action which prevented therapists from simply playing out their favorite stories unimpeded. The occupational therapists I

worked with welcomed me and that made all the difference in the quality of stories I could collect and consider.

This short story I have just told contains its moral through the usual narrative strategy of recounting this and that life event in roughly chronological order. To be quite explicit in my message, I wish to thank a number of people for their help along the way. First, I thank Glenn Bidwell for his long partnership in playing with ideas and for his essential part in shaping my particular vision of story. Thanks also to other members of my family, including my sister Monique and my brother Byron for telling me their stories and considering with me what the stories meant. Nedra Gillette opened up the practice of occupational therapy for this study. Her pioneering efforts were essential in inspiring the idea of this research and in creating the funding which made it feasible. Two friends have been invaluable in helping me think through many of the ideas and interpretations presented here, Eric Jacobson and Maureen Fleming. The hours and hours spent talking with Eric over meals in Cambridge restaurants and with Maureen travelling to and from University Hospital, MIT and her daughter's daycare are by now indelible memories; it is certain that those conversations have found their way into this thesis.

Donald Schon's own early work on how professionals use metaphors and his more recent work on reflection-in-action

have strongly influenced my consideration of how professionals think with stories. Jim Howe and Jean Jackson were both wonderful thesis advisors and I wish to thank them for their insightful comments, their thoughtful reading, their flexibility in the face of last minute requests for help and their very kind encouragement. I only wish I had met them earlier in my graduate life.

The Division for Study and Research in Education and the Department of Urban Studies and Planning at M.I.T. supplied grants and scholarships during the early graduate years, and the World Bank funded my first sustained research into storytelling in professional practice. The American Occupational Therapy Association and the American Occupational Therapy Foundation jointly funded the two year ethnographic study of occupational therapists and opened doors for me where needed. To these Associations and to the many personal friends I made through them, I give a very particular thanks.

This research reported here was not done by myself alone but by an entire team. Cathy Verrier, Cumba Siegler, Terry Sperber, and Linda Blackshaw were graduate students who worked as research assistants, helping in collecting and analyzing the data from University Hospital, sitting with me on my living room floor culling key themes and the best stories from mountains of field notes and interview transcripts or doing endless video viewing. Ellen Cohn and Maureen Fleming from Tufts University were integrally

involved in these same activities though generally we shifted locales to Maureen's daughter's playroom where the good videoplayer was located. Debee Slater, the director of the Occupational Therapy Department at University Hospital and six senior therapists not only supplied the data but assisted in analysis and in generating theories to make sense of what we were finding. They met regularly to examine their videotapes together. Most important, these therapists allowed us into their lives and, as anyone who has ever been on that end of the research pact knows, that is a very significant gift.

In September 1988 I moved to the University of Illinois in Chicago and I gathered supplemental data for the thesis from occupational therapists there. Lisa Richter, a graduate student in occupational therapy, and Daphna Monin worked as research assistants in this process, wading through more mountains of data. Members of my 1989 graduate class in clinical reasoning at the University of Illinois gave me stories, commented on earlier versions of my thesis and were extremely helpful and enthusiastic about this research. Jaime Munoz, Laurie Dylla-Rockwell, and Kathy Barron were class participants who provided case stories which I used in the thesis. In a more general way, the Department of Occupational Therapy at University of Illinois gave me a working environment during the past year which allowed me room to write. I want to thank the faculty there

and the Department chairman, Gary Kielhofner, for the strong support and interest in my work.

I

INTRODUCTION: STUDYING STORIES IN A CLINICAL PRACTICE

Renato Rosaldo concludes an essay on Ilongot hunting stories by suggesting a connection between the act of storytelling and the active shaping of lived experience. "The stories these Ilongot men tell about themselves both reflect what actually happened and define the kinds of experiences they seek out on future hunts. Indeed, their very postures while hunting resemble those used in storytelling, and in this respect the story informs the experience of hunting at least as much as the reverse (1986:134)."

This thesis is an exploration of Rosaldo's concluding premise, that the stories one tells define the kinds of experiences one seeks -- and, I would add -- tries to shape. This premise, that stories shape action as much as action shapes stories, is my starting point.

Storytelling in Professional Practices

The arguments made here about the relation between story and experience have emerged through several years of studying professionals at work. My interest has been the role of storytelling by professionals, particularly how professionals tell stories to make sense of what is going on in some situation in which they are expected to intervene. My corpus of stories are about work and the

practical need for stories to make sense of what one has done and of what one ought to do next.

Stories are accounts of experience. We tell stories of experiences, our own or others, for many reasons: to entertain, to gossip, as evidence for our arguments, to communicate who we are. When experiences are puzzling, powerful or upsetting, we sometimes tell stories in order to render those experiences more sensible. Telling stories offers one way to make sense of what has happened.

Storytelling At The World Bank

I began collecting stories of professionals seven years ago. I first listened to striking air traffic controllers in 1982 tell about the kinds of stressful experiences in their day to day practice that ultimately led to their clashes with management. I was already very interested in stories when I began my research on air traffic controllers but as I interviewed them I became particularly attentive to how much better their narratives were at expressing underlying stresses and anxieties about work, and how much more suggestive they were of ambiguities and contradictions in their perceptions about the meaning of work, than any general, propositional statements they made. I then spent three years at the World Bank studying project officers, those front line Bank professionals who assist in putting together and supervising international development loans.

I had a grant funded to study the process of project development among project officers in the Bank's urban division who helped design and recommend urban development projects for third world cities. I listened to their stories and watched them at work in the central Washington office and in the field. As I observed them in action and gathered stories about their activities, I gradually began to notice that there was a more complicated, interesting and interwoven relation between telling stories and making practical decisions than I had initially realized.

The crucial sense-making role of storytelling became apparent to me when I studied World Bank project officers working with country counterparts on development projects in the field. When I accompanied a mission team supervising several urban projects in Calcutta I began to notice the way project officers used storytelling in the field. A major part of the team's task, as they met at night to drink and share notes, was to construct a collectively shared story about what was going on and, within that story, what their role as interventionists should be. The project officer who ran the mission acted as chief storyteller, gathering story bits and story versions from each team member in turn. Although the team members were technical specialists in various sectors, in water and sewerage, in city finances, in transportation, housing, etc., they did not spend much

time actually trying to understand the technical problems the project was facing. Instead they focused on constructing a story about why key actors in the field -- the heads of city departments responsible for certain pieces of the urban project -- were not dealing properly with these technical problems. They explained these problems not as technical ones but as obstacles created by the actors' problematic intentions, irresponsibility, or "lack of discipline" as they would often call it in development terminology.

They offered narrative explanations, stories which explained what was happening as the result of human actions and explaining those actions as the expression of the intentions of key actors. These were narrative explanations in the strong sense that the key causal factors cited were the reasoning of actors. Philosophers defending narrative history's explanatory power have called this form of explanation "explanations by reason" (Dray, 1971; 1980; Glafson, 1979). For instance, they would explain the sewage problems in the new housing site not primarily with reference to poor soil or inferior cement which might have been immediate causes, but as the result of a collusion between a corrupt high level official in the housing authority and seedy private contractors who were absconding with the funds, or as the result of an undisciplined labor force which could not be

properly corralled into doing good quality work in a timely fashion.

Technical problems were often easily explained, but the focus of storytelling efforts was the construction of reasons why these particular problems had developed in the first place or why they weren't being solved, and of what the team should be doing to try to get them solved. The team would try to understand why the responsible government agency had allowed a housing project to be allocated worthless land that couldn't be properly drained or why they had bought bad cement for the same price they could have purchased good cement -- what private contractor was illegally extracting money, who was in on the syphoning -- these were their focal questions.

I began to see that World Bank project officers, who had the job of intervening in situations they didn't at all understand, were constantly attempting to construct stories that would give them some fix on what was going on, and especially on who was to blame, so that they could figure out what they ought to do next, especially what they ought to say in their reports on the project's progress to the Bank management. This showed me that stories were not just told after experience but could also be constructed while people were very much in the midst of action, as a way of deciphering how to turn the enactment of the story to a more desirable direction.

I also noticed that one of the chief forms of World Bank officers' arguments to country counterparts was narrative. Both the mission team and their counterparts would tell stories about what the problems had been, how the project had evolved to address those problems, what the roadblocks were to carrying out those projects, and what therefore what needed to be addressed to solve the roadblocks -- all as part of a narrative. It seemed that both groups, mission team and country counterparts, were trying to impose a particular history in their storytelling, as a basis for presenting their conception of what ought to follow next as a natural, even an inevitable development given their description of what had led them to the present situation.

Storytelling In Occupational Therapy

Nearly two years ago I began a study of occupational therapists. I was invited by their national association to conduct a pilot ethnographic study of clinical reasoning in occupational therapy. This study was jointly funded by the American Occupational Therapy Association, the profession's national association, and the American Occupational Therapy Foundation, the profession's research arm. I had much better access to the daily work of these professionals than I'd had with either the air traffic controllers or the World Bank project officers. Like the World Bank professionals I had studied, the occupational therapists regularly told

stories to colleagues, especially about troubling or surprising sessions with clients. One motive for such storytelling was to orient themselves, to make better sense of what is going on with particular patients. Occupational therapists also told stories to their clients, as the Bank professionals did, to try to persuade clients to see themselves as actors in particular kinds of stories.

Even more intriguing than this storytelling was the work of therapists and patients to create a story out of the clinical action itself. In this thesis I will explore the idea that therapists try to "emplot" both their actions and their patient's responses so that a certain storyline will unfold. Because this kind of emplotting is also attempted by patients, the work which therapist and patient do to create a shared storyline, and the difficulties and struggles that ensue when the stories they project differ, become one of the most interesting aspects of occupational therapy. Therapists are often required to modify these storylines midstream as these run into trouble in the course of treatment. I do not mean to imply that therapists have complete control of the story that develops out of clinical interactions or even that therapists are more invested in creating a desirable clinical story than patients are. I concentrate primarily on therapists because they were the focus of this research.

The occupational therapist's need to create significant clinical experiences generates a concern with unity and coherence in the succession of treatment episodes, to give a plot structure to what would otherwise be a sheer succession of doings. This last idea, that therapists try to create significant therapeutic experiences and that they do so through an "emplotting" of their actions and the actions of their patients, is a central focus of this thesis.

I believe that this narrative framing of clinical activity supports a narrative conception of clinical reasoning in occupational therapy, and that this mode of clinical reasoning is present along with others in the practice of occupational therapy. There are two ways clinical reasoning takes narrative form. First, clinical reasoning is narratively organized when therapists explain what is occurring clinically through recourse to stories. Clinical reasoning becomes narrative reasoning as therapists construct stories to explain clinical problems and outcomes which are depicted as emerging from the motivated actions of agents. Second, clinical reasoning becomes narratively centered through the efforts of the therapist to emplot individual clinical activities and clinical episodes so that they will be meaningful as part of larger historical contexts -- the therapeutic process as a whole, and the life-history of the patient. Narrative reasoning taken in this latter

way involves more than making sense of experiences which have already happened. It also, perhaps more fundamentally, involves creating sense, generating sequences of experience which will support certain types of meaning because they are patterned in narrative form, with an intelligible beginning, middle and end.

My Practical Interest In Stories

Chapters Two and Three outline the theoretical interests which have propelled this research, but I also entered the study of occupational therapists with a set of pragmatic concerns. I have been interested for a long time in the practical possibilities of reflective storytelling and story analysis. If stories about past experiences are carried into future situations to help make sense of those situations (as they often seem to be), then the kind of stories told about the past are surely important in how actors perceive -- and hence act -- in future situations.

Because storytelling is such a natural way for us to represent experience to ourselves, it might be one of the ways in which we provide the basis for learning from that experience. Experience is obviously an inconstant teacher; it is perfectly possible to live through something and not learn much as a result. (T.S. Eliot once said, "We had the experience but missed the meaning.") But one motive for telling stories is to

wrest meaning from experiences, especially powerful or disturbing ones. Even everyday experiences are continually imbued with meaning, rendered more coherent, more vivid, even more real, through storytelling. "When we return home and 'tell our day'," Iris Murdoch said in an interview, "we are artfully shaping material into story form. So in a way as word-users we all exist in a literary atmosphere, we live and breathe literature, we are all literary artists, we are constantly employing language to make interesting forms out of experience which perhaps originally seemed dull or incoherent (1978:266)."

If storytelling is an everyday way to make sense of, or add sense to, things that happen to us, maybe it could be used more self-consciously as a learning tool. Stories point toward deep beliefs and assumptions that people might not be able to offer in propositional form. These are the "practical theories" which guide their actions. Michael Polanyi (1967), Donald Schon (1983, 1987) and many others have argued that much of such practical knowledge is tacit. Actors may not be able to present their practical theories in explicit propositional form, or might present theories that seem inconsistent with their actions, but they can tell stories about what they have done and about what has happened to them, and others, as a result. If they then

examine these stories, they may be better able to uncover underlying patterns of belief.

If actors are more aware of the beliefs and assumptions underlying their actions, they are more likely to identify situations in which those beliefs are unfounded or in which their theories lead to undesired consequences. Such reflection could have moral consequences. The professionals I have studied intervene with clients who are generally less powerful than they. There is a constant danger that the professional's hoped-for story will be imposed on the client without the professional's recognition or acknowledgement of the imposition. Under the guise of being pragmatic, facing the facts, or doing what is technically required, professionals can project plots which embed a host of beliefs and attitudes which would be questioned by their colleagues as well as themselves if rendered explicit. Since stories reveal the consequences of ideas in action, that is, the sort of experiences created by following certain ideas (Murdoch, 1956; Burrell and Hauerwas, 1977), narrative analysis can afford a moral investigation of the practical consequences of beliefs and theories.

Over the past five years I have conducted a series of learning experiments carried out with project officers at the World Bank and occupational therapists at University Hospital. In these exercises professionals

were asked to tell stories, analyze stories which they or their colleagues had told, and, in the case of the occupational therapists, view videotapes of clinical encounters and analyze these as though they were stories.

In my work with World Bank project officers I began my learning experiments with the idea that the structured telling and examining of project stories could lead them to become more conscious of the practical theories guiding their interventions. I worked as part of a team with four professors from Massachusetts Institute of Technology's School of Architecture and Planning in a series of "debriefing" sessions with two Bank teams that were working on urban development projects in Calcutta and several middle-sized cities in Turkey.

These World Bank experiments were not successful. I was quite possibly the only learner, unhappily reflecting on my own failing practice. I began to confront the tremendous power of stories to obscure the meaning of experience, in fact to disguise the experience altogether, and not only from the audience but from the storytellers themselves. I found myself confronted by an institutional context which determined the kinds of stories that could be safely told. In the context of the World Bank, tellable tales were versions of heroic romance. The darker, ironic tales which project officers sometimes told in private were relatively taboo in public.

For two years, from 1986 to 1988, I worked with occupational therapists at a large acute care teaching hospital in Boston. I engaged them in similar storytelling and story interpreting exercises with much better success. This greater success most likely reflects differences in power positions of the two professional groups and probably differences in institutional contexts as well. The project officers had more to lose as well as more delicate political positions to protect than did the occupational therapists.

Outline Of Thesis

I identify three functions of stories in the clinical practice of occupational therapists:

(1) The use of stories to make sense of clinical experience. I examine storytelling as a mode of narrative explanation. Therapists tell stories about their practice experiences retrospectively, as a way to puzzle out what has happened or why things worked the way they did. They also tell stories about their work with a patient in an on-going way as they work with the patient. This storytelling may occur in the session with the patient or in meetings or casual encounters with other colleagues. Such storytelling constitutes one powerful mode of clinical reasoning.

(2) The rhetorical use of stories as vehicles to persuade others about how to "read" clinical experiences.

Therapists tell stories to persuade others about how a clinical problem should be construed and what the most efficacious approach to it should be. Occupational therapy is a cooperative practice and can be easily subverted if other key actors -- from doctors to family members -- hold strongly contradictory perceptions about the nature of the problem. In actual practice, the storytelling which therapists engage in for the purpose of reasoning about what interventions they should make is not easily separable from the storytelling done to persuade patients, colleagues or themselves of the appropriateness of an intervention. The same storytelling often serves both functions simultaneously.

(3) The use of stories to create meaningful clinical experiences for patients. Therapists not only tell stories, they also take actions and make interpretations in the midst of their work with patients which promote a certain narrative structure within therapeutic sessions. Therapists work, in a partly conscious way, to make certain kinds of stories come true. Sometimes, this story-making can deepen the significance of therapeutic activities so that they become experiences imbued with important meaning for patient and therapist. When this happens, therapeutic activities transcend isolated episodes of strengthening exercises, diversionary games or the acquisition of daily living skills using adaptive equipment. Treatment

activities take on meaning as part of larger life experiences; they become embedded within the life-story of the patient.

The remainder of Chapter One describes the research context. I discuss the overall design of the study and impetus behind its funding. As part of a description of the research context, I give a brief sketch of occupational therapy as a profession, particularly with regard to its roots in "moral therapy" and its revision as a profession in response to pressure from the medical community to conform to a more clearly medically based practice.

The second and third chapters provide a theoretical frame for the examination of story and experience within occupational therapy. Chapter Two introduces the two key terms, 'story' and 'experience.' Chapter Three looks at two frameworks which have been used within narrative theory to approach the issue of how story and experience are related. It might be more accurate to say that Chapter Three constructs these two frameworks, for few narrative theorists would voluntarily place themselves in these slots. They have strong opinions on the matter but mimetic questions are not of such taxonomically decisive interest to most of them as they are to me. In addition to these, I also present a hermeneutic approach as a way to frame the relation between story and experience,

arguing that their relation is dialogical, even confrontational. The relation between the prospective story a therapist forms about where she might "go" with a patient and her actual, on-going clinical experiences with that patient can be treated as analogous to the hermeneutic encounter between reader and text. Therapists, like the reader, come to the clinical encounter with preconceptions (partially cast in a prospective story) which condition their initial interpretation of the experience. As therapy progresses, therapists, like the reader, often finds themselves required to revise those preconceptions. (This hermeneutic reading of clinical work is concretely developed, with case examples, in Chapters Eight and Nine.)

With Chapters Four and Five I turn to occupational therapy as the practical context in which this study of the relation between story and experience has been carried out. I argue that occupational therapy integrates (somewhat uneasily) two practices based on two different conceptions of the body, a bio-mechanical conception which belongs to mainstream medical culture, and a phenomenological conception which arises in large part from the nature of occupational therapy practice. Chapter Four examines occupational therapy as a biomedical profession.

Chapter Five addresses those features of occupational therapy that lead to a phenomenological focus, even among those therapists espousing strongly bio-mechanical theories of therapy such as kinesiological or neurodevelopmental treatment approaches. Occupational therapy involves "doing with" patients, as therapists say. Success in this highly collaborative therapy requires patients to be extremely motivated to participate despite the pain, awkwardness and apparent triviality which are part of many occupational therapy activities. This need for strong patient involvement leads therapists to ponder the interests motivating each patient. This, in turn, often develops into an exploration of how the particular patient's particular disability is affecting their life experience.

These two conceptions of the body are wedded to different forms of practice, different descriptions of the therapeutic process (different discourses) and different reasoning processes. Therapists think differently when treating the phenomenological body than they do when treating the bio-mechanical body. In the chapters which look specifically at storytelling in occupational therapy (Chapters Six and Seven) I connect conceptions of the body, forms of discourse and processes of clinical reasoning. I examine storytelling as a form of discourse which occupational therapists employ to

generate certain kinds of accounts and explanations of what is going on clinically with their patients.

Chapter Six explores relations between discourse, perception and clinical reasoning. I discuss two different forms of talk used by therapists in describing their work with patients and argue that one form of talk is used when they address the biomechanical body and another form -- narrative -- when they address the phenomenological body. I analyze which features of narrative make it a common choice when therapists want to talk about how their treatment activities are engaging the patient's experience of disability.

In Chapter Seven I contrast clinical reasoning as propositional reasoning with clinical reasoning as narrative reasoning. I elaborate my earlier suggestion that the two conceptions of the body within occupational therapy link to two different reasoning processes: propositional and narrative. Nearly all previous research on clinical reasoning, which has been overwhelmingly based on physicians, has implicitly assumed that such reasoning was propositional. (In fact, within medicine at least, this is treated as the only available form of reasoning.) I argue that just as a bio-mechanical conception of the body is inadequate for the practice of occupational therapists, so too a propositional conception of clinical reasoning does not

adequately capture their reasoning which tacks back and forth between propositional and narratives modes.

Chapter Seven examines storytelling as a mode of explanation. I introduce the literary notions of motive and plot in constructing a theory of narrative reasoning. In so doing I draw from literary theory, philosophy of history, folklore and anthropology to fill out a picture of how occupational therapists use storylike thinking in treating patients.

Chapters Eight and Nine examine stories not as discourse told in remembrance but as organizing structures which are called on to guide and implement significant clinical experiences with patients. These chapters also look at how therapists revise these organizing clinical narratives in the course of their practice. Chapter Eight argues that the heart of clinical reasoning is the creation of significant therapeutic experiences. I argue, using case material, that therapists attempt to create powerful therapeutic experiences which position therapy within the life-story of the patient and point towards a possible future to which the patient could be committed. The future life-stories which therapists envision for patients are not necessarily the same ones that patients envision for themselves. Therapists work to create therapeutic experiences which wield rhetorical force in providing patients with a particular 'reading' of their future

story, a reading guided by the therapist's perception of what an appropriate future might be. Often therapists intend that clinical activities will trigger turning points in a patient's life. Given that the onset or exacerbation of a chronic illness often marks a disastrous turn in a life story, therapists often intend their work to mitigate the disaster, hoping the therapy will be a place for patients to formulate a response to the illness which allows them something to hope for in their lives and motivates them to struggle for maximal independence. Placing a therapeutic experience within the life -- past or future -- of a patient in a way which has some force for that patient requires that the experience have internal coherence and drama, be an experience about which a story could be told.

Chapter Nine looks at the revisionary character of clinical practice. Clinical reasoning can be seen as a continual modification of an initial prospective story which the therapist creates from an amalgam of past experiences, generic medically based scripts and other stereotypical frames. Therapists enter each new clinical situation with the need to provide some answer, however provisional, to the question: What story am I in? Or, put differently, Who is this patient and where can I go with him or her? Therapists answer this question with a prospective story which runs ahead of actual practice. But actual, on-going encounters with the patient always

require some revisions and much filling in of this narrative sketch. While Chapter Eight looks at how the therapist uses the concrete episodes of the clinical encounter to build and enact this prospective story, Chapter Nine looks at how clinical events trigger an altering or abandonment of the story.

The final chapter concludes with a discussion about the implications for an anthropology of experience which relies on a narrative perspective. More specifically, it suggests that a particular perspective on narrative which emphasizes the dialogical relation between story and experience could provide anthropology with a useful way of examining experience.

Research Context

This thesis is populated by three kinds of stories. First, there are elicited stories which therapists and patient's told in response to requests by the researchers. These included stories of particular clinical sessions, always ones which the researcher had also observed, stories about the therapeutic history and stories about the history of the illness experience (from patients). The main protagonist in this research is the occupational therapist and she is likewise the central character in most of the stories. But stories were also elicited from patients and some of these are also

included. Most of these stories were tape recorded and transcribed.

Second are naturally occurring stories, the "overheard stories" told to during clinical sessions, at lunch or in staff meetings. Many of these stories were recorded in field notes as researchers heard them, though some which were told during clinical sessions were videotaped and transcribed.

Third are the constructed case stories which I have created from field notes or transcriptions of videotaped sessions, telling my own story of what I witnessed. When I have told my own stories, I have also included direct quotes taken from field notes or transcriptions.

These stories almost all concern clinical sessions, one on one encounters between therapist and patient. Some stories describe a single session; others narrate a history that spans a therapeutic process which may cover weeks or months. The sessions themselves last anywhere from twenty minutes to an hour, depending on the physiological condition of the patient, how much activity can be physically tolerated, the willingness of the patient to participate, and miscellaneous scheduling constraints.

The data for this thesis were gathered in two primary places. Most of the data come from a two year ethnographic study of an occupational therapy department

at an acute care hospital in Boston. Some supplementary data were gathered from therapists at an acute care hospital in Chicago. Also occupational therapists to whom I had access in both Boston and Chicago were occasionally interviewed for narratives about their clinical work. So while the research is primarily based on a single site study, some data are included from therapists practicing in disparate geographical locales and in quite different institutional settings.

The focus of the study, which was jointly commissioned and funded by the American Occupational Therapy Association and the American Occupational Therapy Foundation, was clinical reasoning in occupational therapy. Occupational therapists were unaccustomed to ethnographic research approaches but several influential members within the Foundation, the Association's research arm, felt that an ethnographic approach was more appropriate than a quantitative one for constructing a grounded theory of clinical reasoning. From the funders' point of view, the purpose of the study was to articulate actual practice rather than to test any hypotheses in a quantifiably generalizable way. Because the study concentrated on a small sample of therapists in a single site, it was considered a pilot project.

The impetus behind funding this study was partly the hope that it would increase the credibility of occupational therapists within the health community.

While no one expected that the study alone would perform this feat, the hope was that a systematic articulation of a concept of occupational therapy grounded in research into existing therapeutic practice would make explicit much that was intuitive in the thinking of therapists. The intuitive nature of clinical reasoning in occupational therapy was often cited by therapists as a liability in making a convincing case to other health professionals, especially physicians, for their approach. There was a strong feeling among many influential therapists promoting the study that too much of what therapists, especially good therapists, knew was tacit. They also felt that in the profession generally, too much knowledge was passed on to new therapists on a "trust me, it works" premise and that more needed to be understood about the assumptions and the thinking processes of experienced therapists.

Occupational therapists are in a precarious position in a medical world; this precariousness is not so much financial as intellectual. They are too often seen by other health professionals as recreational therapists, "the play ladies," whose main task is diverting patients from hospital boredom or chronic pain. An alternative and equally annoying view is that occupational therapists are technicians trained in the use of adaptive equipment for the disabled whose task is to educate patients in this use. The comparatively holistic and unspecialized

focus of much occupational therapy, especially when combined with crafts or games used as treatment modalities, make therapists theoretically suspect in the eyes of other health professions.

While many therapists believe they know something special about helping disabled patients adapt in fundamental ways to their living situations, this something is not obvious to others. The lack of a well understood and well respected theoretical base leaves therapists feeling vulnerable in the hospital system, not only to colleagues in other health professions, but to patients as well. Moreover, it has created a morale problem within the profession itself. Occupational therapy currently has more job openings than available therapists. As women's access to well paid, respected professional roles has increased, professions such as occupational therapy with its modest pay, limited possibility for advancement and tenuous medical status, are losing appeal.

Probably more frustrating to the profession's leaders is the high burn-out rate of therapists. Most do not stay long, with average career length at about four years. Some marry and choose to stay home with their children. Others with strong career ambitions leave the field for more promising professions. Only a small portion of experienced practitioners are retained. Without a solid core of experienced expert clinicians to

supervise and train newer clinicians, it is difficult to avoid being reduced to a merely diversionary and technical service, as other health professionals suspect. All of these concerns fueled interest in a study which might render the reasoning of therapists more explicit and comprehensible. A second hope was that the study might provide a basis for improving the teaching of clinical reasoning. There has been wide-spread discontent with the ability of newly trained therapists to apply textbook learning to the particular situations of practice. Experienced therapists felt that what they knew was not well captured in textbooks, and perhaps could not be, and that what was not captured reflected a process of thinking and the ability to make context-appropriate judgements more than a particular knowledge base.

Not surprisingly, the funders were especially interested in a study of the clinical reasoning of "master clinicians." Although I was also interested in looking at the clinical reasoning of experienced therapists who were considered expert in the field, I argued for a research design that did not attempt to develop a concept of clinical reasoning from isolated instances of practice among a scattered group of therapists. Partly this reflected an anthropological bias in wanting to have a grasp of the context of action. I felt uncomfortable examining therapists as individual

actors working in isolation from their surroundings. Also, from my work at the World Bank I was already aware that no professional reasons with only the client in view. The constraints and values of the institutional setting were bound to influence the clinical reasoning of therapists. I assumed from the start that clinical reasoning was likely to involve weighing the conflicting demands of various key actors in the setting. The funders agreed with me and we proceeded to study an entire department.

The study began in October, 1986. The site selected was a 900 bed acute care hospital with some rehabilitation wards, for instance a regional spinal cord unit. The Occupational Therapy Department consisted of fourteen therapists working across a wide variety of specializations: Acute neurology and cardiology, spinal cord, oncology, psychiatry, an out-patient hands clinic, and an out-patient pediatrics clinic. This site was chosen among several possible others because it fit the following criteria: (1) It had a reputation among occupational therapists in the area as a good program. (2) It had a diversity of clinical practices. (3) Over half the therapists had four or more years of clinical experience and many had spent four or more years together at this hospital so they knew each other well. (4) There was serious interest among several therapists there in

participating in the study. Four experienced therapists were committed to working around tight schedules and contributing three hours per week of their time for interviews as well as having their practice videotaped. This number gradually expanded to the seven senior therapists and finally, as the project grew into its second year, it became a staff-wide project.

The research was carried out by a team whose core consisted of myself as Project Director and outside anthropologist, two faculty from the Tufts New England Medical Center occupational therapy department -- Maureen Fleming and Ellen Cohn -- four graduate students in occupational therapy - two from Tufts and two from Boston University, and, in a gradual way, the seven senior therapists who were studied. In addition, Nedra Gillette from the American Occupational Therapy Foundation and Donald Schon, from Massachusetts Institute of Technology, served as advisors and consultants to the project. Finally, there was significant help from a larger group of interested occupational therapists, academicians and clinicians from the Boston area who came together for a bi-monthly workshop which I usually conducted where we discussed the emerging findings of the research and did some collective analysis of the data.

The research team was a cooperative, interdisciplinary group. As an experiment in

collaboration it crossed both disciplinary boundaries in medicine and the traditional boundaries separating academics from practitioners. The interests of the research team were combined with the practical interests in self-examination and staff development held by the therapists whom we studied. This was an action research study, meaning that it was simultaneously an ethnographic study carried out by an outside research team and a staff development intervention which allowed the "research subjects" to become actively involved in researching themselves. It served as an experiment in having clinicians reflect on their own practice, building into their work schedule a regular opportunity to look systematically at their clinical work and the work of their colleagues.

The research team focused on describing clinical reasoning as it was manifested in concrete situations of practice and as therapists reflected aloud on their own thinking with particular clients. We asked therapists to describe their reasoning and to tell stories about their work with patients. We listened to them discussing their work with colleagues, observed them working with patients, and interviewed them about those clinical sessions. They were asked to tell, in rich detail, the story of the session. They were also asked to identify what they saw as key decision points, dilemmas, surprises. Their stories and their experiences of

frustration or surprise served as clues to the assumptions and theories that guided their reasoning. Finally, they were asked to talk directly about their theoretical assumptions and rationale in making particular decisions.

The Dualism of Occupational Therapy: A Brief Historical Review

When I began this research, I knew essentially nothing about the history and beliefs of occupational therapists. This occurred not by design but through the accident of receiving an unexpected yet interesting job offer from their national association to direct this research project while I was still miserably struggling with my research with World Bank project staff. Without knowing anything about occupational therapists as a group, I jumped at the chance to leave the world of international development and study professionals who appeared to work at a more comprehensible, more humanly scaled level of intervention. Given the accidents of how this research began, I did not have time to learn much about the field before I started my observations of therapists at work.

In retrospect, it seems remarkable that my first impression that I was witnessing not one but two professions which treated two different bodies was reflected in the history of how the profession developed.

During the first half of its life, it was based in a philosophy growing out of the moral therapy movement which thought of the human body in ways which bear some resemblance to phenomenological conceptions of the body, a resemblance which increased as the occupational therapy movement evolved its own version of this philosophy. The second half brought with it a powerful biomedical definition of appropriate clinical problems for occupational therapy, what one prominent therapist called a "scaling down" of the profession to "match kinesiological, neurological, or intrapsychic view(s) of human nature (Rogers, 1982:714)." What I was seeing even initially, now appears to me to be an uneasy but sometimes creative integration by individual therapists of these two streams of practice and belief.

Occupational therapy has its official beginning in the establishment of the National Society for the Promotion of Occupational Therapy on March 15, 1917 in Clifton Springs, New York. Six people attended that meeting, a nurse, two architects, a physician, a social worker and a teacher. The most important among them in terms of their influence on the development of occupational therapy as a profession were: Susan Tracy (nurse), George Barton (architect), William Dunton (physician), and Eleanor Slagle (social worker). Although he was not at this first meeting, Adolf Meyer, a physician and leading figure in American psychiatry, was

connected to members of the group and was perhaps the most important figure in providing an underlying philosophy of the curative powers of occupation and the need for meaningful occupation in the healthy human life.

There were two social movements which served as forerunners to the establishment of occupational therapy as a profession. The most important was the moral treatment movement in America, a movement rooted in 18th century reforms in the treatment of the mentally ill in England and France. In France after the French Revolution, Pinel initiated reforms in an insane asylum, Bicetre, where he was superintendent. His theory of mental illness was that its' cause was primarily loss of reason and he advised a treatment of "moral management" which involved "a predictable routine, infused with vigor by personnel who inspire confidence (Bing, 1981:502)." Pinel advocated the use of activities as a form of treatment. He viewed activities as both diversions from morbid thoughts and an avenue for altering patients' emotional excesses. On the English side, Tuke, a Quaker, also set out to reform poor conditions in the insane asylum of his day, setting up an alternative form of asylum in York, "The Retreat for Persons afflicted with Disorders of the Mind." Tuke also believed that self-command was essential to regaining mental health and stated, "regular employment is perhaps the most efficacious; and those kinds of employment...to be

preferred...are accompanied by considerable bodily action (Tuke, 1813 quoted in Bing,1981:504)."

The moral treatment movement spread in the eighteen hundreds and occupation was considered an integral part of the approach. It held to a strongly optimistic view that mental illness was curable if the insane were treated correctly. Insanity occurred when people, through an excess of emotion and faulty habits, lost their connection with the mainstream of social life (Kielhofner and Burke, 1977:678). Moral treatment had embedded in it an assumption that mental illness stemmed in part from maladaptive responses by individuals to their social world and that health could be regained through "accommodating or adapting individuals to the general mores of values of their culture (Engelhardt, 1977:668)."

The Quakers were probably most responsible for bringing moral treatment to the United States. The moral treatment approach was furthered by reformers who wanted to improve conditions within insane asylums such as Benjamin Rush and Dorothea Dix. Among some early psychiatrists (alienists) there was considerable interest in the uses of activities as a cure for mental illness; the view being that idleness promoted mental illness, at least in those already susceptible to it.

The moral treatment movement essentially died in the United States by the mid-nineteen hundreds until it was revived, in a rather different form, in the twentieth

century occupational therapy movement, an amalgam of the older moral treatment philosophy and the arts and crafts movement of the late nineteenth and early twentieth centuries. The arts and crafts movement, influenced especially by John Ruskin and William Morris, was an upper class rebellion against the "machine age" and a pastoral call to an earlier time when craftsmen rather than machines produced society's goods. Ruskin argued that one needed a society where "humans, not machines, completed objects" and thus where "work was not abstracted from life but had a place at its very core. The manufactured goods of [Ruskin's] own time he found to be both aesthetically and morally unsatisfying because the worker was treated like an extension of the machine, completing only part of the finished product (Levine, 1987:248)."

In early twentieth century America, arts-and-crafts societies were formed among the upper classes as an attempt to keep alive the "authentic objects" of the individual craftsperson as well as the idea of meaningful work tied to the production of well made, individually crafted, products. The idea of using craft-making as a medically therapeutic approach to the mentally ill is credited largely to two people, Susan Tracy, a nurse who ran a craft-based "occupations training course" in 1906 for nurses working at Adams Nervine Hospital in Boston, and physician William Dunton, who was convinced that an

"occupations cure" was highly therapeutic to the mentally ill. In addition to the efforts of these two, there were several other early attempts in the first decade of the twentieth century to run what were called "sheltered workshops" for patients to produce well made crafts which could be sold (Levine, 1987:250). The occupational therapy movement was based on the idea that "the 'scientific' prescription of arts and crafts could cure a variety of chronic problems generally considered outside the domain of medicine (Levine, 1987:250)."

The occupational therapy movement was in part a response to the rising prestige of medicine, particularly to a physiologically centered approach to medicine which was taking hold in the first decades of this century (Starr, 1987; Kielhofner and Burke, 1977; Levine, 1987). Occupational therapy grew, in part, out of dissatisfaction among some physicians with this narrowing of the medical perspective. Some of these, notably Herbert Hall, William Dunton and Adolf Meyer, were concerned to develop medical therapies that preserved a sense of mind-body unity and, even more broadly, of the role of the larger social and physical environment in influencing mental and physical health (Levine, 1987). Adolf Meyer's address to the Fifth Annual Meeting of the National Society for the Promotion of Occupational Therapy in 1921 illustrates this dissatisfaction. He began his talk by taking direct issue with a diagnostic

approach to medicine and advocating a much more holistic and social view of medical problems:

There was a time when physicians and the public thought the art of medicine consisted mainly in diagnosing more or less mysterious diseases and 'prescribing' for them. Each disease was supposed to have its program of treatment, and to this day the patient and the family expect a set of medicines and a diet, and a change of climate if necessary, or at least a rest-cure so as to fight and conquer 'the disease.' No branch of medicine has learned as clearly as psychiatry that after all many of these formidable diseases are largely problems of adaptation...and psychiatry has been among the first to recognize the need of adaption and the value of work as a sovereign help in the problems of adaptation (Meyer, 1977 (Reprint):639).

Herbert Hall, Adolf Meyer and William Dunton all turned to the arts and crafts movement as a basis for an "occupation therapy" for the treatment of the mentally ill. The marriage of these two movements is important in its modification of some of the "work cures" that were used in mental asylums. While the new occupational therapy movement firmly believed in work, they were equally adamant about the kind of work they considered therapeutic. In The Human Condition, Hannah Arendt makes an interesting separation between labor and fabrication and, in language that closely resembles the arts and crafts reformers, speaks of the integrity of fabrication -- of a making in which the end product is in an important sense the product of that maker. Labor, by contrast, lacks this integrity for Arendt; it is that sort of activity where people cannot have creative ownership of their work or the sense of integrity which

comes from a process of making things which are an expression of oneself.

While the arts and crafts proponents were by no means Marxists, they shared a sense that some fundamental human dignity was lost with the loss of a craft based production of material goods. Arendt's distinction between fabrication and labor is useful in distinguishing the kind of work the original occupational therapists had in mind, work which allowed the integrity and ownership of the maker rather than work which was useful yet elicited neither creativity nor pride from the worker. The early occupational therapy workshops and clinics stressed solid workmanship and a high quality product. Pictures taken of the products patients made in those early clinics show beautiful woodworking and weavings. Even today, although the crafts focus of occupational therapy has largely lost favor, there is a traditional auction at the annual national association meeting (American Occupational Therapy Association) at which therapists auction their own handicrafts to raise money for the national association.

The notion of "occupation," as it developed in the occupational therapy movement, was not confined to a theory about the curative potential of work, not even the comparatively creative work of the craftsman. There was a more complex notion behind the advocacy of occupation as therapy which had to do with a view about

human life consisting of a kind of occupational rhythm, a movement through time which balanced certain occupations fundamental for human health. Health required not only productive work but recreation -- play -- and rest. This is still a very fundamental tenet within occupational therapy (Kielhofner, 1983; Rogers, 1982; Reilly, 1962). Adolph Meyer particularly stressed this way of understanding the occupational cure:

The whole of human organization has its shape in a kind of rhythm. It is not enough that our hearts should beat in a useful rhythm, always kept up to a standard at which it can meet rest as well as whole strain without upset. There are many other rhythms which we must be attuned to: the larger rhythms of night and day, of sleep and waking hours, of hunger and its gratification, and finally the big four -- work and play and rest and sleep, which our organism must be able to balance even under difficulty (Meyer, 1977:641).

The occupation cure was intended to reestablish this balance in those who had lost it, and to do so not through talking but through activity. "The only way to attain balance in all this is actual doing, actual practice, a program of wholesome living as the basis of wholesome feeling and thinking and fancy and interests (Meyer, 1977:641)." The kinds of work which the early occupational therapists gave to their patients was the sort which is culturally ambiguous in its classification between work and play, handcrafts being work for some and play for many others. Occupational therapists constructed environments, carefully graded to increase the challenge to the patient, into which they introduced

increasingly complex activities, pushing patients to increase their capacities to perform complex, meaningful and socially appropriate tasks and, in this way, to adapt themselves to the "real world" outside the institution.

The patients' engagement in these activities was to prepare them to adapt to reality. The emphasis on adaptation and the definition of illness as a maladaptive response to an external environment rather than an internal disease process was one of the most important distinguishing marks separating occupational therapy from the medical tradition.

There was an early emphasis not only on the kinds of occupational activities which might be therapeutic, but also on the role of the therapist as a "firm but gentle" guide to patients, carefully structuring and adapting activities to the particular needs of the patient at particular points in their recovery process (Bing, 1981; Rogers, 1982; Meyer, 1977).

The beliefs of the early occupational therapy movement dominated practice until the 1940s when many external pressures, especially those from physicians questioning the efficacy and scientific basis of occupational therapy, provoked a reaction in the profession and a move to a more physiologically based practice. Many of the occupational therapists who have traced their own history portray a profession which was strongly grounded in moral treatment theory and the arts

and crafts movement through the 1930s. After this point the field divided as many therapists moved to ground their practice in a more medically acceptable way and the crafts approach to treatment, as well as the broad, holistic conception of the nature of chronic illness, fell into increasing disfavor. These writers tell a story of therapists forgetting their heritage, no longer remembering the thinking which brought their profession into being, and striving to reformulate their practice along much narrower, biomedical lines.

The 1940s appear to be a turning point in the profession in which a new, more medically directed, "reductionist" view of therapy ascended. Rogers describes that shift in thinking:

Like many health care professions, we embraced the prevailing philosophy of reductionism to build our scientific development. Reductionism had the net effect of limiting our view of the client, the environment, and occupation. Instead of conceptualizing independent behavior as a molar event, involving a client in a broad contextual milieu, it became a molecular event, involving fragmented responses and equally discrete external stimuli (1982:36).

There were two primary reasons for this shift toward a biomedical approach to occupational therapy, with its emphasis on exercises and strength-building rather than occupations in the richer sense intended by the early founders. One was the depression and the question of financial survival. Scientifically demonstrable treatment effectiveness became much more important in insuring job security. The other was the rising power of physicians

across the health professions. The American Medical Association became the accrediting body for the profession. Occupational therapy became increasingly specialized, a process which still continues. Much, though not all, of this specialization was related to diagnostic categorization. The three main categories are: physical disabilities therapists who deal with physical dysfunction, psychiatric or psychosocial occupational therapists (both names are used) who deal with psychiatrically diagnosed patients, and pediatric therapists who treat disabled children.

Three approaches to occupational practice arose which better fit a biomedical framework. These are still extremely powerful within occupational therapy. One was based on a kinesiological model in which musculoskeletal integrity was emphasized and treatment approaches emphasized increasing range of motion, strengthening muscles and improvising coordination (Rogers, 1982:714). The principle of this practice was to "mobilize, coordinate, and strengthen bodily segments; to develop physical skills and endurance for necessary bodily improvements; to test the physical components of occupational fitness; and to promote psychological stability through intelligent adjustment to unalterable physical limitations (Kielhofner and Burke, 1977:683)."

A second practice model was neurological where functional independence was treated as related to

capacities to integrate sensory input. This model focused on perception and its relation to cognitive, motor and emotional development. The focus in this approach was the neuromuscular system and the relation between sensory input and motor output. This model was quite sophisticated. It was originally used with children with disability problems but increasingly used with disabled adults as well. Treatment activities involved a gradually increased program of sensory exploration and retraining in perceptual skills.

A third key frame was psychoanalytic treatment of occupation where "primary importance was placed on the unconscious phenomena, with exploration of here and now feelings and behavior as a means to arrive at an awareness and understanding of intrapsychic conflict (Kielhofner and Burke, 1977). In psychiatric occupational therapy, craft activities have survived, but they are put to a different use and are interpreted differently than they were by the original occupational therapists. Within the pschoanalytic frame, crafts are seen as opportunities to help patients express their emotions, to reduce tension, and to obtain gratification.

In response to a perceived reductionism in the profession, many occupational therapists began writing articles in the national journal during the sixties in which they advocated a return to the original, holistic beliefs that the professional had begun with. During the

sixties and seventies yet another frame of reference, called "occupational behavior" emerged from the work of Mary Reilly and her students which attempted to ground occupational therapy once again in the early conception of the occupation cure (Llorens, 1987). This has been most developed by one of her students, Kielhofner, and is increasingly popular in the profession, though most notably among psychiatric occupational therapists rather than therapists who work in physical disabilities.

On the whole, the therapists in this study as well as others whom I have talked to more casually do not tend to slot their practice within any particular theory and are more likely to identify themselves as eclectic if pushed to identify underlying theoretical frameworks. This fits what I observed in practice where the therapists' goals and strategies often encompassed all four practice frames, particularly the first three. In addition, the values and beliefs which belonged to the early occupational therapy movement can still be clearly heard even in the most "reductionist" of therapists, as when the therapist gives her patients strength building exercises but exhorts them to become more self-reliant by reminding them that increases in muscular strength will allow increased autonomy by allowing them to move and live more independently.

TWO

STORY AND EXPERIENCE

Telling stories is a fundamental mode of sense-making. It is very old -- myths and fairytales form the oldest literature. "Indeed," Roland Barthes says, "narrative starts with the very history of mankind; there is not, there has never been anywhere, any people without narrative; all classes, all human groups, have their stories...(19 :)" Storytelling is probably universal and it is learned early. The language competence that allows us to recognize and produce narratives appears in children at about the age of three (Brooks, 1984:3). We seem to need narrative to make sense of situations, moving back to beginnings to discover where we are and where we might go. Narrative provides an explanation that "seeks its authority in a return to origins and the tracing of a coherent story forward from origin to present (Brooks, 1984:4)." Narratives help tell us who we are. They are our most fundamental form for communicating the sense of a life and thus a sense of the person who lived that life (Arendt, 1958).

Stories, then, provide one of our most basic perspectives from which to view our world. As Sartre wrote in his autobiography, "A man is always a teller of stories, he lives surrounded by his own stories and those of other people, he sees everything that happens to him in terms of

those stories and he tries to live his life as if he were recounting it (19 :)." What kind of sense does narrative make of experience? Or, put differently, how is experience construed when it is narrated? This question immediately raises problems, for to say that story offers some fundamental way to make sense of experience is to say that there is some basic form which we call story, that underneath the wide variety of kinds of stories, functions of stories and situations of story-telling, there exists a shared core, a fundamental "storyness" belonging to all particular stories. This is debatable.

Following Russian formalist studies of fairytales, French structuralists have been energetic advocates and explorers in the quest for fundamental narrative form. Their program has recently come under serious attack, however, by some of its own early enthusiasts. Barthes, who is one of these, offers a succinct critique of this enterprise in his opening to S/Z.

There are said to be certain Buddhists whose ascetic practices enable them to see a whole landscape in a bean. Precisely what the firsts analysts of narrative were attempting: to see all the world's stories (and there have been ever so many) within a single structure: we shall, they thought, extract from each tale its model, then out of these models we shall make a great narrative structure, which we shall reapply (for verification) to any one narrative: a task as exhausting (ninety-nine percent perspiration, as the saying goes) as it is ultimately undesirable, for the text thereby loses its difference (1974:3)."

It may just be that no tight, formal model of story can be constructed in a way which does not turn out to be a

uselessly empty category, as Barthes suggests.

Nevertheless, something about the general nature of stories needs to be said in posing the question of their relation to experience. My working definition is as follows: Stories are about someone trying to do something, and what happens to her and to others as a result. This emphasizes the "eventness" of stories, their portrayal of human actions, which has been taken as the ground for most universalizing theories of narrative. It is just as important, however, that narratives recount not only doings but, also, experiences, what happens to the actors, that is, how events act on them and what meaning this carries for them. In discussing the role of stories in occupational therapy, I will emphasize both the focus on action and the focus on experience as essential features of narrative.

There is a third feature which many narrative theorists hold to be both self-evident and essential, namely that narrative is fundamentally a verbal structure (Genette, 1982; Rimmon-Kenan, 1983; Scholes and Kellogg, 1966). This is an assumption I explicitly reject. In this thesis I will argue for a notion of narrative which allows that it may be enacted without ever being narrated as such, without ever necessarily being rendered in discursive form. I believe, as MacIntyre says, that "Stories are lived before they are told -- except in the case of fiction (1981:197)." However I will also examine stories in the more usual sense, as something told. I will take narrative as a discursive act as

the model for understanding clinical experience as a nondiscursive narrative enactment carried out by therapist and patient.

The features of narrative I describe in this chapter and the next are not necessarily universal. They belong most evidently to dramatic tales or to very well told stories of the mundane, where the telling itself reveals the drama of the everyday. But they are features characterizing most of the stories included in this thesis. This is not because the narrators of these stories are particularly gifted storytellers; the stories are not art objects. But the stories are striking because the experiences they deal in are so often about the arrested or shattered lives of patients and what it feels like to enter, even momentarily, into those lives.

The Eventness of Story

Everything moves in a story. Even sameness becomes the mysterious output of travels that only cycle back to the beginning. The shifting landscape of a story is the result of what it is made of: stories are built from humanly enacted events. In stories people do things and as a result situations change, or things happen to people and as a result the people change. Events in a story are construed as a passage, a movement from some initial situation through various twists and turns to some final situation. Stories are about experience as a movement through time. Walter

Benjamin (1968) has said that stories are the ways we tell about how life goes forward. A story has the peculiar quality of not being deducible -- it surprises -- while yet following a plausible path. The ending cannot be predicted with certainty beforehand and yet carries the weight of rightness or even inevitability when it is reached. This is because narratives concern action. Though narratives present a succession of actions which have a certain direction, they are also unpredictable or at least not determined from what has come before (Ricoeur, 1978:163). Stories always show what happens as action, so that even if fate seems to prescribe a certain direction of the plot, the specific events which occur are ascribed to the intentional actions of the characters. And intentional behavior is purposeful but not necessary (Arendt, 1958). Because there is no necessity in the connection of its elements, narrative is not guided by logical reasoning in the sense that abstract argument is. The rules of story development are not logical rules because narrative connects contingent events (Burrell and Hauerwas, 1977).

Stories are not only about actions. They also present actions through a diachronic rendering which reveals contexts and lives in the process of unfolding. They create a "chronological illusion (Barthes, 19)." Speaking of the "eventness" around which narratives are organized, Genette describes narrative as a kind of monstrously elaborated verb. "Since any narrative...is a linguistic production

undertaking to tell of one or several events, it is perhaps legitimate to treat it as the development -- monstrous, if you will -- given to a verbal form, in the grammatical sense of the term: the expansion of a verb (1980:30)."

Stories chain events together in a sequence, but their structure is not reducible to sheer linear sequence, to the next-nextness of a series of discrete actions. The temporal movement of a story is much more complex, connecting particular events chronologically, thematically and teleologically. Stories unwind temporally and yet display a wholeness in which each particular episode takes its meaning as part of the larger whole. The structure of narrative is rather like a fugue, Barthes says. It "'pulls in' new material even as it 'holds on' to previous material (Barthes, 19 :255)."

The plot is one device storytellers use to "hold on" to each event of the story even as the story moves on to recount other events, to "pull in" new material. The key function of the plot is to connect the individual events of the story in such a way that they can be seen to contribute to a final ending. Aristotle sees the organizing of story events by plot as a structuring which turns a sequence into a unity governed by a moral. For Aristotle, the plot is a type of moral argument. Hayden White follows Aristotle in his discussion of historical narrative, distinguishing medieval annals and chronicles organized as sheer chronology from narrative history ordered by a plot: "...by plot we

mean a structure of relationships by which the events contained in the account are endowed with a meaning by being identified as parts of an integrated whole (White, 1980:9)." White sees this ordering as not merely formal but moral; in fact, as formal in service of the moral. Narrativity, White says, "is intimately related to, if not a function of, the impulse to moralize reality (1980:14)" and the story does this primarily through the way events are sequenced and causally organized through plot.

In addition to the sequential and teleological organization of events, story events are also organized and take on meaning as elements in multiple themes that run through a story of any length or complexity. Stories are single figures made up of multiple, intertwining themes. The thematic organization of stories has been analyzed by French structuralists with particular attention to the underlying formal features of narrative that yield this "chronological illusion" which is more than chronology. Narratologists, as they have come to be called, have used the structuralist language of syntagmatic and paradigmatic relations to analyze how narratives organize and connect particular story events.

As a temporal structure stories are organized syntagmatically, as sequential succession. At the level of succession, the narrative appears as a sequence of tightly interlocking elements. This is the ordering principle we can see on the surface, the structure to which we appeal

when we ask that narrative question: "And what happened next?" Paradigmatic ordering governs the thematic development which occurs in a narrative. In contrast to sequential organization, it brings together features developed in various parts of the story to create themes. Themes are built (vertically, as the structuralists picture it) by layering elements scattered throughout the story sequence.

Themes tie a narrative together in a polysemic manner. Any given element, situated in one place in the line of succession, may belong to several different narrative themes, and so may have several different meanings in the context of the story. At the thematic level, the story is made up of many threads which only at a certain moment in the story become joined and can be seen as parts of one whole. This thematic ordering gives narrative a structure of "a-whole-with-a-whole...Each point in the narrative radiates in several directions at a time (Barthes:267)."

Not just any event will do as material for a story. Stories deal in motive. There are, of course, unmotivated dramas, great astronomical and geological and biological processes, bursts of hydrogen, meltings and coolings of entire planets, the invisible warring of genes. We often refer to these as stories, as when we speak of "the story of the universe." But these 'unguided doings,' (Goffman, 1974) however eventful and dramatic, are not the stuff of stories proper. When the gods left the scene, so did the stories.

Stories need not provide complex psychological accounts of intentions but they do foreground intending, purposive agents in presenting how things have come about. Stories are about acts and "As for 'act,' any verb, no matter how specific or how general, that has connotations of consciousness or purpose falls under this category (Burke, 1945: 14)." Action is distinct from motion because of a lack of intention underlying or causing motion. Burke illustrates the difference between the two with this example:

If one happened to stumble over an obstruction, that would not be an act, but mere motion. however, one could convert even this sheer accident into something of an act if, in the course of falling, one suddenly willed his fall (as a rebuke, for instance, to the negligence of the person who had left the obstruction in the way) (1945:14).

This distinction between action and motion is crucial in elucidating the structure of a story. To say that motivation plays a key role in defining an act is to say that even where motions are the same, the acts will differ if intentions motivating them are different. Burke gives another example:

Two men, for instance, may be standing side by side performing the same 'operations,' so far as the carrying out of instructions is concerned. Yet they are performing radically different acts if one is working for charitable purposes and the other to the ends of vengeance. They are performing the same motions but different acts (1945:108).

Stories are investigations of events as actions; they are, to use Burke's vocabulary, "dramatistic"

investigations. Drama stands for the paradigm of action in its full sense as distinct from motion with machine as its paradigm. Galactic, planetary and other "inhuman" events are insufficient in themselves as material for stories, not because they lack drama -- they are certainly dramatic enough -- but because they do not require any look behind the movement for the motive.

Because motive is so central to narration, following a story is an act of interpretation. The search for motives required to follow a story involves more than a simple assessment of individual intentions, for intentions, of course, are intelligible only within a situational and cultural context. Acts must be understood as part of a context. To understand an act as motivated, one must have at least some clues about the situation in which it occurred, clues to such question as: What happened? How did it happen? Who did it? Where and when did it happen?

To follow the story, the audience must be able to place individual acts within the context of culture and the context of situation (to borrow Bronislaw Malinowski's terminology from his study of Trobriand garden magic). The cultural context, which Malinowski defines as a semantic domain, a domain of stable cultural meanings, is often implicit in a story, at least in oral storytelling where storyteller and audience share a cultural background. However, the situational context is just what the story is most likely to provide to help the audience understand the

significance of story events. "Situational context" is the concrete situation in which the actions take place. This situational context matters because the same actions can have different meanings depending on the situation in which they are performed.¹ When simple assessments will do to follow the narrative, this indicates that cultural assumptions are well shared and the context well enough identified so that there is an automatic reading, an unproblematic identification in fact, of cultural meanings, situational context, and individual intentionality.

Story and the Interpretation of Experience

Stories are about the "feltness" of life; they are about events as experienced. Stories account for events not only as doings, as occurrences created by our actions or by the actions of others, but as situations which act on us, which affect us. Stories are not primarily about "what happened" even if this is what they tell. Rather they are about what the events described meant to a self or to several selves.

Stories, in so far as they concern this life of the emotions, can be thought of as essays on how it feels to live a particular kind of experience. They are one way to

1. Malinowski made this argument in the context of garden magic, contending that magical texts and particularly ordinary words uttered ritually changed meaning depending on the context in which they were used (1935:228-9). The difficulty with his argument is that these ritual changes held stable within well prescribed contexts, unlike the shifting meanings I am describing which stories are able to capture.

articulate what is deeply felt, to translate the "feltness" of life into eloquence (Burke, 1931). Stories depict not only actions but also hint at the inner life of the passions. This inner life, what Suzanne Langer (19) calls a person's "inside story," concerns how living in the world feels. Stories express and explore ideas about the life of the passions by creating a concrete, public image of what is a largely intangible experiential process. The story world created by the narrative can often evoke and communicate the meaning of experiences which the storyteller would find difficult or impossible to convey through any literal, propositional language.

The drama of narrative is based, in a sense, on the experience of suffering. Even the happy story, the one which ends well, takes us through a drama of plight -- a lack or need which sets the story in motion, which propels the protagonist in a quest to obtain his goal through the overcoming of a series of obstacles. The process of overcoming, however fortuitous the result, is almost inevitably an experience of suffering for the story's heroes. This is such a pervasive feature of the structure of narrative that Propp (1986) made it central to his analysis of folktales and later narrativists expanded it to include many other kinds of narratives.

Experiences may be happy or sad, of course, or invoke any number of possible responses, but there is something right about Hannah Arendt's view of experience as

essentially connected to suffering. She wrote that narratives are about acting and suffering. They are about doing something (acting) and what happens as a result (suffering). Suffering is a name for experience.

Because the actor always moves among and in relation to other acting beings, he is never merely a 'doer,' but always and at the same time a sufferer. To do and to suffer are like opposite sides of the same coin, and the story that an act starts is composed of its consequent deeds and sufferings (Arendt, 1958:190).

To say that stories are about experience is to say that they deal with events from a particular perspective; they tell us about "life divined from the inside," in Bettelheim's wonderful phrase (1977:23). In speaking of fairytales, Bettelheim argues that what these stories are really about is the inner world of feeling, a world which is made concrete, external, in the tale: "Internal processes are externalized and become comprehensible as represented by the figures of the story and its events. The content of the chosen tale usually has nothing to do with the patient's external life, but much to do with his inner problems (Ibid:25)." The power of the story is just this capacity to depict inner conflicts through a narrative structure which may have no clear relation to the listener's external world.

The capacity of narrative to give form to feeling holds equally well for stories at the other end of the spectrum from myths and fairytales, personal stories told about real events that matter to the narrators. Such stories not only

recount what happened, they also mirror and structure a less visible inner world of feelings triggered by the events.

Experiences worth telling a story about are often of a particular kind. While a wide range of phenomena qualify as experience, from isolated tactile sensations to world wars, only some experiences provide material for a story. Living through something, even when that living through is felt and interpreted, is not yet an experience worthy of a story. Here the term experience takes on a normative character, a deeper sense than in its casual use. Not just anything counts. We have, in everyday discourse, a way of signalling when something was merely an experience in the weak sense and when it was dramatic enough to be "an experience." When, for instance, we are asked what happened at some event, let's say weekly staff meeting, we might reply, "Oh, nothing much. Nothing really happened." 'Experience' in this sense is something which can have more or less depth, depending on how we live through something. Depth of significance to the sheer passage of time. 'More' experience stands for more significant experience and "not much experience" or "not much happened" stands for experience with little or trivial significance. Experiences worth telling a story about, significant experiences, are dramatic. One qualification should be made here. If the storyteller is very good, or the audience tremendously sympathetic, even minor events carry sufficient drama for a story.

Stories are about experience also in the sense that they recount the meanings given to events by the narrator. Having an experience of a particular kind, one which feels a certain way, is intimately tied to structures of meaning. The feltness of experiences, the emotions events create, depend on the personal and cultural meanings these events carry, how they are interpreted and made sensible by those who live through them. Just as the story's listeners must interpret the meaning of actions in light of situational and cultural contexts, thus revealing motives and rendering them intelligible, they must also engage in this same kind of interpretive work to catch the meaning of the experiences for the story's characters. In narrative, the point of view is emic. Events are portrayed as they are interpreted and made meaningful by the narrator. The story's narrator provides the audience an authoritative witness to the events recounted. Even the unreliable, alienated and muddled narrators of modern literary stories provide the audience a guided tour within the narrative scene, however uncertain the path.

The story's narrator may be closely linked or even indistinguishable from the story's author, as in most personal oral storytelling. Or the narrator may be a quite distinct persona, as in most written literary texts. The narrator's point of view defines what the story, rhetorically and morally speaking, is "about." Stories are not especially fair minded. They are unlikely to do emic

justice to each character. Through the descriptions provided by the narrator, the audience is generally given a sympathetic portrayal of events from the point of view of one or a few of the story characters. Since narrative drama centers on overcoming obstacles, stories are often about tensions and disagreements among characters. Those actors cast in roles oppositional to the goals of characters who have been presented sympathetically will probably not receive the same interpretive attention to their particular perspective on events; the meaning they make of story events will likely be neglected or misconstrued.

The power of stories to link outwardly observable events, personal meanings and cultural meanings can be seen in the very abbreviated tale Clifford Geertz (1973:7-9) tells to illustrate what he means by "thick description." Geertz gave a brief account of a certain sheep trader named Cohen who came to grief through a series of confused encounters with Berber tribesmen and French authorities. The story centers on a series of concrete events, which are placed within a narrative framework that allows the culturally driven motivations of the actors to become both apparent and intelligible to the reader. Intelligibility derives from the way the account connects particular actions to the cultural beliefs and assumptions that lends them their reasonableness.

The Narrative Nature of Illness Experience

Narrative form has been linked to illness experience in some recent writings. The neurologist Oliver Sacks makes a case for narrative in gaining an understanding of the experience of disease and disability. Speaking critically of forms of medical discourse, he distinguishes the traditional medical history from narrative proper in which the "human subject" rather than the pathology is the central character. "Such [medical] histories," he writes, "are a form of natural history -- but they tell us nothing about the individual and his history; they convey nothing of the person, and the experience of the person, as he faces, and struggles to survive, his disease. There is no 'subject' in a narrow case history; modern case histories allude to the subject in a cursory phrase ('a trisomic albino female of 21') which could as well apply to a rat as a human being (1987:viii)." He advocates narrative discourse as a way to bring persons, with their particular experiences of illness, into center stage.

To restore the human subject at the center -- the suffering, afflicted, fighting, human subject -- we must deepen a case history to a narrative or tale; only then do we have a 'who' as well as a 'what,' a real person, a patient, in relation to disease -- in relation to the physical (1987:viii).

Kleinman's The Illness Narratives, to give another example, presents a sustained argument for distinguishing disease as a phenomena seen from the practitioner's perspective (seen from the outside) and illness, the phenomena seen from the perspective of the sufferer, "the

innately human experience of symptoms and suffering."

(1988:3) In Kleinman's account, experience is connected to personal and cultural interpretation as well as emotion.

The illness experience includes categorizing and explaining, in common-sense ways accessible to all lay persons in the social group, the forms of distress caused by those pathophysiological processes. And when we speak of illness, we must include the patient's judgments about how best to cope with the distress and with the practical problems in daily living it creates (1988:4).

Kleinman is more explicit than Geertz in recognizing narrative as a vehicle which reveals the motives and experiences of the protagonists as well as the interpretive systems which make those intelligible. While Kleinman's central concern in the book is to create a category of "illness experience" which is clearly distinguished from disease and to give that category some depth, he assumes, as his title shows, that the way to get at illness experience is through illness narratives. "But to evaluate suffering requires more than the addition of a few questions to a self-report form or a standardized interview; it can only emerge from an entirely different way of obtaining valid information from illness narratives (1988:28)." Such narratives, if studied appropriately, are the essential guides, the basis for "creat(ing) knowledge about the personal world of suffering (1988:28)." Illness narratives provide the path into the inner personal world of illness experience and for recognizing the larger family and cultural networks that help make the illness something which is felt in a particular way.

The Experience of Following A Story

A story is also about why a listener should care about the events recounted. By configuring events to reveal their significance for the story's heroes, narratives make a case for how an audience should read the significance of those events. A narrative is a rhetorical structure, not simply a formal one. Stories are not intended to be objective accounts viewed from some Archimedean perspective. Nor are they intended purely to convey information. Hayden White considers narrative a particularly brilliant rhetorical device for invoking a moral position without ever having to make that position explicit; without ever even having to warn the audience that a moral position is being argued. The special persuasive cleverness of storytelling, White contends, is that events just seem to "tell themselves," as though there were no narrator behind the scenes organizing and evaluating them at all (White, 1980). The great rhetorical illusion is that stories just seem to tell what happened.

Stories have strong persuasive force for another reason. They invite participation from the audience. The story's focus on motives and feelings brings with it a certain rhetorical force, a perlocutionary weight. "Stories lure the hearer into the process itself. In this sense [the story] is like drama in which, even when the play is being witnessed as a spectacle, the viewer is pulled into the action (Carnes, 1970:113)." The narrative form -- if

successful -- compels an empathic response. Listeners are implicitly, seductively, asked to identify with the plight of the story's heroes, to see the world in the way that the hero or, at least the narrator, does. If the story is effective, the audience should care about what happens in that story as the narrator does, love what he loves, hate what he hates. The story should cast a spell, entrancing listeners to enter a story world and adopt, for a time at least, the feelings and perspectives of story characters. And this should all happen without the audience even noticing that they have done so.

In his studies of storytelling among inner city black youths, Labov (19) has pointed out that the most important narrative question which the storyteller's narrative must answer, and in fact must answer so well the question is never explicitly raised, is "So what?" A failed story is one which leaves the audience wondering why anyone bothered to tell it. A story may be well formed from a purely structural point of view, and may have a clear "point" but if the audience doesn't know why the point matters to them, if the events in the story never touch them, the story doesn't work.

In conveying and evoking experiences, stories call upon the audience to follow a story in a feelingful way, through a certain emotional experimentation, "trying on" the feelings of the story characters (Burrell and Hauerwas, 1977). Following a story is more than an interpretive

exercise. It also invites -- a good story seems to require -- having an experience of that story world. To follow a story is to have an experience which the listener, with the help of the story, creates. This experiential aspect of following a story provides narrative a third rhetorical strategy. The successfully told story draws the listener into the story world in such a way that the listener creates an experience of that world as part of the action of following the story. Story and experience are linked not only in a referential way, stories being about experiences. They are also linked in a generative way; stories initiate experiences in the listener.

The work of some theorists in the phenomenology of aesthetic experience is particularly helpful in explicating the notion that following a story involves more than an act of interpreting experience but is itself an experience. This idea has been extensively explored by Wolfgang Iser, who follows Roman Ingarden's phenomenology of aesthetic perception. Ingarden argues that aesthetic perception is really a form of experience. He is concerned to describe the aesthetic perception process and to distinguish this from a cognitive perception process. He argues for the difference between cognitive perception and the kind of perception which belongs to aesthetic experience.

In a cognitive mode, Ingarden says, we adopt an "investigating attitude." We are concerned to perceive what is immanent to the object -- what its properties are. This

leads to a concern to understand the condition of the perception so as to be able to judge which properties belong to the object. Circumstances are considered so as to try to factor out those which might have caused us to perceive in the object properties which are not immanent in it but are created by the circumstances of its observation -- e.g. lighting, other neighboring objects, emotional disturbances. One needs to make judgments which allow one to separate those perceptions caused by foreign factors and those caused by the nature of the object (Ingarden, 1967:306).

Aesthetic perception is quite a different matter for Ingarden. It involves a state of excitement, a preliminary emotion, with which we perceive the object. Aesthetic perception -- or experience -- begins when a quality "strikes" us, "imposes itself on us (Ingarden, 1967:309)." He uses the term experience rather than perception to describe our attending to an aesthetic object for it is more like having something happen to us than directing our attention to something: "we receive the impression of it, we experience it rather than perceive it." This initial excitement with the object initially "'touches' us, excites us, and stirs us up in a peculiar way (Ingarden, 1967:306)." This initial excitement sets in motion a constructive process on the audience's part.

The experience we have in being drawn into a powerful story is not merely an entranced state of reception but calls into play a creative response. The most interesting

aspects of the theory of aesthetic perception developed by Ingarden and Iser is the constructive process they attribute to the audience as part of the process of apprehension of the aesthetic object. Iser states, "The phenomenological theory of art lays full stress on the idea that, in considering a literary work, one must take into account not only the actual text but also, and in equal measure, the actions involved in responding to that text (1974:274)." Both Ingarden and Iser contend that the object is a product of an experience of encounter between audience and story and that this is so fundamental to the nature of the aesthetic object that it is better considered not as a tangible object but a "virtual object" brought into being through the reader's experience of encounter. Or, rather, the story does not exist -- at least not as aesthetic object -- as a text apart from its apprehension. It is constituted in the encounter.

For Ingarden, what is constituted in the encounter is a "harmony of qualities." We ourselves must actively make that formation -- we do not simply apprehend it. It is a constructed object and the construction may take some effort.

The formation of a harmony of qualities is many times a difficult and painful proceeding, especially if the work of art perceived, on account of its properties, refuses the amount of help that would suffice. It happens, therefore, that we are forced to compose the supplementary moments or parts of an ensemble, and feeling the lack of them as well as anticipating the final harmony quality we are, nevertheless, as yet unable to explicitly "see" the missing qualitative

complement and, in consequence of this, to "see" the final harmony Gestalt (Ingarden, 1967:319).

Iser elaborates Ingarden's explanation of aesthetic experience specifically in the context of following stories. Iser describes the reader of the literary story as participating in a "game of the imagination." At the simplest level imagination comes into play as the reader forms sensory images to accompany the words he reads. This feature of story-following is easily illustrated. Ingarden gives the example of seeing a movie based on a book previously read and finding oneself completely disconcerted at how different the movie scenes and movie characters look from the pictures one had conjured up when reading the book. I remember my own annoyed surprise as a child when an illustration would come pages after a character had been described and I would be astonished at the difference between what I had imagined a character to look like and what I would discover he or she "actually" looked like. (At the time I didn't realize the illustrator had also had to use imagination.)

At a more interesting level of complexity, the process of reading is a process of imagining the possibilities that may lie ahead as we read or hear a story. We project possible futures, possible turns the story may take based on clues and foreshadowings we have already heard. As we read further or hear more, we revise these possibilities, projecting new possible endings. Iser sees the process of following a story as a process of revisions in perspective

based on a confrontation between expectations about future story events generated from what one has already read and the turns the story actually makes:

the activity of reading can be characterized as a sort of kaleidoscope of perspectives, preintentions, recollections. Every sentence contains a preview of the next and forms a kind of viewfinder for what is to come; and this in turn changes the 'preview' and so becomes a 'viewfinder' for what has been read (Iser, 1974:279).

This revision in perspective is not only a formal revision of the plot but also involves revisions in the reader's interpretation of the meaning of the story. As Iser nicely says, following the story involves constructing a perspective that is "continually on the move." (1974:280)

Iser also makes a crucial emendation to Ingarden's theory by seeing this encounter between the audience and the story as essentially confrontational. Confrontation, which so essential to the dramatic quality of lived experience, also belongs to the experience of following a story, at least as explicated by Iser. While the story the listener hears reflects what the listener brings, if the story is an interesting story, if it "captures our imagination," as we say, then our experience of it will be dramatic and the text will not merely a mirror our prior dispositions. This may merely mean that for the space of the story we leave behind our familiar world and create an imaginative world which we inhabit and revise in the course of following the story. If the story catches us up, we may make for ourselves, with the

help of the story, a (partly) alien place and experience ourselves living in that place. Experiencing the story may be confrontational in a much stronger sense if we take that foreign experience to heart, if the experience catalyzes some revising of preconceptions that are not merely story specific but part of our general interpretive apparatus.

Hermeneutics provides another useful framework for considering how following a story -- literary or not -- involves experience as well as interpretation. Experience is treated in a strongly confrontational sense in the hermeneutics of Gadamer and Heidegger. What distinguishes the hermeneutic experience of encounter is that the attempt to understand the object requires a change in the observer. As we are confronted by the object, by its hiddenness and alienness, and come to value and "take-to-heart" that which was merely foreign, we ourselves change. The hermeneutic structure of experience captured by the phrase 'hermeneutic circle' unfolds through a process of confrontation. Something presents itself to us in a powerful, unforgettable way; it presents itself as significant, meaningful, disturbing. An intrinsic part of its meaning is that we cannot initially place it or name it according to the way we have previously made sense of things. This is why we are struck by it and call that confrontation experience. Having been struck by something which both overwhelms us and evades our grasp we question it, initiating a "question and answer game" with the other. Through the initial experience and

the dialogue it brings, we become changed. The experience of understanding is an experience of coming to see things in a new way. This experience necessarily changes the interpreter, modifying earlier versions of how the world was seen.

Gadamer uses the phenomenology of aesthetic experience as a model for what he takes to be the general process of understanding in the human sciences. Experience taken in its hermeneutic sense is a dialogue with otherness. In outlining a hermeneutic concept of experience as an encounter with "otherness," I am perhaps closer to Gadamer in my understanding of the nature of experience than to the way experience has been considered in much of interpretive anthropology. Or it might be more accurate to say that I am especially concerned with the encounter with otherness not only as posing a problem of interpretation but as provoking a certain kind of experience.

Gadamer uses our experience of art and of the beautiful as paradigmatic of the hermeneutic encounter. The beautiful serves for Gadamer as the most striking example of what it means to be overwhelmed by being, where "we are drawn into an event of truth and arrive, as it were, too late, if we want to know what we ought to believe (1975:446)." The beauty of the object, Gadamer says, "charms us, without its being immediately integrated with the whole of our orientations and evaluations (1975:442)."

This encounter with the beautiful teaches us about the object as an other which presents itself, confronts us, and compels thought. The hermeneutic object "stands-in-itself" as Heidegger says. This standing-in-itself is most evident in the ultimate hiddenness of the object. The other's hiddenness reveals that it has an existence independent of our thoughts about it. That hiddenness, the sense that there is always more than meets the eye, initiates a quest for understanding.

Gadamer and Heidegger emphasize the mysteriousness of the other partly because they treat understanding as a problem of overcoming misunderstanding. The centrality of understanding in hermeneutics is due to an existing alienation which must be overcome. Because there is an original distance to be bridged, understanding does not happen naturally but requires a certain work. Following Schleiermacher, Gadamer speaks of an original misunderstanding which requires effort to become understanding.

The effort of understanding is found wherever there is no immediate understanding, i.e. wherever the possibility of misunderstanding has to be reckoned with.

Schleiermacher's idea of a universal hermeneutics starts from this: that the experience of the alien and the possibility of misunderstanding is a universal one. In a new and universal sense, alienness is inextricably given with the individuality of the "Thou" (1975:157-158).

Another way of saying this is that there is something which strikes the listener as strange and "calls for

interpretation (Kisiel, 197 :155)." The object leads the listener from what is familiar and known to what is unfamiliar and alien. We bring to any situation a "preunderstanding." This is our as yet unchallenged presuppositions about what we ought to expect of the situation and the meaning which should be inferred from what we see. If we are to understand the situation in a hermeneutic sense, we must be prepared to discard these expectations. We must be prepared for our prejudices, our "pre-judgments" to be called into question.

We face the world with opinions, values, theories -- these constitute our "world view." These, give us, as we face each new situation, our prejudices, our "pre-judgments," without which we would have no starting place to see the object at all. How is it that we ever move beyond these preconceptions to see their inadequacies and learn from the world, perceiving the world in new ways and extending our horizons? In Gadamer's words, "It is opinion that surpresses questions. Opinion has a curious tendency to propagate itself...how, then, can the admission of ignorance and questioning emerge (1975:329)?"

Gadamer suggests that this admission of ignorance comes through our experience of the object, especially that quality which he calls the "negativity of experience." We are able to perceive more or the other than our opinions can account for, to perceive strangeness, because our senses, guided by our prejudice, allow us to experience the object

as misfitting what we had anticipated. Our experience of such a misfit comes in the form of a question, one which, if the experience strikes us strongly enough, we will not be able to avoid asking. "A question presses itself on us; we can no longer avoid it and persist in our accustomed opinion (Gadamer, 1975:329-330)."

We are described by Gadamer as recalcitrant viewers, seduced almost against our will or surprised into an unexpected attentiveness to something outside ourselves, pressed into experiencing something we cannot immediately understand or explain, something whose meaning is still a puzzle for us. We are even pressed into asking questions which we had not intended to ask because we can no longer persist in our accustomed opinion. The values and meanings with which we customarily explain the world are disturbed; we are compelled to "widen our horizon," in the language of hermeneutics, through taking up the question the object poses, a question not previously our own. We discover new significance. This discovery, while depending on the worldview we brought to the encounter, is not solely shaped by it because our worldview is in some way negated and surpassed through our experience of the object.

Gadamer describes this quality of experience as "a contrast of life with mere concept (1975:60)." An experience has an immediacy, Gadamer says, one which "eludes every opinion about its meaning (Ibid.)." Gadamer uses the term experience in the strongest sense here. It has moved

quite far from the sense of experience as something one just has by virtue of living through a moment, or coming into any sort of contact with the object. "What we emphatically call an experience thus means something unforgettable and irreplaceable that is inexhaustible in terms of the understanding and determination of its meaning (Ibid.)."

Story and Experience in Occupational Therapy

The stories of occupational therapists and their patients concern disability, disfigurement, despair. What do these stories of stigma have to do with the phenomenology of aesthetics? Whatever else, neither therapists nor patients are "charmed" by their confrontation with disabled bodies. And yet there is a remarkable similarity. Stigma, even more than beauty, defamiliarizes the world and makes everything strange. Occupational therapists treat patients confronted by bodies which are suddenly or increasingly alien to them. Some, like spinal cord patients, are newly disabled and are caught up in an experience of trying to make sense of themselves and their lives from an utterly, horrifyingly foreign vantage point. For such people, faced with irrevocably changed bodies, it seems foolish to speak of reality as a purely mental or cultural construction. While it is commonplace in anthropology to speak of what we experience as being shaped or even controlled by our cultural worldview, as though we were never confronted by anything which overwhelmed our systems of meaning, the

experience of those suffering from devastating illness is often just that sense of not knowing how to make sense.

The hermeneutics of Heidegger and Gadamer, with its stress on the role of the "other" in shaping our experience and of being caught up in an experience before we know what to think, may seem to impute too much power to the objects which confront us, overemphasizing our ability to be "overwhelmed" by experiences which force a reshaping of our ways of seeing. But if there is one place where an alien experience forces itself on unwilling recipients whose response must be a change in fundamental perceptions, disability, especially sudden disability, is that place.

This study is primarily about occupational therapists, and they, of course, are not the ones whose bodies are impaired. They do not face this shock. Still, they are witnesses, even instigators, of situations where patients confront new aspects of their disability. Occupational therapists work with patients on ADLs -- activities of daily living. These are the basic, habitual activities like dressing, eating, standing, bathing, urinating, writing, driving, and the like which we learn early in our human careers and which are ordinarily part of the humdrum background of everyday life. Their meaning in constituting a sense of ourselves as independent humans is unnoticed until these capacities are damaged or lost. Therapists train disabled patients in skills and in the use of adaptive equipment to help them regain these capacities where

possible. The stories therapists tell about their work often focus on the difficulties of assisting patients in these relearning tasks and the resistance or anger patients display at their own weakness and at the vulnerability they feel in revealing this to the therapist.

Therapists tell stories about experiences of confrontation -- the confrontation of patients with their disabled bodies or patients with their therapists. A recurrent theme in the therapists' stories recorded in this thesis is the confrontational quality of therapeutic experience. The confrontation of story with experience is the central topic of the final chapters when I examine the stories therapists project ahead of practice about how they will guide their patients through a process of confrontation with disability. The drama of these stories of clinical experience are closely tied to the dramas of illness experience which patients unavoidably face. Therapists draw on borrowed narratives of other clinical dramas to provide them ways to anticipate the kind of experience of confrontations they believe their patient will have.

Therapists think with stories in the sense of creating clinical stories to guide their work with patients, creating prospective stories of where they will go in therapy with particular patient. When these prospective stories run into trouble, as they often do, because the patient resists the role into which he has been cast by the therapist, because the patient's illness takes unexpected turns, or because

unanticipated opportunities open up in the course of therapy, therapists are confronted -- just like Iser's readers -- with a frustration of expectation. The story they had projected "ahead of themselves" confronts their clinical experience as their work with a patient progresses. These experiences of trouble, explored in Chapter Nine, are central to my argument that the therapeutic process is often fraught with such frustration of expectation.

THREE

THE MIMETIC QUESTION

If one thinks at all about the relation between stories and experiences (especially personal stories about life experiences) an ambiguity immediately arises. We may begin quite simply with the idea that stories are something told about experiences. First we have an experience, we live through something, something happens to us, and then -- if we choose -- we tell a story about it. Somebody may ask us, "So tell me what happened?" or "What was the experience like?" and we will likely tell a story.

So far it is all quite straightforward. But what about the fact that when we tell what happened our story is shaped to fit the interests of the audience or to persuade our listener to adopt a certain perspective? Such shaping is unavoidable. We know this very well for as listeners of the story, we may consider the story a simple representation of the experience, a transparent mirror, but we are just as likely to recognize that story as one possible version of the events and know that other stories could be told. When the storyteller is done, for instance, we may ask "So what was the other person's story?" In so asking, we raise the question of in what sense that story is "about" the experience. We cannot even rest with the notion that "each participant has his story" for the same narrator could well

tell his story any number of ways, depending on inclination and audience. This means a story is not even a clear mirror of a person's own particular experience of some set of events. The Roshomon problem is compounded. If a story is not a clear mirror, what kind of mirror is it? How does the structure of the story relate to the structure of the experience as lived through by its participants?

While many writing about personal experiences of disease and disability connect experience to narrative (e.g. Sacks, 19 ; Kleinman, 1988), assuming without elaborate argument that experiences are best expressed and communicated through stories and that the natural referent of story is experience, this is not at all the assumption among those who take story as their primary object of interest. Quite the contrary. Modern narrative theorists, for the most part, see it as both naive and false to treat narrative as a direct or natural expression of action and experience. They do not just deny a simple empiricism, a notion that stories somehow directly describe events apart from interpretation (a view also contrary to those writing about illness experience); they even deny any direct relation between experience as felt and interpreted by an individual and the story that individual might tell about his experience. They doubt that the structure of experience and the structure of narrative have much to do with one another.

The strong argument in literary theory is that the structure of experience is distinct from the structure of narrative and particularly that experience lacks the unifying structure which plot gives to literary narrative. They distinguish 'story', treated as a sequence of events which the story is 'about,' and narrative, the actual discourse that recounts the events. I make no such distinction in my own work on narrative, freely interchanging the two terms. But within this chapter, in order to keep the terminology clear, I will follow this convention in narrative theory and abstain from speaking of 'story' when referring to a form of discourse.

Narrative theorists have not only argued that different narrators will tell different narratives about the "same" set of events but that narratives simply are not representative of experience at all. They especially object to the notion that experience is "closed off" the way time is in a narrative. Louis Mink, for instance, argues that "the closing off of a sequence of events provided by the narrative's beginning and end, is a structure derived from the telling of the narrative itself, not from the events it relates (1987:)." Seymour Chatman is even more emphatic that endings belong only to narrative events, not to life. "Aristotle's discussion of the terms 'beginning,' 'middle,' and 'end' apply to the narrative, to story-events as imitated, rather than to real actions themselves, simply because such terms are meaningless in the real world. No

end, in reality, is ever final in the way 'The End' of a novel or film is." (1978:47) These critics believe that what allows narrative to help us "make sense" of our experience is precisely this structure of beginning, middle and end but that such sense making, whether the content is purportedly 'true' or not, is an "explanatory fiction." We have a need for endings, Frank Kermode tells us, but these are myths, fictional patterns imposed on historical time. Narratives give us various fictions of the end, though "the end is like infinity plus one and imaginary numbers in mathematics, something we know does not exist but which helps us to make sense of and to move in the world (Kermode,1966:37)."

Literary theorists influenced by the structuralist tradition make an even stronger case for the separation of narrative from lived experience. Their claim is that narrative is not in any important sense concerned with time at all while lived experience is. In dividing narratives along a diachronic axis and a synchronic axis and favoring the latter as providing the deep (i.e. 'real') meaning of the narrative, they dismiss time (and experience) altogether. Roland Barthes closely follows Claude Levi-Strauss in declaring that in narrative, chronological succession is "absorbed" into an atemporal configuration. And Vladimir Propp uses a mathematical metaphor in his analysis of folktales, treating the various elements of the

tale as "functions" which can be restructured atemporally in any number of ways to produce different meanings.

In the face of a strong tradition that separates narratives from experiences, on what basis can I claim that there a "storyness" to experience which comes from the work of actors to make a plot out of their interactions? The problematic relation between story and experience becomes acute in this thesis for I claim that therapists emplot actions in order to create significant therapeutic experiences and this claim involves me in a number of serious questions. In my argument I especially consider the concept of plot as it connects to the question of the relation between the structure of lived experiences and the structure of narratives. "Plot" is a literary term; it refers to the structuring of action in narrative -- especially fictional narrative -- not to the world of practical action. In what reasonable sense can I speak of "plot" in relation to the structuring of lived experience? In what sense (if any) is the structure of actions within a narrative analogous to the structure of actions carried out in the "real world"?

This chapter considers the question of mimesis. This question has been answered in two primary ways by those who study narrative. These two perspectives on the relation between story and experience do not cover all the major perspectives by which narrative has been studied.¹ The

1. Those who study narrative as performance, to give a primary example, comprise a large and important group but

following sections outline these two main perspectives on the question of what (if any) mimetic relation exists between narrative and experience. I offer a third alternative which rests on a hermeneutic understanding of the nature of experience and which views the relation between narrative and experience as essentially confrontational.

Narrative As Imitation

In Western literary theory, the discussion of the relationship between narrative and experience begins with Aristotle's Poetics. Aristotle's view is considered a representational one. Narratives mirror, through imitation, the world of action. However, as will become apparent below, Aristotle's view is complex, especially when he discusses poetic narrative. It is not difficult to see that he provided the basis for a rejection of any representational relation between narrative and experience.

Narratives are "imitative processes" (Aristotle, 1984:15) and what they imitate are "men in action (1984:17)." Aristotle did not distinguish action from experience. Experience was considered part of action.²

they do not take the mimetic question as especially important. Bauman (198), for instance, declares that there has been too much emphasis on the issue of the relation between the narrative and what it is taken to represent. He advocates instead an approach which looks at narratives as performed texts and leave aside the mimetic questions.

2. Else, who has translated and written extensively about Aristotle's Poetics notes that "Aristotle does not recognize either feelings or experiences as objects of imitation

Aristotle sees the urge toward poetic art as rooted in human nature. There is a natural human capacity to imitate, he argued, a capacity which distinguishes humans from other animals. "Actually man differs from the other animals in that he is the most imitative and learns his first lessons through imitation (1984:20)." Humans derive a special pleasure from witnessing imitative acts. Aristotle's proof of this is the pleasure we take in witnessing imitations of actions which would horrify us as literal acts. "There are things which we see with pain so far as they themselves are concerned but whose images, even when executed in very great detail, we view with pleasure." (1984:20) Pleasure comes because we learn through witnessing the imitation of action; imitation is our primary form of learning.

While for Aristotle narrative is imitative, poetic imitation is not a simple copy of events for actual events are necessarily particular but poetic imitation concerns kinds, universals. He contrasts historical from poetic narratives because he views historical narratives as purely imitative. Historical narrative is inferior to poetic narrative because history deals in "what has happened" and therefore in particulars:

the historian speaks of what has happened, the poet of the kind of thing that can happen. Hence also poetry is a more philosophical and serious business than history; for poetry speaks more of universals, history of particulars. 'Universal' in this case is what kind of person is likely to do or say certain kinds of things, according to

alongside acts (actions). The tragic pathos is an act." (Aristotle, 1984:80, Translator's note.)

probability or necessity; that is what poetry aims at, although it gives its persons particular names afterward...(Aristotle, 1984:32-33).

For Aristotle, the contrast between narratives which are sheer imitation of action from poetic narratives centers on the vehicle of plot. Aristotle names plot as that structuring device which gives poetic narrative its capacity to deal in universals. Plot is the "structuring of events" (Aristotle, 1984:26), a structuring which unifies actions into a coherent whole. This structuring gives both pleasure and intelligibility. He says, by way of explaining the nature and power of plot, "the most beautiful pigments smeared on at random will not give as much pleasure as a black-and-white outline picture." (1984:26) Plot gives the outline. The plot allows one to comprehend a succession of incidents in a single, unified figure. The poet narrating an actual historical event takes license to include some incidents and leave others out in accordance to the demands of the plot. (A licence Aristotle does not believe historians take.)

The well plotted narrative ought to be such that every single element is necessary to that whole and is ordered so as to best bring out that whole: "the component events ought to be so firmly compacted that if any one of them is shifted to another place, or removed, the whole is loosened up and dislocated; for an element whose addition or subtraction makes no perceptible extra difference is not really a part of the whole." (Aristotle, 1984:32) Through

this artful structuring, no incident happens by mere random chance; rather each leads inexorably (though in the best plots, unexpectedly) to the conclusion. One event follows another in a necessary or probable way, not because of the arbitrariness of chance.

Histories lack plots, as Aristotle sees it. This is because histories must include everything that happens; historians are disallowed the selective licence given to the poets. More important, Aristotle views life events as occurring, often as not, in a chance relationship. The historian is bound by what actually happens, not by the demands to create a single unified action as structured by a plot. Since the historian is required to report all that happens as it happens within some given time period, he cannot shape the succession of events in such a way that they are clearly "pointed toward the same goal (Aristotle, 1984)."

The emplotted unity Aristotle speaks of is ordered teleologically, as a movement toward an ending in which each episode takes its necessary (or probable) place. But Aristotle thinks that life as lived does not guarantee any such clearly marked unity, is unlikely to cleanly reveal relationships among events and their contribution to a final "single result." Actual events, as they fall out, do not lend themselves in their natural order to the workings of a plot. Relations among events in life in any particular case are likely to be merely chancy, unrevealing of any deeper

laws about probable or necessary relations. Hence Aristotle contrasts life as lived which is liable to trivial succession, one thing just happening to follow on another, to life as emplotted, structured by a compacted movement with a clear beginning, middle and end and with each episode in its proper and necessary place. "For just as the sea battle at Salamis and the battle against the Carthaginians in Sicily took place about the same time of year but in no way pointed toward the same goal, so also in successive periods spread over time it often happens that one event follows another without any single result coming from them (Aristotle, 1984:62)."

Already in Aristotle, then, despite an emphasis on narrative as imitation, an opposition is set up between life as lived, the life of real time, and the artificial unity given to life through the structuring device of plot. This unity is artificial in the sense that it is an artifice of the poet. At a deeper level, by declaring the philosophical seriousness of poetry as compared to history, Aristotle is claiming that this artifice allows us to contemplate the deeper truths of the nature of action and experience. The key opposition for Aristotle, Ricoeur (1984) points out, is "one thing after another and one thing because of another." One thing after another is merely successive but one thing because of the other is causal (Ricoeur, 1984:41). History deals in the first; poetics in the second.

In classical Greek culture there was a second basis for distinguishing life as lived from a narrative about past events. Not only was the narrative different because historical events were merely contingent, the purpose of a narrative was not simply to tell what happened but to provide a moral perspective on past events. (Arendt, 1958) Aristotle judged poetic narrative as one which connects actions in a causal way and which, therefore, allows moral lessons to be drawn about connections between actions and their consequences. While classical Greek culture is credited with an essentially representational view of narrative, the Greeks believed that the story outlived the act itself only if it was said well. It was not enough merely to report something. The bard "straightened the story" -- set it right (Arendt, 1958). The point of the narrative was not so much accuracy but a powerful rendering. Although they saw the narrative as a remembrance, a reflection of a past experience, they also thought that the confusion and ambiguity which characterizes living through events is distilled into a harmony, a whole, from which the particular meanings of the actions can be understood.

Arendt's discussion of the relation between narrative and experience follows the Greek representational view. She emphasizes the role of narrative as remembrance which is not mere imitation; the narrative provides the place where the real meaning of the experience is available in a way that it is not as it is lived through. She argues that there needs

to be a certain distance in time for the meaning of actions to become apparent. Actions, as she sees it, are really only beginnings and their meaning only emerges as they play themselves out in the "web of human relations" which they necessarily enter. The narrative reveals the meaning of actions because the sequences of occurrences and sufferings they bring about is played out in it. This meaning is not available to the actor in the midst of action for he cannot yet know what consequences will follow from what he does. A narrative, in this sense, is a kind of summing-up. It is only by looking back that the real meaning of the initial actions can be understood (Arendt, 1958).

Arendt gives the following example from Homer. Odysseus weeps when he hears the story of his quarrel with Achilles which ultimately led to Achilles' death. The storyteller, through his eloquence, creates a sorrow in Odysseus that living through the event did not. From the distance of spectator, listening to the narrative about his own experience, Odysseus sees the terrible loss and suffering which his quarrel caused. He is even made to recognize his own suffering which he previously hid from himself. For the first time, and only on hearing the story, Odysseus weeps for the loss of his friend. The artfulness of the storyteller in telling the narrative well is what allows the meaning of the experience to press upon Odysseus.

Even the ancient representational view of narrative, then, does not equate poetic narrative with a mere reporting

of experience. A well-told narrative, at least a poetically well told one, "straightened" events in order to bring out a deeper meaning. The anti-mimetic view currently powerful in narrative theory can be seen as an intensified focus on how stories are "straightened" and an accompanying disinterest or disbelief that life as lived bears much resemblance to the narratives we tell about it.

Narrative as Transformation and Distortion

The anti-mimetic view questions any simple correspondence between narrative and experience. Modern literary theory generally holds that narratives are a dramatic transformation of lived experience because there is a difference between our life in time as we actually live it and the way time is structured in narrative. Narrative, in this view, is a mythical imposition of coherence on what is otherwise formless experience and in particular, the structure of beginning, middle and end is one we find in narrative and lack in life.

The distinction between lived time (experience) and narrative time is critical to modern conceptions of plot, point of view and style. All these fundamental literary concepts are defined in part by their role in transforming and distorting life as lived. This can be seen in the now commonplace distinction many literary theorists make between 'discourse' and 'story.' Jonathan Culler sums up the major traditions of narrative study represented in the American,

French, Russian, German, Netherland and Israeli schools by saying: "There is considerable variety among these traditions, but if these theorists agree on anything it is this: that the theory of narrative requires a distinction between what I shall call 'story' -- a sequence of actions or events, conceived as independent of their manifestation in discourse -- and what I shall call 'discourse,' the discursive presentation or narration of events (1981:169-170)." Story and discourse are defined precisely by their difference.

Culler's argument is that the notion of a set of events is analytically prior and necessary to any discussion of narrative which is always treated as a particular rendering of those events. What can be said about this prior state of events? The 'story', 'fabula', or 'histoire' as it is variously called? It is treated as a chronology. Mieke Bal offers this clear definition: "'the story consists of the set of events in their chronological order, their spatial location, and their relations with the actors who cause or undergo them...'"The events have temporal relations with one another. Each one is either anterior to, simultaneous with, or posterior to every other event (From Culler, 1981:171).'" Narrative theorists give, as evidence for this prior chronological "content" the fact that we can know the same 'story,' say Tom Thumb, although we will not necessarily have heard the same narrative text. "There are different versions; in other words, there are different texts in which

the same story is related (Bal, 1985:5)." We can recognize the story as the same across different textual versions, even when these differ considerably. Discourse has to do with the reordering of sequence. "The analyst must assume that the events reported have a true order, for only then can he or she describe the narrative presentation as a modification or effacement of the order of events (Culler, 1981:171)."

In order to talk about presentation at all, for instance about the point of view from which events are seen, the events themselves must be assumed as an "invariant core." This core sequence becomes the "constant against which the variable of narrative presentation can be measured." (Culler, 1981:)

Within the Anglo-American tradition, the separation of lived time and narrative time can be seen prior to the influence of the Russian formalists and French structuralists who have so shaped modern narrative study. E.M. Forster, writing his highly influential Aspects of The Novel in 1927, is a prime example. He distinguishes 'story' and 'plot' and in so doing distinguishes narrative time and lived time. He relies on a disparity between sequential time and emplotted time to analyze the nature of plot. He distinguishes story from plot along the same lines that Aristotle distinguishes historical from poetic narrative and later theorists distinguish story from discourse: in the opposition between sequence and plot. For Forster, as for

the later structuralists, story is mere sequence. It is just one thing after another. The story "runs like a backbone -- or may I say tapeworm, for its beginning and end are arbitrary (1927:27)." In being mere sequence, the story "narrates the life in time (1927:29)." Life in time is regulated, for Forster, by the clock. Time sense is the ticking of the clock; one moment succeeding another in an endless series. The story, as structured by time, is an arbitrary slice out of that series. The story is "the chopped off length of the tapeworm of time (1927:85)."

While no novel, Forster tells us, can do without this basic chronological organization since no narrative can do without time, time structure is its most primitive feature on which a much more complex organization of action is built. This more complex organization is given by plot. Forster visualizes plot as "a sort of higher level official" who is concerned that everything which happens is marshalled in such a way that it "contributes to the plot." Through such marshalling, events are transformed from a relation of mere sequence, the monotonous structure of time, to a relation based on causality. Forster defines plot as against story, causal relations as against sequential relations. And most of all, plot as against time.

We have defined a story as a narrative of events arranged in their time-sequence. A plot is also a narrative of events, the emphasis falling on causality. "The king died and then the queen died" is a story. "The king died, and then the queen died of grief" is a plot. The time-sequence is preserved, but the sense of causality overshadows it. Or again: "the queen died, no

one knew why, until it was discovered that it was through grief at the death of the king." This is a plot with a mystery in it, a form capable of high development. It suspends the time-sequence, it moves as far away from the story as its limitations will allow (1927:86).

The shift from story to plot, in Forster's vocabulary, is the difference between the "whatness" of an experience and its "whyness." To the story our only response can be "What next?" But to the plot, with its causally related events, our question is "why" (1927:86)? Here are strong echoes of Aristotle who in the Poetics equates plot with argument. For Aristotle, a plot is an argument. It answers why questions. In telling what happens, it answers why things happen.

The (largely) French structuralist tradition has been powerful in effecting a separation between lived experience and narrative. The role of structuralism cannot be overestimated in the popular anti-mimetic treatment of narrative within narrative theory. It reinforces a view that the meaning of texts is within the text or between texts, intertextual. One ought not to investigate the meaning of the story by looking at what it points to in the world but rather by investigating formal structures existing within the text itself or among texts belonging to a certain genre or tradition.

Structuralism has defined narrative as a "way of speaking" rather than a "form of representation," as Hayden White notes. "The idea that narrative should be considered less as a form of representation than as a manner of

speaking about events, whether real or imaginary, has been recently elaborated within a discussion of the relationship between discourse and narrative that has arisen in the wake of Structuralism and is associated with the work of Jakobson, Benveniste, Genette, Todorov, and Barthes (White, 1987:2)." Structuralism distances narratives from experience by promoting a focus on textual meaning which can be defined formally rather than by reference to cultural and personal experiences existing outside a textual universe. Narrative theorists have been less and less interested in identifying narrative meaning with what a narrative seems to be saying about how we live our lives or how a narrative (whether fictional or 'true') evokes an experience which readers can translate by analogy into a reading of their own lives. Meaning becomes an increasingly grammatical affair.

Narratologists, particularly Roland Barthes, have been heavily influenced by Levi-Strauss' study of myth and by the Saussurian framework Levi-Strauss employed in his analysis. The attempt to uncover a pure consistent form underlying the multiple versions of narratives was prompted both by Russian formalists and by Levi-Strauss' innovative study of myths. A major underlying assumption in structuralist studies of narrative is that meaning lies in relations among elements, not in their isolation -- or in any direct reference to a world. This is an elaboration of Saussure's study of the 'sign' applied to larger textual works. Levi-Strauss helped

fuel an interest in applying linguistic theory to larger textual units like narrative.

Saussure sees the basic element of language, the "sign," as itself a relation of signifier (the sound-image) and signified (a concept) (1959:67). A sign, which is already a relationship, only takes on meaning in relational context with other signs. This semiotic concept of meaning creates a way for literary theorists and anthropologists to analyze more complex textual and cultural wholes as systems of connection and especially of contrast. (Leach, 1976:13) Levi-Strauss' study of myth follows Saussure's semiological assumptions. The constituent units which make up myth are like the constituent units, the signs, present in language, except that they belong to a higher and more complex order. Just as signs are a relation, so are the constituent units in a myth -- "mythemes" as Levi-Strauss calls them. A single myth is a construction of relations where the elements which make up the relations, the mythemes, are themselves bundles of relations that exist apart from their use in any given myth. Mythemes are to myths as words are to sentences.

The influence of Levi-Strauss can also be felt in the analysis of narrative along syntagmatic and paradigmatic axes, a division which also originates in Saussure. This dichotomy reinforces the comparative unimportance of the "syntagmatic" as against the paradigmatic. The syntagmatic is associated, in narrative theory, with the chronology of

the 'story,' a simple diachronic structure of movement through time.³ Levi-Strauss analyzes the elements of myth in terms of the two sets of relations outlined by Saussure: syntagmatic and associative or paradigmatic. Syntagmatic relations are linear, corresponding to the linear feature of discourse and to its temporalness, its diachronic character. Each mytheme in the syntagmatic relation takes its meaning from an opposition to the elements which precede and follow it. Syntagmatic relations are like the melody, the tune.

Paradigmatic relations are synchronic, linking mythemes to intertextual sets which include elements outside the particular given myth. Reading a myth (in the structural sense) is like reading an orchestra score:

An orchestra score, to be meaningful, must be read diachronically along one axis -- that is, page after page, and from left to right -- and synchronically along the other axis, all the notes written vertically making up one gross constituent unit, one bundle of relations (Levi-Strauss, 1963:212)

Of the two axes, the paradigmatic is privileged in the structural study of narrative. To tell the myth, to recognize its storyline, Levi-Strauss (1963) tells us, we need only recognize the syntagmatic relationship. But to understand the myth, he says, we must read it paradigmatically. To understand what Levi-Strauss has in

3. There is an interesting inversion, however. For Levi-Strauss, the surface structure is the 'story' and only at deeper levels, through intertextual readings of myths with other myths, does the paradigmatic structure of relations become apparent. But in narrative theory, it is precisely this chronological story which is invisible, hidden beneath discourse.

mind by a paradigmatic reading of myth, we need only look at his bricoleur. Mythemes are like the material with which the bricoleur endlessly tinkers. The bricoleur works odds and ends, left-over things which at others times had other uses but which happen to be available and are rearranged to suit some new purpose which he has in mind. (1962:17)

Mythemes, like the odds and ends in the bricoleur's scrap bag which are kept around because they may come in handy, form a limited repertoire of heterogeneous items which must be applied no matter what the task at hand. These scraps are the vestiges of past events, Levi-Strauss suggests, although he does not necessarily refer here to historical or even mythological events. The entities which the bricoleur uses are "reconstrained" in the sense that they were made for other purposes and have features which are predetermined by those previous uses. They have neither the transparency nor the malleability of linguistic signs. Mythical thought "builds up structured sets...by using the remains and debris of events...fossilized evidence of the history of the individual in society...Mythical thought, that 'bricoleur,' builds up structures by fitting together events, or rather the remains of events..." (SM: 21-22) Because mythemes are really the remains, mythical thought is not free to make any construction it chooses. It is "imprisoned in the events and experience which it never tires of ordering and re-ordering in its search to find them a meaning (1962:22)." Mythemes, then are the items in the

myth presumably once linked to actual or mythological events (though Levi-Strauss would also include non-eventful elements) which occurred in the culture and in some truncated ahistorical form have been saved in case they come in handy.

Paradigmatic or vertical relations get at the "deeper" (unconscious) layer of meaning of the myths taken as a system. These vertical relations form associative groups of elements which look different in their content but actually "carry the same message," Levi-Strauss argues. Particular narratives are, in this view, merely structural transformations of one another -- a reordering of odds and ends in yet another attempt to answer some logical problem.

Mythological analysis, as Levi-Strauss practices it, does not show how humans think, in the sense that humans are only partially and intermittently aware of the structure and mode of operation they use when creating and telling myths. As evidence for his claim, Levi-Strauss draws on the analogy of linguistics where we use language without knowing the linguistic rules. The principles of mythological thought are similarly not at the conscious level, and so, in a way, have little to do with concrete, felt human experience. Levi-Strauss wants to separate minds, which have certain innate structures, from the humans who use them consciously. He claims to show "not how men think in myths, but how myths operate in men's minds without their being aware of the fact (1962:12)." For this reason it is better to "disregard the

thinking subject completely, proceed as if the thinking process were taking place in the myths... (Itid)"

The real meaning is thus not in the "chronological" story itself. (It is not even, for Levi-Strauss in the narrative as discourse in itself.) Nor is it, for Levi-Strauss, in any experience to which the story ostensibly, "syntagmatically" refers. Rather meaning is only to be located in the combination of elements which are part of the structural underpinning of the storyline. This underlying combination is like the grammar which underscores discourse. To use Levi-Strauss' orchestral analogy, for semiologists it is in the harmony rather than in the melody that the heart of the music lies.

This separation of experience and narrative is not confined to literary accounts of narrative concerned primarily with the imaginary or structurally oriented anthropological accounts of narrativizing savages. It has also been strongly taken up in philosophy of history which concerns itself with real events. Hayden White, following the structuralists, argues that stories are a certain kind of artful illusion in which "The events seem to tell themselves (1987:3)." But real events, White notes, do not in fact "tell themselves" at all. This makes the possibility of narrating stories about real events a puzzle. "It is because real events do not offer themselves as stories that their narrativization is so difficult (1987:4)." This story which is created out of the "chaotic

form of 'historical records' is, for White, because of a kind of wishful "fantasy that real events are properly represented when they can be shown to display the formal coherency of a story (Ibid.)."

White's argument is that narrative is a cultural form which imposes a structure of moral meaning on the bare chronicle of events. Relying on the same distinction between 'story' as chronology and 'discourse' as an emplotted ordering of chronology common to literary narrative theory, he distinguishes history as chronicle from narrative proper. A narrative is distinguished from a chronicle by the fact that it has a discernible beginning, middle, and end. The chronicle arranges the events to be dealt with in the temporal order of occurrence. The chronicle is transformed into a narrative by a further arrangement in which the events are treated as "components of a 'spectacle' or process of happening which is thought to possess a discernible beginning, middle, and end." (White, 1987:)

This is not merely a formal difference. White distinguishes chronicle from narrative proper on the basis of the presence or absence of morally driven ordering of events into a plot. Narrative proper is organized by a "principle" for assigning significance to events which is lacking in the bare chronicle (1987:11). "It is this need or impulse to rank events with respect to their significance for the culture or group that is writing its own history that makes a narrative representation of real events

possible. It is surely much more 'universalistic' simply to record events as they come to notice (White, 1987:10)." The ghost of Aristotle is present here, since Aristotle also thought that the superiority of poetic narrative, ordered by a plot, over mere history as contingent sequence of events, was in the capacity of the poetic narrative to make a moral claim on its listeners. White is arguing that history too, when told as a story, as distinct from the annals of medieval times which were sheer chronology, is a poetic structure around which particular events can be charged with moral significance and which provides culture certain moral lessons.

Thus for White history provides the same "chronological illusion" that Barthes claims for fictional narrative. History, White says, appears to be a structure which is sheer chronology, in which events seem to "tell themselves" but this is an illusion because it is a specifically retrospective and rhetorically driven moral ordering that belongs to the discourse, not to the events as lived. History is a "narrative prose discourse" which merely "purports to be a model, or icon, of past structures and processes in the interest of explaining what they were by representing them (White, 1987:2)." Historical narratives don't just tell or show events, White is claiming, they explain them through a particular mode of representing them, one which, paradoxically, seems perfectly natural -- as though the events explained themselves. This mode of

explanation White calls "explanation by emplotment."
 Explanation by emplotment explains a story by telling what kind of story it is. "Emplotment is the way by which a sequence of events fashioned into a story is gradually revealed to be a story of a particular kind (White, 1987)."

In sum, the argument of most modern narrative theory, especially that theory most heavily influenced by French structuralism, is that life as lived is at best a chronicle but lacks the moral coherence provided by narrative. Even 'true stories' from this point of view are fictions because they pretend to a coherence and integrity missing in life (Herrnstein Smith, 1980). Within modern literary sensibility, to equate story (defined as against discourse) with lived experience is a false representation of lived experience. It presumes that story (the prior events) is a brute sequence, a chronology of next-next chance occurrences. These brute events are taken up and restructured through the work of plot in their presentation as discourse, as the told story.

Against this, I will argue that actors have a practical interest in plot, that plot is part of lived experience and not simply of its rendering through the telling of a story. We plot, as actors; hence the structure of lived experience already contains a (partly) plotted structure. Contrary to Aristotle and later literary theorists, history as lived experience is not formless succession. Lived experience doesn't occur as one thing after another because actors work

to create a story-like quality to their actions. Being an actor at all means trying to make certain things happen, to bring about desirable endings, to search for possibilities that lead in hopeful directions. Even if most of experience is suffering, as Arendt says, because our actions are taken up, reworked and redirected by the responses of other actors, we still have some success some of the time in working toward endings we care about. And sometimes we are even able to negotiate with other actors so that we can move in directions cooperatively, cumulatively. Formlessness is not so much a description of the structure of everyday life as a depiction of despair. The essence of meaninglessness is when lived experience seems to be driven by no form other than brute sequence.

The opposition between story and discourse registers sensibly only by positing a false notion of what "prior events" are and how they are structured. If lived experience is treated as more structurally complex than brute chronology -- one thing just happening to come after another -- then this necessarily lessens and muddies the division between the two, a claim I will work to prove throughout this thesis. Whatever it is that discourse -- story as told -- represents, it is not brute chronology. In the case of narrative fiction, this may not matter. But if we are speaking of true narratives, ones that purport to be about actual experience, then the distinction throws a fictitious light on the nature of experience.

A Dialogical View of Narrative and Experience

There are occasional moments of doubt in the minds of those narrative theorists who so strongly want to separate narrative from experience. When Gerard Genette offers a first definition of narrative as "the representation of an event or sequence of events, real or fictitious, by means of language (1982:125)" he moves quickly to dispel any easy mimetic definition. To define narrative in this way, he warns, "Is to give credence, perhaps dangerously, to the idea or feeling that narrative tells itself, that nothing is more natural than to tell a story...(Ibid)" He approves the modern literary sensibility which has recognized the artifice of narrative. Yet there is a worry that perhaps the separation has gone too far. On the one hand Genette and others want to liberate narrative from its role as imitation of action, events, experience. On the other hand, this release from imitation also seems to spell the end of narrative itself. The ambivalence is eloquently marked by Genette:

It is as if literature had exhausted or overflowed the resources of its representative mode, and wanted to fold back into the indefinite murmur of its own discourse. Perhaps the novel, after poetry, is about to emerge definitively from the age of representation. Perhaps narrative...is already for us, as art was for Hegel, a thing of the past, which we must hurry to consider as it retreats, before it has completely disappeared from our horizon(1982:143).

Forster, like Genette after him, tries to loosen the distinction he draws so strongly between story and plot. He

blurs the two when, almost parenthetically, he notes that life as lived (and not merely as recounted by the complex and emplotted narrative) is itself experienced as more than mere sequence. There seems to be something else in life besides time, he says, something called value. This something is "measured not by minutes or hours, but by intensity, so that when we look at our past it does not stretch back evenly but piles up into a few notable pinnacles, and when we look at the future it seems sometimes a wall, sometimes a cloud, sometimes a sun, but never a chronological chart (1927:28)." He concludes from this that our daily life run along both tracks, it is composed of two lives, a life of time and a life of value. The job of the novel (the complex narrative) is to treat the life of value as well as the life of time.

If our experience of our passing time, of its movement, is not sheerly equatable with chronology thus opens a window to a much more complex reading of the shape of life experience, one which brings it closer to a narrative structured by plot. This has been taken up by a minority of theorists and has led to some interesting revisions of those favoring or rejecting a representational view of the relation between narrative and experience. One interesting development in narrative theory reverses the relationship between story and experience, proposing that rather than action preceding story, stories precede and help us to make action coherent.

This line of argument has developed in two separate domains, cognitive theory and literary theory. Cognitive psychologists and anthropologists have become interested in the notion of narrative "scripts," learned action patterns that individuals carry from one situation to the next which they use to help make sense of what to do and how to understand what is going on in any particular situation. Here narratives refer to "prototypical event sequences" which are standardized sequences of events which guide us through our daily routines (Quinn and Holland, 1987). The notion of narrative here becomes a means for considering how knowledge is organized in the mind.

Some theorists of narrative, though not working within a cognitive frame, also argue that narratives govern experience. This view is that, as one proponent puts it, "Events are not the external raw materials out of which narratives are constructed, but rather the reverse: Events are abstractions from narrative. It is the structures of signification in narrative that give coherence to events in our understanding...(Bauman, 1986:5)" From this perspective, learning the genres that dominate a culture's storytelling means coming to understand the basic ways members of that culture make sense of the particular situations they enter. Levi-Strauss makes the extreme case when he declares that "myths operate in men's minds without their being aware of the fact." (1962:12)

There is too much determinism in most of the arguments that stories govern our lives, particularly among those with a strong cognitivist leaning. What gets neglected is what happens to cultural narratives when actors try to put these into play in particular, concrete situations. First, actors have their own pragmatic reasons to improvise on cultural scripts and rules, as Pierre Bourdieu (1985) has pointed out.

Second, the idiosyncratic demands of particular situations often require an individualized narrativizing. (A point illustrated in Chapter Nine.) An archetypal or prototypical treatment of the relation between narrative and action dismisses any complex account of practical reasoning. Aristotle argues in Nichomachean Ethics that the special feature of action is that it is particular and practical reasoning, directed toward making right actions, similarly involves judgments which are particular to the situation. In my own argument, even while promoting a conception of narrative as preceding and guiding action, I stress the particularity of each action context and look especially at the inadequacy of narratives imported from prior particular experiences or directly applied from cultural scripts until they are modified to make a better fit to the new practice situation.

Any deterministic view about the relation between narrative and experience is too simple. Experiences themselves do not determine the narratives therapists tell

about them. Narratives do not refer in some naively empiricist way to "events out there" or even to "experiences out there." The experiences therapists have are not independent of the narratives they tell. Their narratives help shape their experiences. But cultural or prototypical narratives do not determine their experiences. Narratives are not scripts which therapists simply live out. I view the relation between narrative and experience as dialogical, even confrontational, prospective narratives being projected, unravelled, and remade in the course of trying to live them out.

In any situation we, as actors, have a narrative interest in constructing, an 'untold story' out of discrete episodes. We have a need not only to make sense, as Goffman says, but to create sense out of situations and a fundamental way we create sense is by shaping the next-next character of on-going action into a coherent narrative structure with a beginning, middle and end. The interest in coherence and order is only one motive for attempting to play out a situation in such a way that a narrative (a desirable one, the right kind of one) can be told. As actors, we require our actions to be not only intelligible but to get us somewhere. We act because we intend to get something done, to begin something, which we hope will lead us along a desirable route. We suffer because it so often does not. And we act, with what Kermode (1966) calls the "sense of an ending." Because we act with the sense of an

ending and because we care about that ending, we try to direct our actions and the actions of other relevant actors in ways that will bring the ending about. We try to make actions cumulative (Olafson, 1979). Put narratively, we try to take the episodes of action and structure them into a coherent plot.

A plot gives unity to an otherwise meaningless succession of one thing after another. Quite simply, "emplotment is the operation that draws a configuration out of a simple succession (Ricoeur, 1984:65)." What we call a story is just this rendering and ordering of a succession of events into parts which belong to a larger narrative whole. Particular actions then take their meaning by belonging to, and contributing to, the story as a whole. To have a story at all is to have made a whole out of a succession of actions.

This "making a whole" is also making meaning such that we can ask what the point or thought or moral of the story is (White, 1987; Ricoeur, 1984). Narratives give meaningful structure to life through time. The told narrative builds, to borrow from Ricoeur's argument, on action understood as an as yet untold story. Or, in his provocative phrase, "action is in quest of a narrative (1984:74)."

In developing my argument I rely heavily on a small group of narrative theorists, all philosophers: MacIntyre, Ricoeur, Carr and Olafson. They posit a fundamental relation between narrative and experience which is not a

copy theory, at least not in any simple sense, but which also is not a deterministic theory that sees experience as governed, mapped, by pre-existing narratives. Ricoeur's major recent work, Time and Narrative (1984, 1985, 1988) makes a sustained argument for the mimetic function of narrative. What is powerful about Ricoeur's argument is that he is not saying narratives mirror experience because they simply copy it but because there is a fundamental homology between the structure of narrative and the structure of life in time.

In many ways, Alisdair MacIntyre's (1981) argument is the easiest to follow. He does not come from a phenomenological tradition but from an Anglo-American analytic one and his argument is with the analytic philosophers. The analytic tradition in philosophy of action treats action atomistically, demarcating isolated "basic actions" as the proper unit of analysis. MacIntyre regards the equation of experience with the passage of isolated events (basic actions) untenable. He argues that actions, conceived in such an isolated way, are not even intelligible. We are not even able to name actions apart from a larger narrative context (or even, a series of historical contexts) in which they take their part. He finds this unrealistically isolated compared to the ordinary actions we carry out in everyday life. Action is only comprehensible as part of larger narrative contexts. To understand the actions of another, we need to identify those

narrative contexts which render the discrete actions meaningful.

He illustrates the unintelligibility which ensues when narrative contexts become confusing. He offers the presumably fictitious cases where in the middle of his Kant lecture he suddenly breaks six eggs into a bowl and adds flour and sugar while proceeding with his Kantian exegesis or where he is standing waiting for a bus and a young man standing next to him suddenly says: 'The name of the common wild duck is *Histrionicus histrionicus histrionicus* (1981:194).'

He means to show by these examples that while the actions themselves are clearly actions in the analytic sense they are not intelligible unless placed within some larger narrative which explains them. What is missing in each of these examples is the narrative context that would render them intelligible. For instance, perhaps the young man is a Soviet spy uttering a code sentence or has just come from his psychotherapist who has told him to try to overcome his shyness by talking to strangers and say anything that comes to his head.

Not only are the actions when devoid of narrative context unintelligible, their unintelligibility makes them unnameable. Which possible action is the young man performing? Is he giving a coded message? Is he following his therapist's instructions? The narrative context allows us to identify intentions which the action flows from, therefore to identify the action at all.

Carr takes it that "narrative is our primary (though not our only) way of organizing our experience of time..." (1986:4-5) Carr argues "that narrative structure pervades our very experience of time and social existence, independently of our contemplating the past as historians." Taking direct issue with Kermode, he objects to the connection of real experience to sequence. "The reality of our temporal experience is that it is organized and structured; it is the 'mere sequence' that has turned out to be fictional, in the sense that we speak of a 'theoretical fiction (1986:25).'"

David Carr builds a careful argument about the formal continuity between experience and narrative that begins with the "simple" experiences of sensations. Carr borrows from Maurice Merleau-Ponty and especially Edmund Husserl's concept of experience as involving protention and retention. He notes that even "mere sensations" have a time configuration in which we experience a particular sensation as an element of larger scale events and processes. When we sense something, it does not belong to a pure present but carries with it a "protentional and retentive 'gaze' which spans future and past (1986:24)." He uses Husserl's example of hearing a note in a melody where the experience of that note is connected to a remembrance of what has already been heard, the past notes, and an expectation of what is to follow. He argues that we cannot perceive at all without that perception being organized somehow, being part of a

configuration. He quotes Kermode approvingly on this point. "Kermode is quite right, then, to say that 'we can perceive duration only when it is organized (1986:25).'" The way any particular sound is heard depends on its surrounding temporal context. This becomes most apparent when we experience frustration or surprise, for instance, when a note turns out to surprise us. "Tunes can take surprising turns; that is, we have protentions that are not fulfilled. When this happens, it has turned out that, in effect, we are not hearing the melody we thought we were. The notes, even the past ones, are not parts of a different whole; what they are 'heard as' is revised retroactively (1986:29)." The frustration of expectation is the basis for one important theory of aesthetic experience, as in Iser's (1978) conception of the experience of following a story.

All this explodes any simplistic view of experience as a kind of spontaneous reception of sensations whose only order is sheer succession. But the homology between experience and narrative structure only really comes into play when we look at experiences of a more complex kind, ones which involve complex and long-range phenomena, where planning, deliberation and reflection all play a part. For narrative is more than configuration, as Carr says, it is a configuration of a particular kind, one dominated by the ending.

The experiences with which phenomenologists have concerned themselves are largely passive ones. The relation

of narrative to experience becomes much more apparent when we shift to experiences which are active rather than passive. Active experience, because it is explicitly purposive, is even more obviously characterized by a complex temporal structure -- configurations created by remembrances and anticipations -- s against a mere sequence of presents. How can we speak of action at all, Carr wonders, without attributing to the agent some conception or image of a future state: "is it not necessary to say that the agent envisages, somehow, a state of things which is different from the present one, and then arranges things to fit it, and that that is what action is (1986:35)?"

It is not merely that the agent, somehow, "pictures" a future state which he then tries to attain. The future belongs to the present because we are, as Heidegger says, "thrown forward" in a stance of commitment, of care, toward a future. We are always ahead of ourselves. Our concern with a future strongly organizes the meaning of the present and makes us vulnerable to a disjuncture between what we have wished for and what actually unfolds.

The primary difficulty in treating narrative as a structure of lived experience is that what allows for configuration in the narrative is the narrator's point of view. When narrative theorists describe narrative as something told rather than lived, they especially have in mind the role of the narrator. Narratives, as told, rely on a disparity among points of view. A narrative incorporates

three different points of view: the characters, the audience, and the narrator (Scholes and Kellogg, 1966:240). The narrator has an authoritative voice (Scholes and Kellogg, 1966).

Unlike the characters and (possibly) the audience, he knows the ending. From his retrospective perspective, he is able to select the relevant events and reveal their causal relations because he knows how events unfolded to bring about the particular ending which, narratively speaking, gives meaning to those events. Stories, as Ricoeur says, are read backwards. Narratives are teleological structures. They are ordered around an ending and it is the ending which has a fundamental role in shaping the meaning of the narrated events (Olafson, 1979; Ricoeur, 1984). The narrator begins at the end in his organization of the story though he is likely to tell it, more or less, from the beginning, creating Barthes' "chronological illusion." Events may just seem to naturally unfold in a narrative as though they "told themselves" as White says (1987). But in actual fact, the story's structure comes because the narrator knows where to start, knows what to include and exclude, knows how to weight and evaluate and connect the events he recounts, all because he knows where he will stop.

The characters act from their limited perspective, unable to read the eventual meaning that their actions and experiences will take on. The narrator, who knows what happens, tells the story teasingly, suspensefully hiding and

revealing the meaning of actions by giving the audience clues and foreshadowings of what is to come. Even a familiar audience who knows the ending as well as the narrator may, if caught up again by the story, adopt a certain breathless questioning. Following a story involves a continual "and what then? and what then?" questioning, as Ricoeur (1976; 1978) points out. In this the audience shares with the characters a stance of openness toward the future which stretches before them unknown and still potentially shapeable.

Is there any sense in which we, as actors, adopt the point of view of the narrator, reading our actions backwards from an ending which we somehow know? We may not know the future but it seems fair to say that we evaluate and interpret our experiences from the perspective of an anticipated ending. To follow Heidegger, we are in a stance of commitment toward the future, "ahead of ourselves," reading the meaning of the present in light of a past but especially of a future, anxiously scanning the future for hints of the endings to come and, more aggressively, plotting to bring about desirable endings. Like the story's narrator, we are oriented toward an ending and that ending helps us interpret the meaning, even the feeling, of present experiences.

Carr, MacIntyre and Olafson each point out ways in which we, as actors, bring a retrospective stance to plot out our actions. We look back over our shoulders from the

perspective of a hypothesized ending. Carr speaks of agents operating from a stance of "as if retrospection." And Olafson describes our "capacity for self-temporalization (1979:102)." What he means by this is that we see our actions within a temporal context even as we are acting. We select out of innumerable events those which we characterize as relevant for an unfolding story. We describe those events to ourselves in a way which shows them to belong to that story. We see someone's smile as encouraging or as subversive, for instance. In that simple labeling, we are both relying on and elaborating a narrative context, naming the smile as part of a larger, unfolding narrative. Once a narrative context is well formed in our minds, we can then read the meaning of other actions as taking their place within the narrative. "Once it is placed within a context of this kind [a narrative context] the original event takes on a meaning -- as a threat, for example, or as creating an opportunity -- which gives it an orientation in time as blocking or facilitating other possible events or actions (Olafson, 1979:101)."

When we lose our way in this projected story shaped by our imagined ending, confusion and frustration are our likely responses. MacIntyre contends that when sense we have lost a narrative context and this begins to pervade our perception of our life as a whole, this is tantamount to the loss of self. "When someone complains -- as do some of those who attempt or commit suicide -- that his or her life

is meaningless, he or she is often and perhaps characteristically complaining that the narrative of their life has become unintelligible to them, that it lacks any point, any movement towards a climax or a telos. Hence the point of doing any one thing rather than another at crucial junctures in their lives seem to such a person to have been lost (1981:202)."

According to the philosophers cited above, we perceive events not as mere chronological sequence but as a cumulative movement. This perception guides and motivates action. (This is a reciprocal relation since action, of course, which gives us certain interests and concerns, guides this perception.) Olafson notices that complex actions are not accomplished by a single discrete act but require cumulativeness among a series of actions and often among a set of actors. The need for individual actions to accumulate, to move in a favorable direction, makes narrators of us all. Driven forward toward some goal or image of the future, we try to emplot particular actions so that they become part of a process which will move us toward that ultimate goal. We try, as far as we can, to take the position of the narrator, to predict and control a desirable future as though we could read our present situation from a backwards glance: "we are constantly striving, with more or less success, to occupy the story-teller's position with respect to our own actions (1986:66)." And, Carr also adds, we must be able to do this with fair regularity because "for the most part, our

negotiation with the future is successful. We, are after all, able to act (Ibid.)."

On this last point I take issue. Rather than claiming that agents simply assume the perspective of the narrator, it is more accurate -- and much more narratively interesting -- to say that the actor operates from multiple points of view, sometimes with the backward glance of the confident narrator standing at the story's end, sometimes with the bewilderment or naivete of the partly informed character or audience. The agent acts holding all those perspectives simultaneously, driven forward by images, goals and plans as though she could foresee the ending she works toward but at the same time immersed in the contingencies of a present which resists the ending and requires improvization or even outright abandonment of those images of the end.

The anti-mimetic theorists are right to point out that life as lived, except in the most habitual cases of very simple actions, tends to be thwarted, twisted, unexpected. We may be able to act but often not as we had originally intended. Furthermore, even when we are somehow able to do what we had planned, we often find that we have created unintended consequences, that our very success produced new difficulties we had not foreseen. And even in those lucky times when we can do what we intend and no unpredicted and unwanted consequences follow, the meaning of our actions often looks different in retrospect than when we were busily steering toward that future.

While as actors we try our best to occupy that (comparatively) omniscient and authoritative point of view given the privileged narrator, life itself does tend to get in our way and things do often turn out differently than we had expected. But rather than taking this as a sign that the story operates from a very different structure than experience, one could argue just as well that this only ties the structure of story and experience more closely. After all, the encounter with the unexpected is the most basic structure which belongs to narrative. Very often narratives are precisely about the experience of things turning out differently than the characters anticipated.

Teleological though it may be, a story is not driven forward like some instrumental machine. It is not a plan, not even an account of the successful implementation of a plan. The future orientation of the story is powerful because it reveals experience as a struggle toward an ending which evades us, or which turns out to hold a different meaning than we had originally guessed. The collision between expectation or desire and experience gives narrative its drama. Even in those genres of romance and comedy where the heroes' desires are fulfilled, the tales themselves mostly concern surprising obstacles, evasions, help from unexpected quarters. No one has a story to tell about the happy ending. In fantastic or adventurous tales, the surprises are likely to come from outside agents, from dragons, demons, princesses, or the odd catastrophic event.

In comparatively prosaic realist genres, the unexpected may be predominantly psychological, outward events triggering inward dramas, alien thoughts and feelings, conversions, hallucinations, reformulations of an inner vision. (See Frye (1957; 1976) for a discussion of this difference in genre.)

Hermeneutics provides one framework for examining the structure of experience (at least that sort of experience associated with complex actions) which captures the unexpectedness of experience as it presents itself to the agent. To follow the analogy of reader and text, occupational therapists are readers of the contexts they find themselves in. They bring with them prejudices, "prejudgments" that hermeneuticists argue inform our initial encounter with a text. (Gadamer, 1975; 1979) These prejudgments often come in the form of powerful, culturally informed stories of past experiences which provide the therapist a starting point with an unfamiliar patient. "This patient really reminds me of Joe, the one who was discharged a week ago," therapists will say. This story provides them an initial script which they use to organize their identification of key problems and treatment goals. And sometimes the patient is passive enough or the therapist inattentive enough so that this initial script is never challenged through the course of treatment. The new patient just does act out another instantiation of Joe, or of the

many Joes who represent members of some much larger category.

But often, their initial script runs into trouble. The course of treatment is a course in revision of the story they initially imposed and attempted to carry out. Through successive encounters with the patient they, like the reader of the text, come to revise and reframe their initial understanding, modifying the borrowed story and gradually developing one which is individualized to capture the particularities of the particular patient.

In these cases, where therapists are confronted by troubles created by inadequacies in the story they originally attempt to impose, therapeutic action becomes a kind of storymaking -- not simply the playing out of an already created script. Creating narrative sense is, often as not, a struggle, for action occurs in an Arendtian "public space" where other actors are pursuing their own endings, driven by their own particular commitments. Even for the professional who holds unequal power over clients, creating a coherent story out of a series of interactions is nearly always difficult. Creating narrative sense means negotiating stories, both stories about the past -- where we have come from -- and the "future stories" envisioned or at least sensed by the actors. Perhaps action isn't an untold story so much as the struggle for a story.

This struggle for the story within occupational therapy is the subject of the rest of this thesis. I examine the

particular stories therapists envision about where they might go with particular patients as they are informed by two broad frameworks for understanding disability which certain medical anthropologists have described:

biomechanical and phenomenological (Good and Good, 1979; 1980; 1985; Kleinman, 1988). These anthropologists have juxtaposed a biomechanical framework which the medical professional relies on with a phenomenological one which the patient brings to medical encounters. But I see both these frameworks playing a role in the medical professional's "gaze," at least the gaze of the occupational therapist. The infiltration of the phenomenological in occupational therapy is due to certain underlying beliefs about the need to treat the "whole patient" which are central to its professional culture and, probably more important, the need to harness the patient's active cooperation in order to practice occupational therapy effectively. The kinds of accounts therapists give of clinical work with their patients reveal a need to see clinical problems from both biomechanical and phenomenological perspectives. And the prospective stories therapists create to envision and shape their therapeutic work with a patient also reveal an intermingling of both these visions of disability.

FOUR

OCCUPATIONAL THERAPY AS A TWO-BODY PRACTICE

BODY AS MACHINE

Before considering the narrativizing practices of occupational therapists -- the subject of chapters Six through Ten -- I examine the place of this narrativizing within the larger context of professional practice. Not everything therapists do or every way therapists think is usefully construed as narratively organized. Certain aspects of therapists' work seem to demand a narrative framing of the clinical problem while other aspects of their work resist such a framing. This chapter and the following one are important excursions into the heart of occupational therapy. These two chapters outline some of the central dilemmas and commitments in the practice, particularly regarding the tension therapists feel in how they address the clinical problem and the kind of thinking most appropriate to solve the problem.

Telling and creating stories is not an isolated or purely mental act and it is important to see how they fit into a larger picture. The picture I paint in these two chapters is of a tension between two ways of construing clinical problems, one which is closely linked to narrativizing but carries little legitimacy within the medical world, the second which is predominantly non-

narrative, even anti-narrative, in its formulation of clinical tasks but carries the status of "real work" for which money can be paid and credit can be given.

There is a political dilemma associated with narrative reasoning in occupational therapy; it is not some pure cognitive act. The dilemma is that to envision clinical problems as personally meaningful experiences about which stories can be told and for which future stories can be imagined and acted upon, is to adopt a vision which runs counter to the medically dominated world in which therapists practice. (And unlike some professions, say medical social work or psychiatry, occupational therapy is not recognized as licensed to think with stories.) These chapters provide some context for considering the specifically narrative aspects of the occupational therapist's work and hint at the political ramifications in seeing their patients through stories.

When I first began this study in October, 1986, I was struck by the fact that the occupational therapists I observed shifted between two quite distinct ways of approaching patients, approaches that appeared to co-exist uneasily. During a single session, therapists talked to the patient, got stories of the patient's problem as the patient was experiencing it, found out about how the patient lived and who their family and friends were, heard about the patient's worries at changing jobs or having to retire as a

result of the illness or accident. At other times in the same session the therapist ignored, or tried to ignore, the patient's stories and complaints and began attending and asking the patient to attend to the body as a purely physical entity.

Patients sometimes resisted the move from an experience-focused discussion of the pathology to a treatment of their body as a malfunctioning object. They often grew more childlike in the transition, more passive. In fact, passivity was often required in order for patients to follow the therapist's instructions about how to attend to their bodies, to notice if they could feel the prick of a pin or if moving an injured wrist hurt.

During early observations, occupational therapy looked like a loose confederation of two different practices, each involving distinct conceptions of the body. When listening to patients tell their stories, therapists were treating a phenomenological body, the body as seat of experience. When pricking fingers or ranging arms, they were treating the biomechanical body, the body as machine or organism, an entity quite separate from the person because it is treated as distinct from the meaning the body has for a person's life. These two conceptions of the body spring not from the various practice theories internal to occupational therapy, but from a deeper stratum. They are rooted in underlying conceptions of the relationship between mind and body which have become embedded in Western thought.

Two years of observing, listening to and consulting occupational therapists has modified my early perception that it consists of two distinct practices. It is true that the occupational therapists I studied often expressed a sense of tension and unease in their practice as they tried to treat both bodies. In this sense, my early observations reflected a genuine dilemma in their practice. But therapists also were able at times to flow quite easily and naturally from one framework to the next, to borrow from both conceptions of the body in framing the problems of patient treatment, and to use either biomechanical means for achieving phenomenological ends or the reverse.

This chapter considers the biomechanical body and its place in the practice of occupational therapy. It is about the "medical gaze" in occupational therapy. Drawing examples from field notes, transcripts of videotaped sessions and audiotaped interviews, I look at those instances where therapists clung most carefully to a biomechanical frame in treating their patient. I also examine here the tensions attendant upon the attempt to be faithful to a strictly defined medical gaze in cases where patients are demanding a more experiential treatment of their disability.

The Medical Gaze

The conception of the body as machine is based on a Cartesian and Kantian notion of the body as completely

distinct from mind. In these views, mind is the seat of intentions, intelligence and will; the body a material object, a passive container for the mind. The mechanistic view of the body is particularly appropriate to a practice of medicine which understands the patient as the assemblage of mechanistic processes that are malfunctioning. The body could be conceived mechanistically once it was separated from the mind, a separation native to the Western Judeo-Christian tradition and articulated and emphasized for science by seventeenth century philosophers, Descartes in particular (Johnson, 1987; Leder, 1984).

Descartes is popularly credited with providing medicine the legacy of a dualism, a split between mind and body, that recognized the body as "merely a machine driven by mechanical causality and susceptible to mathematical analysis (Leder, 1984:)." However, Descartes and other philosophers may simply have articulated a way of perceiving the body which was already penetrating society as a whole, and medical practice in particular. Foucault gives us a much more cultural reading of this dualism, painting a seventeenth century French society initiating bureaucratizing practices in a wide variety of domains -- school, prison, the workplace, the army, the hospital -- which were based on, and in turn promoted, an increasingly biomechanical conception of body. This was largely motivated, Foucault contends, with an increasing sophistication and emphasis on the "disciplinary gaze."

Training, in many domains, was connected to 'strict discipline,' Foucault notes (1979:170). The problem of surveillance of large masses of people became of primary concern. Foucault notices the use of uniforms in many settings, dressing the bodies in an indistinguishable way. He argues that people were being trained, in effect, to see themselves as objects, possessing biomechanical bodies whose special feature was that they were the same as everyone else's. Describing the eighteenth century organization of school, as one example, he speaks of the "disciplinary gaze" as a "normalizing gaze" exerting pressure on individuals to "conform to the same model so that they might all be subjected to 'subordination, docility, attention in studies and exercises, and to the correct practice of duties...So that they might all be like one another (1979:182)." He singles out the growth of the "examination," used in schools, hospitals, the military, at work, and the like, as exemplary of a whole social world moving toward a normalizing, objectifying perception of the person:

The examination combines the techniques of an observing hierarchy and those of a normalizing judgement. It is a normalizing gaze, a surveillance that makes it possible to qualify, to classify and to punish. It established over individuals a visibility through which one differentiates them and judges them. That is why, in all the mechanisms of discipline, the examination is highly ritualized. In it are combined the ceremony of power and the form of the experiment, the deployment of force and the establishment of truth. At the heart of the procedures of discipline, it manifests the subjection of those who are perceived as objects and the objectification of those who are subjected. The superimposition of the power

relations, and knowledge relations assumes in the examination all of its visible brilliance."
(Foucault, 1979:184-5)

The biomechanical view in medicine is constructed on the realization that as a machine the body is susceptible to mechanical interventions. This assumption is basic to the explosion of medical discovery that began in the seventeenth and eighteenth centuries and still continues. "The scope of clinical possibilities thus widens commensurate with that of expanding research and technologies. As machine-like, the body can be divided into organ systems and parts to be repaired, surgically removed or technologically supplemented in relative isolation."
(Leder, 1984:30)

In making medical diagnoses, physicians sought to free themselves from phenomenology, that is, from linking the diagnosis to the patient's experience of the illness. The history of medicine since the eighteenth century is a history in which medical professionals have come to depend less and less on the patient's perceptions and understandings of their illnesses. Diagnostic practice has come to rely, in part, on ignoring or passing quickly from the less reliable data of patient reports to more precise information gleaned from diagnostic instruments and laboratory tests.

Foucault argues that this process began with a revolutionary shift in the basic categorization of disease. "The doctors of the eighteenth century," he says,

"identified (disease) with 'historical,' as opposed to philosophical, 'knowledge (1975:5).'" Disease was reclassified as an object which had an observable history. The task of the modern doctor as he emerged in the 1700s was to carefully observe and track that history and in this way to come to an understanding of the nature of particular types of illness. Medical case histories were developed to record that process.

A critical consequence of this new understanding of disease was that the patient and the disease were separated. Prior to the advent of modern medicine, doctors thought of each sick person as having his own ailment. The radical shift of the eighteenth century was that instead of seeing ailments as belonging to the patient, diseases were believed to "have their own identity (Feinstein, 1973:215)." Diseases were seen as completely distinguishable from the patient and his or her personal history. They had their own "natural history" that could be observed from the clinical course the disease took in patients in general. A new form of medical case record recorded that natural history and carefully separated it from the way the disease held meaning for the patient and for those involved with the patient as a person, from the way in which its history was involved with the personal life of the patient.

The notion that diseases had their own natural history was not completely new. The Greeks as far back as Hippocrates held such a view (Sacks, 1987). The new

conception may have been reintroduced as part of a new form of institutionalization of treatment, the "birth of the clinic (Foucault, 1975)." Increasingly, the ill went to hospitals to be treated rather than staying at home, and this allowed the comparative observation of the same disease processes across numerous cases.

The separation of patients from their disease was also strengthened by the new study of corpses. As doctors began doing autopsies they could look beneath the surface manifestations that ill patients presented to them and trace effects that could not be seen by the naked eye. Through examination of corpses, doctors developed a "medical gaze" into the basic anatomical structures of the body. This allowed them to know more about the nature of diseases and their routes through the body than the patient could reveal or directly sense.

The development of new diagnostic instruments in the nineteenth century further separated patient from an experienced body and patient from physician. The medical sociologist Starr describes the impact of new technical tools, like the stethoscope, which allowed the physician to extend his medical gaze. Such instruments encouraged and sometimes even required the physician to "move away from involvement with the patient's experiences and sensations, to a more detached relation, less with the patient but more with the sounds (and sights) of the patient's body." (Starr, 1982:136) These instruments allowed doctors to see

and hear the body in ways the patient could not and gave the medical professional access to cues which the patient could not interpret. In an important sense, medical professionals came to know their patients' bodies much better than did the patients.

The biomedical mode of conducting medical practice and clinical reasoning are now a familiar part of chart notes, reimbursement procedures and medical rounds. They are institutionalized in myriad forms throughout the medical system and they underlie the way most medical professionals see their patients and their patients' ailments. Treating disease as an entity apart from the patient and the patient's experience of it was a critical turning point in the development of Western medicine.

When occupational therapists operate within a biomechanical frame, they focus especially on the development of the patient's skills and strength; activities are conceived as exercises in skill-building. This may involve exercises in the usual sense (e.g. lifting weights) or functional exercises, such as learning how to guide a wheelchair after a stroke or learning to do a bed transfer as a paraplegic.

Occupational therapists in this study almost always asked patients to work with them during treatment. Even when they attended to the body in a strictly mechanistic way, the patient was rarely as passive a partner as in other medical encounters. Patients were never as separate from

their disability as they are when, for instance, a surgeon operates, or a nurse listens to a pulse. Even initial assessments by occupational therapists generally required some level of participation by patients because occupational therapists gather so much of their information about the extent of functional disability through asking the patient to perform tasks, rather than through examination of the patient's passive body with specialized instruments. Thus in occupational therapy passivity and detachment of the patient are not the best indicators that therapists are operating within a biomechanical mode.

When therapists worked within a mechanistic frame, this was most evident by the way they defined the problem they were treating. In addressing the biomechanical body, problems were defined as deficiencies in strength or skill, as in the following example of a therapist working with a spinal cord patient. This example records an interchange between therapist and patient which occurred at the beginning of a treatment session. As the scene opens the patient and the research assistant sit in a corner of the large spinal cord treatment room together. They are waiting for the occupational therapist who has left to get some adaptive equipment for the session. The patient asks the research assistant what she is doing there. The researcher says, "I'm here to watch the therapists to try to learn what makes good therapy." The patient replies, "It's in getting

stronger." The therapist returns to the patient and they have the following conversation:

Therapist: What did we talk about that we are going to do today?

Patient: (No response.)

Therapist: (Unclear) and the stick?!

Patient: I'm tired.

Therapist: You've already had your PT today?

Patient: Yes. We're going to use the deltoid aid?

Therapist: You need more power. The deltoid aid will help and the weight class too.
. . . (Some discussion between them about schedule changes as the therapist begins to range the patient's hand.)

Patient: Could I use the deltoid aid to get my arms to come up?

Therapist: Let's see. It pulls you up, right? In order to get your arms strong enough to lift them up you must hold them up as long as you can once they are up there. We can later rig up weights and attach them to your arms so that you pull them up as you lift. Did you want to use the deltoid aid to help pull your arms up or down? (Therapist begins to have patient actively exercise his left arm. Counts to ten.) Now hold it. Let's try to do four sets. Maybe on the otehr side we'll be able to do five sets. You are stronger over there, aren't you? (She repeats exercise three more times.) That was the fourth set. Can you do another?

Patient: Yes.

Therapist: OK, let's go for it! Could you really feel it?

Patient: Yeah.

Therapist: I could see the muscle popping away. (She moves to the other side and starts the exercise. The patient lifts his arm and tries to hold it for the count of ten. Exercising continues.)

Here the therapist defines the patient's problem as lack of strength. "You need more power," she tells him when he asks if they are going to use the deltoid aid. The entire session is devoted to exercises with the deltoid aid which are intended, as the therapist tells him, to build his strength. The patient shares the therapist's perception of his problem, at least as it relates to occupational therapy, for he tells the researcher before the session begins that what makes good therapy is "getting stronger." And although he appears reluctant at first to begin work, he is soon actively considering the possibilities of the deltoid aid for strengthening his body, as when he asks the therapist if he could use it to get his arms "to come up." He not only appears to work his body hard in the session (evidenced toward the end of the session when the therapist asks him twice if he wants to quit and he tells her he wants to finish), but he participates at another level when he hypothesizes additional possible uses of the adaptive equipment for arm strengthening. Here he defines a problem he wants to work on. The patient comes to attend to his body, much as the therapist does.

Therapists provided ways for patients to attend to the mechanical aspect of their bodies more carefully and precisely than they otherwise might, learning to recognize the healing process in terms of subtle measurements of bodily change. They trained patients to read their bodies

for signs of biomechanical progress and to interpret these signs as markers along a successful therapeutic path.

In the following example, a hand therapist is using a goniometer to measure the range of motion a patient has in his injured hand. She tells the patient to lift his hand off the table as far as he can, bending at the wrist. With effort he lifts his wrist. They then have the following conversation.

Therapist: "I think it's right now where it's going to be."

Patient: Yeah, there's only so much you can do for it.

Therapist: Yeah, actively you can move it about twenty degrees, which isn't a lot, but it's still better than zero. And you can bend it down about 50% which only gives you a motion of 30 degrees, you know, the actual amount of motion you can do back and forth, which isn't much. So anything we, this (upcoming surgery on his hand) will do, will obviously be better.

. . . (Continues measuring in other positions.)

Therapist: Just for a lark, let's look at your improvements. Good, you gained 40 degrees of motion going up and you gained 30 degrees of motion going down. That's a lot and that's a big, that's what I was most concerned about because if you can't do this (she rotates her forearm -- supination and pronation), if you can't do it, there's not much you can do."

Patient: Yeah.

Therapist: You can't turn a key.

Patient: You can't turn anything.

. . . (Therapist continues asking the patient to position his hand in different ways and taking measurements.)

Therapist: Bring your thumb down towards your little finger and hold it.

(Patient does so. Therapist measures his thumb motion.)

Therapist: Thumb's better, you can bend this part.

Patient: I can bend the whole thing more.

Therapist: It's loosening up. Hopefully your thumb won't be that tied up. I don't know.

(Patient agrees in low tone. Words were unclear.)

The therapist mentions later in interview that she measures the progress of her patients partly for her own records and partly for them, to help them see improvements. Hand therapy is very painful and tedious and gains are often difficult to observe. Measuring becomes a way to show that the pain and frustration is worth the effort. The therapist uses a special measuring device, the goniometer, and interprets the numbers to help the patient see improvement. She tacitly asks the patient to see his problem -- and hence his progress -- through the subtle increasing ranges in hand motion that have taken place.

By the end of the interchange recorded above, the patient is also noting the improvement in his thumb range. He echoes the therapist twice in this exchange. Once it is to amplify her statement of his problem, her "You can't turn a key" becomes his, "You can't turn anything." The second time it is to amplify her statement of his progress, "You can bend this part" becomes "I can bend the whole thing

more." In his repetitions and amplifications, he is aggressively taking up her way of seeing his body.

The extent to which the two examples above stay within a mechanistic way of seeing the body is more strongly evident by what is omitted than by the conversation and focus of activity itself. It is almost surely true in both these cases where the patients are invested in regaining strength and mobility in their body, that regaining strength carries immense meaning in terms of self image as well as quite practically in terms of what they can do in the world. A few degrees of mobility or a few pounds more weight lifted can mean all the difference in what these patients, both working class men in their twenties, can make of their lives.

Such focus on the biomechanical body has direct, well understood implications at the phenomenological level for the patient. In the above examples, neither patient nor therapist voice a translation of their explicit focus on biomechanical improvements into the implicit meanings which the patient's injury and recovery carry for them. The treatment activity in both these examples carries strong cultural meaning as an exercise entailing significant pain, which requires them to make a "manly" effort. What is omitted is any explicit focus, either through activity or conversation, of the broader phenomenological world which the patient inhabits. The hand patient who comes to echo the therapist in her statements of his problem and his

improvement leaves unspoken a more experientially and semantically dense way of seeing his problem.

As is the case with all the therapists in this study, however, this therapist does not always treat his injury purely as a hand injury. On other occasions this patient has talked to the therapist about what this hand injury has meant in his life, including increased depression, increased drinking, and increasingly serious marital problems. Prior to the injury, which was sustained at work, he was a construction worker, the major wage earner in his family. After the injury, his wife went to work while he stayed home with the two children. Biomechanically speaking, the injury was to his hand. Phenomenologically speaking, the injury was to his life.

When therapists and patients frame problems biomechanically, there is a personal resonance which is bracketed, as if by tacit common consent, but rarely disappears. Patients, however, do not always consent to this biomechanical framing, and in such instances the therapist may choose to reassert a biomechanical reading of the problem, as in the following instance.

A therapist who treats acute neurological patients is seeing a patient who has suffered a second stroke. She is focusing on certain motoric and perceptual problems that the strokes have caused, especially the patient's inability to attend to his left side. During the following interchange, the therapist has placed his arm in a transparent air

cushion, a plastic wrap which she then blows up. A nurse has come in the room and is curious about what the air cushion is used for. The therapist and nurse have a short conversation about it, in which the therapist explains, "I'm using it for isolated motor control." The patient, who has been almost silent throughout the whole session, then suddenly says, "I wish God could do a miracle on me. I can't use my arm as I should." The therapist then turns to him and replies, "Well, you are doing much better. You can give yourself a lot of credit. You and others have been working hard. What keeps you in the hospital is not so much weaknesses as a lack of attention on your left side. You don't need a wheelchair. It's safety. It's attending to the left side. So that's the most serious thing. That's what you need to work on."

The patient frames his problem in religious and existential terms, in the language of despair. His drastically weakened arm is not a biomechanical condition but one of life's cruel tricks. His statement follows on the "medical talk" between therapist and nurse, and stands in jarring contrast to it. The therapist's quick response is to reject his interpretation of his problem and to reframe it in biomechanical terms. She does this in three successive moves.

Her initial response is to simply deny the existential meaning he has assigned to his disability, declaring "You are doing much better." Next, she then reframes the

problem, telling him his difficulty "is not so much weaknesses as a lack of attention on your left side." She might be telling him that he is mistaken about the problem giving him the most trouble, believing it is his motoric weakness when it is actually a perceptual problem. But given the statement he has made, "weaknesses" seem to refer to the way he projected himself as weak, as needing a "miracle" in order to improve. Finally, she moves without pause from her reframing of the problem to an attempt to direct his attention to his hand in a biomechanical way. She directs how he should think about his problem, and she asks him to participate with her in careful attention to his biomechanical body:

Therapist: "Now on this one, just use your wrist to come up gently. I don't want you to stiffen your body. So look at your wrist and make your wrist stay up. You're doing it without working too hard. Mr ----- you are not looking at your hand. Are you looking at your hand?"

Patient: trying to.

Therapist: Don't look at me, look at your hand. Make it come up to my hand. You are learning how to move all over again. You are telling yourself how to move. That's why you have to look at your hand. I cannot make it work on my own. We both have to do it together.

Patient: Yes, yes.

In shifting the patient away from his way of seeing to her own, the therapist is also asking the patient to see how he can improve his condition. She tells him that what he is doing with her is "learning how to move all over again."

The foregrounding of the biomechanical gaze is interesting in this example because it provides the more optimistic view. Enclosing the disability within a biomechanical problem opens the possibility to see successes which might be invisible from a phenomenological point of view. The two different ways of seeing operate at different depths of suffering and despair.

Most of the occupational therapists in the study were torn between a concern to "treat the whole person" and a concern to be credible within a medical world which pushes the therapist to redefine problems and treatment goals along much narrower biomedical lines. Though functional assessments are intended to capture something of the patient's experience of his disability, it is often the case, as Joan Rogers and Gladys Masagatani (1982) noted in their earlier study of clinical reasoning in occupational therapy, that therapists can by-pass the functional assessment and select a treatment approach directly on the basis of the medical diagnosis. Rogers and Masagatani have noted that the medical diagnosis was used to organize standard problem lists and that "therapists regarded the medical diagnosis as the most essential information for formulating assessment plans (1982: 213)."

Findings from this research indicated neither a rejection of nor a comfortable accommodation to the biomechanical model on the part of therapists, but an unease at the heart of their practice. Most therapists were deeply

ambivalent about the experiential aspect of their practice. This ambivalence appeared both in the way therapists talked and in the structure of the clinical sessions in which they attempted to straddle two very different approaches to their patients.

One consequence was that when therapists departed from the medical model during a therapeutic session to treat the patient's "lived body," to treat the disability as it affected the patient's work, relationships, independence or other areas of concern, this was often done more casually, less directedly, and was easily relinquished if it interfered with therapeutic exercises intended to improve the biomechanical functioning of the patient.

Perhaps the most striking and consistent evidence of a dichotomous practice was the therapists' demarcation of a clinical session into "work" and "non-work." "Non-work" was categorized as "rapport building," "chit chat" or "not strictly OT." When therapists described and analyzed clinical sessions, they nearly always separated certain parts of a session which they labeled as peripheral (e.g. "getting set up," "building rapport," "distracting the patient," "making the patient comfortable") from the "work" of the session, which was almost always identified with carrying out particular treatment modalities. Put simply, among most of the physical disabilities therapists, "therapeutic work" referred to carrying out a treatment

activity while peripheral aspects involved talking with the patient.

When talking and activity went together, as when the therapist engaged the patient in conversation while the patient was carrying out an activity, the talking was not considered the real work of the session. This view was evidenced both in therapists' descriptions of clinical sessions and in what the therapist paid attention to when working with patients. Even when therapists spoke with patients in a way which clearly encouraged them to discuss feelings about their disability, those therapists would often dismiss this aspect of the treatment in public discourse. For instance, at the end of an intense session which centered on talking, in which a patient told the therapist he had lost his will to live, the therapist was asked to describe what had happened in the session. She replied, "I went in and he wanted some water, so I gave him some water. And I started ranging his right hand because he has (unclear) on his left hand. So we started with that. I tend to say, I ranged his right hand, I ranged his left hand, I scratched his upper lip and that was the end." There is more than a little irony in this description and, when pushed by the interviewer who says "but so much more happened in the session" the therapist is prompted to tell a much longer, more detailed story of the conversation between herself and the patient. However, at the end of a ten or fifteen minute account of what was said and the meaning of

what was said for the patient's depression she concludes her story by saying "You know, I pretty much ranged him." The message about what counts as "real therapy" in the public world (if more ambiguously, to this therapist herself) comes through clearly.

In the above example, the therapist focuses on the patient's experience but discounts that focus in her description of her work. In the following example, the therapist clearly subordinates talking -- and with it the experiential dimension -- to the biomechanical activity. This is evident in the scattered focus of the conversation, in which two occupational therapists are working side by side with two hand patients. The patients are both Hispanic, and one whose English is better is serving as translator for the other. Each patient is engaged in a series of exercises which the therapist has set up and is overseeing. While the patient performs the exercise, the therapist initiates conversation. The following interchange occurs between one of the therapists and her patient:

Therapist: What do you do?

Patient: Mechanic

Therapist: Mechanic. So you need your hand. Is your right hand your dominant hand?

Patient: Yeah. I use my tools with my right hand.

Therapist: Now if I feel I'm doing more work than you, you're in trouble. (watching him work.) Good, switch'em around. That's what I like to see.

Therapist: Now, what does a wrench do? You work with wrenches, right?

Patient: When I work, I use a lot of different wrenches.

Therapist: What did you do to it? (his hand)

Patient: You know, like a bike (unintelligible) chain in a wheel. That machine goes back and forth and (demonstrates with arm how it swings back and forth and his hand got caught in it)

Second Therapist: Did you pass out?

Patient: Yeah. When I looked at my hand, I could see the bone. It make me sick.

Therapist: Where do you come from?

Patient: Puerto Rico.

Therapist: Is the Spanish in Puerto Rico different than the Spanish in Mexico?

Patient: Yeah, some words are different.

Therapist: Try and squeeze your hand. Try and pick this up. (Patient is putting clips on and then taking them off a glass jar. She demonstrates to him how to do it.) See the difference?

In the interchange above, the direction and focus of the treatment session centers on the activities. While most of the discussion is about the patient's life based on inquiries made by the therapist, these inquiries are not pursued in any systematic manner. Although she seems to be going through a mental checklist, she does not pursue any of his replies in depth. She seems to be primarily concerned with establishing rapport by gathering a small amount of information on a number of topics. To this end, she introduces three topics in the space of just a few minutes: His work (and his tools), the accident, and his homeland.

She asks only one or at most two questions on any given topic and these questions do not seem to be dictated by her need for any specific information. For instance, when she asks "What does a wrench do?" she does not seem interested in the answer. She might be asking him to demonstrate how he works, but she in fact follows that up, before he has time to reply, with a second question, "You work with wrenches, right?" When he says he does, she asks nothing further on that topic. After observing his work on the treatment modality a few seconds she simply moves onto another topic.

The power of the bio-mechanical frame was demonstrated most strikingly at those moments when patients directly asked therapists to deal with the difficulties they were having in adjusting to disability. These pleas for help or, sometimes simply for attention, often caused therapists to feel torn between doing what the patient seemed to need and doing what appeared to be the most appropriate professional path of action. When therapists were confronted with a patient asking them to help in working through feelings related to the disability, they generally felt called upon to do something. At such times therapists expressed their own anxiety about such roles in post session interviews, often worrying aloud that they were "moving beyond OT" either by crossing professional boundaries, thus trespassing into the domain of social worker or psychiatrist, or by

abandoning of their professional role altogether and "acting like a peer."

In the following example, the therapist is trying to sort out her role with a patient who has turned to her for help with life problems. She states, "My responsibilities to him are to get his hand better, and to be very real, very open, very honest because he doesn't get -- his doctor's a very closed-mouthed person." By attempting to be real, honest, and open, the therapist allowed the possibility for the patient to confide problems to her, to reveal himself as a "lived body," to discuss his experience of his illness.

Therapists' desires to treat the "whole person" was an ambivalent one. Despite the concern not to neglect the whole patient, that is, to resist a mechanistic reduction of the patient, when the patient does develop trust in the therapist and begins to confide deep personal problems attending the illness or disability, this can throw therapists into a quandary. They may feel they have strayed out of her depth, out of their role as an occupational therapist, and are being called upon to act in a way which they do not feel professionally competent to do. Thus the therapists' concerns to treat the whole patient may lead to a level of discussion which therapists reject as no longer occupational therapy. The therapist quoted above describes this dilemma to a researcher (also an occupational therapist) as it arises in her work with one patient.

Interviewer: Do you think that's one capacity of OT, that we go beyond a single hand to try and look at all...?

Therapist: Yes, I think we do. I think it's important to look at the whole dynamics and I think it's not realistic to treat him (a patient being discussed) not looking at all these issues. But I think...

Interviewer: But yet you said you felt as though you did step beyond (your boundaries as an OT).

Therapist: Right, because I think that the idea is for him to be seeking psychological and social support from a trained professional...If he wants to share what's going on in those sessions, sort of in a more informal way, that's fine, but I should not be that person. I can't be both roles. I can't be an objective therapist.

Interviewer: An objective occupational therapist knowing..

Therapist: Becoming very involved in all the dynamics...I know we have a lot of empathy for our patients. As OTs, I think we're like that. But...it's a hard time drawing the line. It makes it more complicated to treat. Because rather than knowing he's going to get that support somewhere else and that I can really focus my treatment on that extremity, you find that you do a little work and maybe not as much work as you should have. You are spending time talking and you are still limited in time because you have another patient coming.

This discussion presents the dilemma of working within two different discourses, the examination and treatment of "that extremity" which involves a mechanistic discourse, and a second, very different kind of discourse in which the patient begins to reveal deep problems raised by his disability. In this case, the therapist outlined these problems as sexual problems with his wife, drinking and depression. The therapist describes her problem as one of having "two roles." The first, treating the extremity, she

refers to as "work." She also characterizes her role here as being "objective," implying that her treatment of an extremity is a role with credibility. She opposes work to talk when she notes that she doesn't get as much work done as she should have because she ends up spending more time talking. Yet she cannot abandon the idea that she is also responsible for initiating and carrying through discussions with the patient because when the interviewer says, "So the talking part of the treatment is not really the issue at hand. You'd rather be working on the activities?" she replies, "Talking too, and conversation."

In the case of this patient who has come to trust the therapist and to attempt to share personal problems which he has refused to take to a psychologist, the therapist faces the dilemma of feeling wrong no matter which direction she goes, because she has presented herself as someone who is sincerely concerned about the patient as a person and he has responded by beginning to talk out his problems with her. The therapist's response to the patient's request that they discuss his experience of disability and how it has changed his personal world, is to feel uneasy and conflicted. While talk is important she is not, as she says, a "trained psychologist or social worker." Her stated strategy for avoiding the problem of having talk go "too far" is to try to maintain a precarious balance of "superficial personal conversation." She finds herself in difficulty when "the person goes deep into their interpersonal relationships."

Perhaps a significant reason for the scattered and non-directive questioning of patients mentioned earlier is precisely to prevent conversation from deepening into serious discussion of the trauma associated with disability or disease.

Even among occupational therapists working in a psychiatric setting, conversations often tended toward a superficial and broad noting of "facts" about the patient's life rather than an exploration of the patient's concerns and meanings. This was sometimes the case even when patients raised issues that are particularly "occupational" in nature, such as major career changes, or the horror of having to depend on others for self-care. Here, for instance, is an example from an initial evaluation done by the psychiatric occupational therapist. They are discussing a leave of absence the patient took from her regular job which gave the patient a chance to work in politics, working for the reelection of the Mayor. The patient is extremely concerned about her job situation and about what career choices she ought to make, as she reveals at several points during this initial assessment interview with the therapist,

Therapist: Was the two year LOA [leave of absence] ok with you?

Patient: No, but it was a good opportunity. [Patient is referring to her chance to go into politics and start a new career] I love politics, just love it! Rather than quit, I took LOA, because you never knew if the Mayor would be re-elected.

Therapist: When's the LOA up?

...

[The therapist has been discussing the groups the patient will participate in.]

Patient: It seems so vague to me. It's like, I know it's important but it's hard to think of getting better.

Therapist: I know, you've been in the hospital a long time.

Patient: I don't want to build up to something else, because then something comes up, it's like protective devices. I know I have two options, working in the Mayor's office or going back to my old school job. I have a difficult major decision. [This is the second time she has raised this in the interview.]

[The therapist responds by describing in more detail the groups they have, finds out if the patient has schedules for the group.]

Here again the general strategy seems to be a check-list approach to a discussion of the patient's life, even though the main issue this patient raised was one of major career choices. Although occupational therapists are not usually vocational therapists, issues around work are considered central. Yet this therapist does not ask for more detail, nor does she indicate that this will be pursued in more detail at some later time. The first time the issue is raised, the therapist responds by asking a factual question about her work situation and the second time the therapist simply ignores the subject. In light of how common this therapist's response was among therapists studied, this example indicates an often used therapeutic strategy of using a "check-list approach" to problems which

allowed therapists to stay very near the surface of the patient's life.

The surface orientation was not merely a personal strategy of therapists, but was built into the standardized assessment tools used by therapists to identify salient clinical problems during initial patient evaluations. The surface treatment of problems was guaranteed by a very long list of questions so that no one subject was dwelt on at any length. Important themes, such as that of work raised repeatedly by the patient in the excerpt above, may not be picked up by the therapist. The superficiality of the initial evaluation in regard to the patient's illness experience and personal concerns is often duplicated in treatment in the level of conversation the therapist encourages, as in the example of the hand therapists given earlier.

The institutional context of the hospital is powerfully restrictive on the occupational therapists' practice, funneling therapy into an acceptably biomechanical channel and constraining the sorts of creative alternatives considered. In general, these constraints are maintained by means other than explicit rules and regulations. Where such regulations exist (e.g. regulations concerning what can be reimbursed), they are easy enough to circumvent. The influence of the institutional context is more covert. Medical values and authority structure become internalized in the way therapists view themselves and their ability to

treat patients. This internalization is evident in therapists' expressions of concern about how a particular treatment activity might appear to other staff members, about whether a treatment will cross turf boundaries of other professionals, and about whether a treatment will be seen as "professional" by the medical staff.

Clinical reasoning about what would be best for the patient thus becomes inextricably mixed with reasoning about the politics of maintaining respect and not causing trouble for oneself with other members of the staff. This observation is not in itself a criticism of occupational therapy practice, since clinical reasoning does not occur in a vacuum and the therapist who ignores institutional issues will not be able to win battles with more influential staff members. The more serious drawback of the hospital context for occupational therapy is that it is governed by doctors and insurance companies who operate within an almost exclusive biomedical view of the patient. When this frame is internalized by an occupational therapist, as, for instance, when the therapist is concerned with gaining approval from a doctor, that therapist's ability to address the broader experiential aspect of a patient's disability, those aspects beyond the biomechanical problem can be precluded.

Here are two examples of the way institutional concerns directly enter into their clinical decision-making:

-- A psychiatric occupational therapist decides not to give a patient a project to work on over the weekend because the request comes from a nurse and the nurse asks in an inappropriate way. The nurse asks, "Why don't you give this person an activity to keep them busy over the weekend?" which cues the therapist that the nurse perceives psychiatric occupational therapists as "the fun people." This therapist sees part of her task here as "staff education" of nurses and psychologists who seem to confuse occupational therapists with recreational therapists. She says, "The bottom line is that OT is not a department store and we don't have the funds also to be just giving things out." In deciding not to give an activity to the patient, she does not consider the particular patient and whether this makes sense. She considers the attitude of the nurse requesting the craft activity and bases her decision on that.

-- A physical disabilities therapist who works with respiratory patients has a patient who continually asks to be taken to chapel during occupational therapy time. In thinking through what to do, she considers her role as an occupational therapist on the floor. She feels that going to chapel would be very beneficial to the patient, who is quite religious, because this patient is extremely depressed, has been in the hospital off and on for two years and hasn't been able to go to church because of her physical problems. She eventually decides not to take her patient to

the chapel, and explains this decision as follows: "I guess I thought in my own mind, is this something that I can do as an OT?...I didn't want to set any kind of precedent." She wanted to avoid creating the perception by either the patient or other medical staff on her floor that she does activities requiring no skill, activities which could be done by an aide. It is not the patient's need which determines her action here, for she is clear that going to chapel would be beneficial. Rather it is her professional identity, especially her public identity within the hospital staff community, which she is concerned to preserve and which finally determines her decision not to comply with the patient's request.

What these examples point out is that clinical reasoning is not conducted only with reference to the contact between a patient and therapist. There are other people in the room, so to speak, who have decisive voices in determining what treatment is appropriate and what is not. When occupational therapists decided to act without regard for the institutional environment, as though their reasoning was shaped only by patient needs and their skills, they could pay a heavy penalty in reprimands from influential medical staff. For instance, one therapist told a story about treating one of her spinal cord patients when the doctors came in to examine the patient during rounds. This patient had just left the ICU (Intensive Care Unit) a few days earlier where he had been in critical condition. During

rounds that morning, the attending physician turned to patient and asked, "If you go into cardiac arrest again, do you want us to try to save you?" The patient was aghast and, being ventilator dependent and unable to speak aloud, just looked at the therapist in horror. The therapist reassured the patient that the doctors would do everything to keep him alive and that this didn't mean he would go into cardiac arrest again. The chief physiatrist turned to the therapist and said, "Professor, let the doctors do their job and you do yours." The therapist was mortified and later apologized to the chief and the attending physician although she still strongly felt she had done the right thing as far as the patient's welfare was concerned. Such instances of public ridicule from or subversion by a strong authority figure made it difficult for occupational therapists to reason about treatment with only the patient's welfare in mind.

While the hospital context discourages a phenomenological approach to treatment, interactions with the patient discourage a strictly biomechanical approach. This chapter has examined some of the ways in which the biomechanical emphasis appears to dominate the therapeutic process and the framing of clinical problems. The following chapter considers the incentives which prompt therapists to include experiential aspects of their patients' disabilities in their practice.

CHAPTER FIVE
OCCUPATIONAL THERAPY AS A TWO-BODY PRACTICE
THE LIVED BODY

Phenomenologically speaking, sickness and disease are not a matter of malfunctioning parts but involve the breakdown of the patient's social modes of being-in-the-world, the ground of experience, what gives a life-world. The disabled patient is one who suffers a reduction of this ground of being-in-the-world in the form of a failure of bodily movement which, as we have seen, can be described at one level in biomechanical terms.

The "lived-body paradigm," as it has come to be called, derives from phenomenology, particularly the work of the philosophers Edmund Husserl and Maurice Merleau-Ponty who opposed the Cartesian legacy of the mind-body split. Merleau-Ponty (1962) argued that bodily acts are not merely mechanical and many volitional acts are not merely mental, that is, they do not merely arise out of explicit judgments and acts of will. Phenomenologists argue that the body mechanism is intentional in the sense that it is directed outward toward the world, so that one can speak of bodily intelligence or even of the bodily ground of all intelligence. "The body," Simone de Beauvoir wrote, "is not a thing, it is a situation...it is the instrument of our grasp upon the world, a limiting factor for our projects

(quoted in Murphy, 1987)." There may be no better description of the phenomenological body.

Merleau-Ponty based his argument on studies of sensory perception. He saw sensory perception as neither a mechanical process nor a type of thought. Working from the findings of gestalt psychology, he argued that sensing already recognizes a set of meanings since the perceptual field is always at the outset structured by the observer into foreground and background features. The features which make up the foreground of the scene are then treated as its significant features. He linked the existential work of creating significance through the initial act of seeing -- sensing significance so to speak -- with the active body.

The sensing of the lived-body is tied to its capacity of self-movement. Through movement new perceptual fields are revealed; movement helps bring some objects more clearly into focus while neglecting others. Self-movement is an essential aspect of sensory perception, and perception lays what Merleau-Ponty considered the precognitive groundwork for all more clearly volitional, purposive and cognitive acts, for acts of will.

The body is the way seeing takes place. Merleau-Ponty means the notion of body 'seeing' quite literally. The house that I see depends on where I stand. When I stand here, I see one house. When I move over there, I see another house. The object 'this house' is actually a construction, a synthesis of the many perspectives from

which I have viewed it. In this way, my world of objects is constructed from the many perspectives from which I've seen them. Movement, the capacity to physically shift from one place to another, allows me to create richer, more complex objects because it allows me a much broader range of perspectives on the object than any one vantage point can offer. If I see that house from my window and from atop a hill and from the street, in the winter as well as summer, in daytime and twilight, each of these viewings, many of which depend on my capacity to physically move my body, contribute to a rich and complex object, much richer and more real than if I could only see 'that house' from my window.

Not only is a person's experience of his body reduced if he is disabled and movement is constricted, he also quite literally loses much of the world around him. He is no longer able to construct the objects of his world in the complex, multiply viewed way that he could when his body moved freely. This means that a loss of bodily movement, a constriction, is not purely mechanical. It directly affects body intelligence, body seeing.

This loss of body, of the possibility of movement, directly impacts a person's self. Merleau-Ponty argues that a phantom limb, for instance, is not merely a physiological or psychological problem but also a problem of being-in-the-world. Our body gives us a "natural momentum which throws us into our tasks, our cares, our situations, our familiar

horizons (1962:81)." When our natural way of moving through the world is lost, the world itself, as we have inhabited it, is lost. For if the objects that make up the world are constructed from perceptions, and perceptions depend on our movements which orient those perceptions, then loss of movement and accompanying loss of ability to perceive in the normal way means loss of objects. We can no longer grasp the world as we did when we could move freely, unimpaired.

It is this loss of our way of being-in-the-world when we are disabled, he argues, that makes it so difficult to accept the bodily losses that come with disablement. Our capacity for movement is directly connected to our sense of self. Merleau-Ponty writes:

What it is in us which refuses mutilation and disablement is an I committed to a certain physical and inter-human world, who continues to tend towards his world despite handicaps and amputations and who, to this extent, does not recognize them de jure (Merleau-Ponty, 1962:81).

In their practice of talking to patients and eliciting stories from them, the occupational therapists in our study were closer to a phenomenological framing of disability than to the biomechanical. They also addressed the lived-body in the course of positioning therapeutic activities as a basis for the patient's reorientation in the world, as well as when this understanding of the meaning of therapeutic activity was already recognized by both patient and therapist. In concrete terms, for instance, this meant that activities like toilet transfer were seen not just in terms of skill-building but were also understood by patients and

therapists in light of the patients' experiences of losing old capacities and orientations in the world and of the meaning of learning new ways of orienting themselves.

The anthropologist Robert Murphy (1987) has recently written an autobiographical account of his own illness experience, a degenerative disease caused by a spinal cord tumor which left him paralyzed from the neck down at the time he wrote his account. He notes the difference he experienced between his treatment by neurologists and by rehabilitation specialists. He was struck with the irony that neurosurgery and clinical neurology were among the most prestigious medical specialties while rehabilitation medicine ranked among the lowest. The irony was that neurology, as Oliver Sacks (1986) has also noted, "is essentially a passive science" because neurologists can only examine and diagnose. Rehabilitation, on the other hand, is an active science, where both patient and therapist work together to discover the patient's real limitations and to continually try to transcend those limitations. Because of the problems occupational therapists tackle, they deal not only with physical ailments but also with the patients who have them.

Robert Murphy experienced rehabilitation therapy as a kind of game where therapists "urged, cajoled and nagged" him and his fellow patients to push harder than they felt able and where "today's painful overreach may become

tomorrow's routine accomplishment (1987:)." He tells of one day when

a young paraplegic woman was helped to her feet, given a walker, and told to walk. After about five steps, she told the therapist, who was walking just behind her, that she was tired and wanted to stop. The therapist told her that she was giving up too soon and ordered her to continue. The other therapists and their patients echoed him, telling her that she could do it, forming a cheering section as she struggle onward. She soon stopped again, this time begging to be put back in the wheelchair, but the therapist was adamant. Finally, after she broke down in tears and shows signs of collapsing, the chair was brought up behind her and she fell into it. Everybody in the gym applauded, and she wiped away the tears and grinned in triumph." (1987:)

This happens to be a story about physical therapy but it belongs just as surely to occupational therapy. Rehabilitation medicine in general and occupational therapy in particular fit precariously in the medical mold, requiring so much more active and collaborative a relation between clinician and patient than is the norm in biomedicine.

In rehabilitation patients are very much involved in their own recovery. They must claim their disability rather than separate themselves from it. The powerful autobiographical accounts given by vivid and informed writers like Murphy and Sacks about their own experiences of disability, as well as the everyday talk of patients to their therapists, emphasize over and over again the assault to one's sense of identity that deep injury to the body causes. To become disabled is to become disembodied, alienated from one's own body. Therapists' efforts are

directed, in part, toward a patient's "re-embodiment" -- a reclaiming of the body -- and this involves helping patients articulate a new sense of self.

Occupational therapists have always presented themselves as concerned with the patient's relationship with the disease, with the 'whole person.' They are concerned with disability as a meaningful experience, especially in as much as it has affected the patient's capacities to move through the world, and to take up the occupations that have shaped his life and given it significance. "We (occupational therapists) are concerned with understanding the occupations of human beings, the ways in which people organize the activities that fill their lives and give their lives meaning (Parham, 1987:555)."

The functional assessment, which is the occupational therapy equivalent of the doctor's diagnosis, generally requires the therapist to go beyond gathering information and assessing the patient's physiological condition. It requires that the therapist pay some attention to the patient's unique life history and how the patient sees and understands his condition. In the course of treating patients, occupational therapists generally address in some way the experiences and perceptions patients have of their disabilities, their struggles with these disabilities, and how those activities that have given their life meaning are affected.

This concern with a patient's experience of disability derives in part from deep beliefs which belong to occupational therapy's professional culture. Yet the phenomenological perspective, from which illness and disability are treated as meaningful experiences, although seemingly fundamental for the problems occupational therapists tackle, is actually quite neglected as an articulating and legitimizing framework for practice. Occupational therapists are trained much more systematically in the biomedically related sciences that provide them a way of seeing the biomechanical body. They are required to take courses in anatomy and physiology, in biomechanics and neurology. Such courses form the core of their education. There is no such core of courses to equip occupational therapists to treat the phenomenological body. They learn little or no philosophy, sociology, anthropology or psychology of disability as an illness experience, except incidentally in less pedagogically emphasized, clinically-oriented courses designed to teach skills in group leadership and in interacting with patients.

Yet the phenomenological body is the one they encounter just as often as the biomechanical one in attempting to carry out their practice with real patients. They are drawn into the phenomenological world of these patients by the way they work with them as much as by the questions which they ask. The meaning that the patient makes of an illness enters directly into the therapeutic process because this

process is built on a practice of "doing with" the patient. This requires therapists to devise treatment goals which are meaningful enough to patients that they are motivated to work hard as partners in the therapeutic process. The therapists thus find themselves constantly confronted with the interpretive task of translating between their way of seeing and the patient's. If the goals which the therapist pursues are too far afield from the patient's perception of their functional needs, therapy is likely to be stalemated.

Therapists also continually refer to their interpretations of patient meanings to modify treatment directions or attempt to persuade patients to see their disability in a different light. They often see possibilities where patients see none, and commonly attempt to help patients fight despair and passive resignation in the face of their disabilities.

Robert Murphy, commenting on his own resistance to therapy and his enormous depression as he faced a deteriorating body, notes that "(rehabilitation) therapists must breach imposing psychological barriers to reach their patients and enlist their cooperation in the long tedious process of reconstructing their bodies (1987:)."

Effective therapy requires that patients be committed to a long path where gains are so slow they are difficult to perceive or are counteracted by a faster rate of deterioration. This means that therapists must address the problem of motivation. They must tap into commitments and

values deep enough within patients to commit them to such a process. No matter what the technical and physiological expertise and orientation of the therapist, or what practice theories she relies on, effective collaboration requires treating the disability as more than a biomechanical matter which can be separated from the experience of the patient.

The Practical Necessity of a Phenomenologically Minded
Therapy: Building Alliances With Patients

In the hospital setting where patients are not in the middle of ordinary lives, "doing with" patients often means having patients care for themselves as far as possible. Occupational therapists say, "Nurses do for patients. We help patients do for themselves." "Good nurses" are ones with the patience to let the patient do what he can. Doing with patients also means having patients practice exercises in the hospital during the times when they are not being seen by the therapist. Patients are asked to take an active role in their treatment, and this contrasts with the comparatively passive one they generally assume as patient.

Even when therapists would like to ignore the patient as a "whole person" the cooperative nature of the practice compels them to acknowledge the patient's meaning world at some level in order to devise strategies for inducing the patient into taking the therapy seriously. Clinical reasoning in practice means reasoning not only about what is wrong and how to fix it but also about how to engage the

patient in that fixing process. This, in turn, involves understanding enough about the meaning of the disability from the patient's perspective to develop a shared account of what "fixing" the problem could amount to in terms of their lives. Even therapists who prefer to avoid delving into a patient's life and try to restrict their practice to more narrowly construed physiological problems find themselves taking on the "whole person" as the quest for collaboration makes this unavoidable. If therapists cannot succeed in getting the patient to collaborate with them, they may discontinue treatment. So, for instance, one therapist tells the staff in a planning discharge meeting, "If Leo doesn't make some treatment goals, I'm going to discontinue therapy."

If therapy is going to work, patients must form an alliance with the therapist and agree to play their part in the therapeutic effort. How does the therapist go about proposing this contract? There is strong evidence that the therapist's interest in building rapport with patients is linked to this need to gain the patient's cooperation. The importance of this cooperation is evident in the number and variety of strategies which therapists in our study had developed to engage the patient more personally in the therapeutic process. The strategies most pervasively used in the group of therapists which I studied are enumerated below. We found that therapists working with quite

different patient populations had devised or borrowed a similar repertoire of such strategies.

One common strategy involved structuring a situation in which the patient had to make a choice about what to do, generally among a limited range of options. The therapist would often say something such as, "What do you want to do tomorrow? Put on your shoes and socks, more work on transfers, or brush your teeth?" Sometimes therapists wanted patients to continue working on an activity, but also wanted to allow them some choice in the matter, as one pediatrics therapist did with her four year old patient who had just finished coloring a drawing: "Now what one should we do?" The general strategy of presenting options within a range allows the patient to make some decisions but also gives the therapist room to structure the overall treatment plan. Some of the more experienced therapists who participated in our study would allow their patients to do things outside the list of choices they presented. For instance, in response to the pediatric therapist's question above, the child responded, "I want to show my drawing to my Mom" and the therapist agreed.

A second strategy went beyond giving patients choices among a generic set of treatment modalities and involved therapists in creating individualized treatment activities. Ingenuity is required to devise treatment activities that fit the patient's individual interests and also achieve the overall physiological or skill-building goals that have been

set. The goals themselves may not change from patient to patient, but the way the therapist structures particular activities to achieve those goals must be adapted to the particular patient. For example, one therapist had worked with an artist whose injured hand was worsening as reflex sympathetic dystrophy seemed to be setting in. The therapist was very worried about this, because reflex sympathetic dystrophy is a serious condition, difficult to remdiate and very painful for the patient. The artist was highly motivated, since the use of her hands was essential to her work, which she cared about. One of the treatments the therapist devised was having the woman make dough sculptures. Stirring the dough was an especially good strengthening exercise and the patient was also doing something which had special significance for her.

Another example involves a hand therapist whose young male out-patient had not been improving and who did not seem motivated to do the exercises which had been assigned at home. In one of the treatment sessions we observed, the therapist began thinking aloud about activities he could be doing in his daily life that would exercise his hand and yet be more interesting to him. Her first suggestion was activities that could help around the house, "folding things or vacuuming." When the young man did not respond to these suggestions (not surprisingly), she then had the idea that he could do a project in which he would make something for the children in pediatrics. Her office was right next to

the pediatric occupational therapy room and she had mentioned to me before the session that he liked children.

Her suggestion of a project did not have the intrinsic fit which sculpting in dough had for the artist, but it illustrates a common move from routine to non-routine treatment activities in the thinking of therapists when a patient has refused to cooperate with earlier proposals. In this session she considers abandoning her standard program of exercises, suggests housework which the patient resists by his silence, recognizes that resistance and finally suggests doing a project for the children. She may have stopped short of arriving at a project more closely fitting the patient's sense of identity and pride in occupational skills, but she did break out of the standard treatment framework she had been unsuccessfully trying to impose on him for several months.

A third strategy which therapists used to build alliances with patients led them to treat disability in an even more personal way. This was "doing for" patients, going outside their formal role to help the patient with a task and in this way create a strong social bond. A hand therapist called up the insurance company to find out why one of her patients was not getting his work compensation benefits; a pediatric therapist knitted a sweater for a patient's mother; a psychiatric therapist notes that the patient she is evaluating has an arm in a cast and promises to get her some adaptive equipment (a personal move here

since she is going outside her formal responsibilities, hence "doing a favor").

In each of these examples the therapist goes out of the line of duty, stepping out of a narrowly defined professional role to send the message to the patient that she is willing to care in a more personal way for that patient. This obligates the patient to, in turn "care" for the therapist by cooperating with therapy. Setting up a personal bond through "gift exchange" is a powerful means for influencing another. Sociologists have done extensive work on the exchange of intangibles. Anthropologists, notably Mauss in his seminal work, The Gift Exchange, did some early pioneering exploration in this area, arguing that particularly in societies lacking elaborated formal systems of legal contract, gift exchange was used as a substitute. The giver indebted the receiver which gave him a kind of social power over the recipient of the gift. The occupational therapist confronts the same problem which members of small societies did. Therapists need to be able to obligate patients to do something for them and often use gift-giving as the means for doing so.

A similar strategy for creating personal bonds through exchange was evident in the exchange of stories of personal experience with patients. This was probably the most common strategy for building rapport and most therapists were self-conscious and explicit with researchers about their use of

personal stories in creating relationships with their patients.

Here is a typical example which illustrates the informal and unobtrusive use of this kind of exchange. A pediatric therapist is working with a child who will not stop crying. The mother is looking uncomfortable. They have talked earlier about the fact that the child is teething. The therapist, though concentrating on dealing with the child, glances up at the mother and says, "It's funny how teething affects kids different. To some kids, it's nothing. Now Jamie, my friend's kid, he's young to be getting teeth. And both parents are working. So it's just chronic exhaustion." The therapist does not stop to tell an elaborate story for she is also treating the child. But in this off-hand "story in a nutshell" -- an extremely common form of storytelling by therapists -- the therapist lets the mother know indirectly that she understands why the baby would cry, she also simultaneously uses a personal experience about a friend.

Most of the therapists at University Hospital, especially the more experienced ones, relied heavily on telling personal stories and jokes in their clinical sessions. In using personal experiences, in sharing a personal self as a way to create bonding, the therapists were constantly reasoning about how much of the self to reveal, how to make themselves rather than the patient the momentary center of attention without losing the basic

therapeutic structure in which the therapist gives and the patient receives treatment.

A fourth commonly used strategy for developing cooperative relations was asking patients to problem-solve along with the therapist. For instance, one therapist working in the spinal cord unit described joining the unit with no previous experience in spinal cord injuries. She was unfamiliar with much of the adaptive equipment used, so that many of the patients knew more than she did about equipment, though one of her tasks was to teach the use of this equipment to patients who were unfamiliar with it. At first she was embarrassed about asking other patients to help, and about receiving advice from the patients she was supposed to be teaching. But she began to discover how much patients liked having a role to play by teaching her. When working with a new or unfamiliar piece of equipment, I often observed her calling for other patients to give their advice about how to use it. This became a strategy not only for creating a personal bond between herself and the patient but also for creating a social group out of isolated individuals. Many of her patients were adolescent boys, often with some mechanical expertise, and solving such problems allowed them to take a strong, active role, if only for a little while.

A fifth common strategy for promoting alliances with patients involved structuring successful treatment sessions. All the therapists in this study were concerned with

devising activities which the patient could successfully perform. They saw this as important for maintaining motivation. Each could discuss at length the need to structure activities so that they could push the patient as far as he could reasonably be expected to go without pushing him so far that he failed. In occupational therapy terminology, this is the "just right challenge."

Success depends not only on judging the patient's physical ability but also on how far he would be willing to push himself. Such clinical judgment becomes extremely fine-grained and necessitates sensitivity to subtle cues from the patient. For instance, a pediatric therapist working with a child who was performing an activity improperly had to decide how much she should correct the child. Here was the interchange:

Therapist: You know how to make a square, right?

Patient: Circle! Square!

Therapist: Uh oh, we're losing our square.

[Patient seems to be veering from square to circle.]

Patient: Is that better?

Therapist: Much better.

The therapist decided to correct the first time, and not to correct, but validate, the second. She was asked after the session how she learned to judge when to correct and when not to. She said,

It's something you learn by trial and error, by reflecting on the sessions that went badly

afterwards and trying to isolate what went wrong and correcting for that the next time. In correcting a child, you have to set your acceptable limits, have an idea of the child's limits, what you'll accept for now, what you think they can do. As you get to know them, you learn what they can tolerate, how much they can stand to be corrected, and how much you have to let go for now. It varies with the kid. With some, there's always a contingency plan, 'OK, five more, then we'll do something else.'

Therapists described such reasoning in peripheral terms, as a critical but intuitive and atheoretical aspect of practice. The considerations involved in making this kind of small, ordinary decision are quite elaborate, based on the therapist's understanding of the patient's inner world of motivations, commitments and tolerances. In this example, the therapist had to refer tacitly or explicitly to a number of theories about the child in answering such questions as: What are her limits for this task, based on past experience with her and other children like her? What can the child do in the context of this task? How much can the child stand to be corrected? How much do I have to let her go for now?

This theoretical structure is refined when the therapist's decision does not give her the results she had expected -- if trouble arises. This therapist is clear that much of her learning comes from past problems. However, what she characterizes as a "trial and error" method appears upon closer examination to be more systematic: What she tries is driven by theories about the patient and what the

patient can handle; she is not merely randomly experimenting.

Patients were regularly told by therapists that they were performing successfully and they were often asked to validate that success. Validating success is another strategy, sometimes an explicit one, for trying to induce the patient's commitment to therapy. Here are some examples from a single session:

Therapist: At first you couldn't sit up at all. Now you've learned to sit up by yourself.

Patient: Yes, yes.

...

Therapist: Is that as hard as it was?

Patient: (response unclear)

Therapist: Not too bad. Because you really couldn't do it for the longest time.

...

Patient: I wish God could do a miracle on me. I can't use my arm as I should.

Therapist: Well, you are doing much better. You can give yourself a lot of credit. You and others have been working hard.

The therapist was asked after the session about these validation points. She felt that his agreement (as in the first two interchanges) was an important confirmation from him that things were improving and that such a confirmation mattered because it showed some active involvement on his part. She recounted her description of the session. "I was saying to him, 'Last week you had more difficulties. Now it is easier. You must be feeling easier.' Before, everything

was lousy in his view. I want confirmation from him that things are improving." The concern for confirmation and the tacit theory that the patient's pessimistic view will prevent him from improving is probably what drives her to directly contradict the one personal statement he made during the treatment session quoted above, in which he portrayed his disability as not having changed sufficiently.

Claiming The Disability

Therapists were often required by their own interest in involving patients in therapy to create stories and theories about who patients were and how they experienced their disabilities. But the therapist's interest in the phenomenological body is not necessarily motivated so directly by strategic concerns. Therapists often revised their planned treatment activities in small ways as the patient voiced concerns which they had not anticipated prior to the session. In fact, they often insist on interrupting their plans to respond to such concerns.

A concern for the patient's experience of disability is revealed when the therapist begins an activity that reflects her agenda and, in the course of carrying out that activity, shifts what she is doing to accommodate the patient's concerns. In the following example, taken from field notes, the therapist opens the session by initiating an evaluation on a paraplegic patient she has only seen once or twice before. The evaluation involves a standard set of questions

intended to provide information on the patient's cognitive, motoric and self-care status.

Therapist: Do you remember what my name is?

Patient: No.

Therapist: What letter does it start with?

Patient: Patty.

Therapist: What did you have for breakfast?

(Patient replies. She asks questions about the tape recorder which he has put on his bed and he replies.)

Therapist: How is your back doing?

Patient: It's giving me some pain.

Therapist: Remember how I was going to ask you some questions? We can do that or we can do some relaxation exercises first.

Patient: You're the doctor.

Therapist: Well, I'm not the doctor. Which do you prefer? How about the relaxation first, to help with the pain?

Patient: OK

In this interchange, the therapist interrupts her evaluation when she asks the patient how his back is doing, he tells her he is in pain, and she stops to teach him how to do a relaxation exercise, an interruption which lasts for about ten minutes, including the exercises, before she returns to her evaluation format. She takes his pain seriously, and seems to expect him to demand that she do so, as when she tells him, "Well, I'm not the doctor. Which do you prefer?" After telling him he is to choose, she chooses

what she believes he ought to prefer, relaxation exercises to help relieve his back pain.

She implies that being a good patient for the occupational therapist is not the same as being a good patient for the doctor. Good occupational therapy patients are ones who make choices -- albeit choices within a list presented by the therapist. Good patients are also those who take their experiences and the feelings related to their disability seriously. The therapist later tells the patient to "know that when you have pain, it's telling you something. You can separate yourself from the pain, but you also have to take care of it."

Later in this session, they discuss his medications. He tells her, "I don't give a crap about what a medicine's for but I guess I should." She replies, "You do need to know about your meds' side effects. Suppose you start getting a reaction of some kind, you'll know that it's from the med. You have to be your own pharmacist. Know what to do when you start feeling side effects." This exchange is similar to the one about pain quoted above. The therapist again picks up the themes that being a good patient -- or a competent disabled person -- involves taking responsibility for one's condition, coming to know your body and what it is telling you, knowing how to treat yourself. But this time she asks the patient to attend to his body as the medical professional might, learning to read his body so that he can recognize the effects of medication. In both instances, but

especially the latter, the therapist wants the patient to use his bodily experience as a source of information that will help him to caring for himself somewhat medical professional might. Competence here means learning to "be your own pharmacist." Phenomenological and biomechanical frames blur.

Treating The 'Whole Patient' -- Finding The Person Behind The Disability

The phenomenological frame enters practice in quite another way as the therapist/patient roles become less clearly defined when therapists ask patients to become partners in ordinary conversation. Therapists rarely relinquish control of interchanges. There are many markers that the setting is professional. "We are not equals here," is one indelible message of the hospital setting. And yet there are moments, often initiated by the therapist, when the patient is asked to participate in an activity or conversation as a "whole person," as someone who brings a whole self to the interchange.

Therapists make an extraordinary effort to talk with patients, to find some way of making contact no matter what their physiological status. The two following examples are situations in which therapists work to engage or include in conversation patients who cannot speak. In the first, the patient is comatose. In the second much more elaborate and complex conversation, the patient is very alert but is

unable to speak aloud because of a tracheotomy and can only mouth words.

In the first of these examples, a therapist is seeing a patient for the first time. What is telling about this example is not what gets said, which is very little and strictly medical, but the therapist's sustained efforts to make contact with a comatose patient. This session involves an evaluation of the head injured patient, a twenty-nine year old female who was in a car accident the week before. The therapist begins by approaching the patient and saying, "Hi, I would like to look at your eyes." After lifting her lids, touching her chin and the bandages on her head, the therapist tells the patient, "I am going to look at your arm." She then tells her, "I am going to move your arm a little bit." After ranging the patient a few minutes she says, "Ginger, see if you can lift up your arm for me." There has been no discernable response by the patient to any of this, but the therapist continues to speak to the patient. The following day the therapist again sees the patient, this time in the company of a physical therapist. She begins her second day's work by saying, "Hi Ginger, it's Susan. We are going to work with you and move your body." She continues to speak directly to the patient as she works with her, though speaking of her in the third person when she discusses her with the physical therapist. After this session, the occupational therapist was interviewed by the researcher and asked about why she talked to the patient.

Interviewer: I noticed that you did a lot of talking with the patient and the physical therapist did almost none. Could you explain that for me?

Therapist: In general the OTs do more talking and interacting with the patient. I am dealing with the cognitive-sensory aspects of the person. OTs do a lot more problem solving with patients. For OTs, technique is secondary...She (patient) responds to tactile stimuli, that is why I touched her when I talked to her."

The therapist "overreads" what the patient can offer as a partner in conversation. She acts on the assumption that the patient may be able to understand her and she continually probes, watching for responses. The therapist justifies her communicative attempts, in contrast to the physical therapist who speaks directly to the patient only once during the session, by saying that occupational therapists need more mental involvement from their patients. Although the therapist only addresses the patient in what (if the patient were awake) fits narrowly into a biomechanical mode, her persistence in attempting to establish contact with this comatose patient, on however minimal a level, exemplifies the pervasive concern among occupational therapists to bring their patients into the therapeutic process.

The second example is, in one sense, the natural extension of these interests in bringing patients in. Therapists tended to overread more often than underestimate the capacities and commitments of their patients as active partners and willing collaborators. This was connected to their constant emphasis to patients that though they were

disabled, their personhood was not completely identical with their injury. Although the patient in this second example is also a silent participant, the conversation itself could hardly be more different in tone from the preceding one.

The therapist initiates a three way conversation involving the patient, herself and a physical therapist. This conversation occurs in the large spinal cord unit when a physical therapist happens over to chat with the occupational therapist as she is treating a patient. The patient, who is quadraplegic and has lost both legs, has also had a tracheotomy and cannot be understood except by lip reading. This therapist, like all the therapists I observed, was adept at lip reading, and she functions here as an informal interpreter, ensuring that the two men, patient and physical therapist, are in a conversation together. The therapist initiates the conversation by introducing the two men and then asking the physical therapist if he had heard what the patient, whom we will call John, had said to a famous football player, a Boston Patriot, who had come in to visit another patient the day before.

OT (to PT): Long day, huh? You love your job.

PT: I like it.

OT: Good. Do you know John?

PT: We have met on occasion.

OT (asks John): Do you know that guy?

PT (to both): The good looking one.

OT: Yes, dream on. That is what John keeps saying about himself. Do you know what John said to Andre Tippett yesterday? (John mouths something to the OT which causes her to laugh but which the PT and the researcher cannot understand.)

PT: What is that?

(OT laughs)

PT: What did he say?

OT: He didn't say that. He was seeing Mike (another patient) and Andre came in and we were talking for a while. And then I said to him, "Did you meet my friend John?" He says, "Who's John?" So John went to say something to him and he couldn't hear him, so he comes down like this to John's ear to listen. And I said, "You won't get it that way. You can't hear him. You have to read his lips." So the first thing John says to him is, "What happened in Denver?" (The Patriots had just lost the Superbowl in Colorado.) So Andre looks sort of baffled and then John says, "I was very disappointed."

PT: Is that what he meant?

OT: Yes. Right to him. And you should have seen his face. He was like

PT: He knew.

OT: John is like hysterical. So Andre realized John was joking and he started laughing too. We were all laughing.

PT: You know, I know him.

OT: Do you really?

PT: Yes, we both went to the University of Iowa.

Patient: Is my time up?

OT: No.

PT: We both went to the University of Iowa and he was a senior and I was a freshman and I was on the swim team and he was on the football team and all the athletes in the college were in the same dormitory.

OT: Yes

PT: So I had friends on the football team, wrestling... and one night we went downtown and there aren't that many bars. There was only one or two, so I was where everyone goes dancing to meet people of the opposite sex. And I went down with some of my friends and I saw him and we started hanging out in this bar. And he would go dancing and he was getting every girl he wanted. Probably because he is Andre Tippett, so I didn't have any such luck. I was trying my damndest.

OT: Ahhh, we feel bad for him, don't we John?

PT: So finally I went up to him, and back then I couldn't handle myself well enough. I put my arm around him and went, "Andre, how did you get all these girls, you have got to tell me." He is like, "What are you doing?" "Well, I just go ask them to dance, and as soon as we starting dancing, bam, they are gone. They hate me." And he said to me, he said, "You dance too much like a white man. I will teach you how to dance." So he brought me out on to the dance floor and was like, "No matter how fast the dance, be slow, be cool, because girls like that. They see all you white guys jumping around, hopping, raising your hands. Don't do that. Just be cool. It is always like this, no matter how fast you dance."

OT: John agrees.

PT: It is true.

OT: Say this again?

(Patient says something which is not audible.)

OT: And you, 'cause you dance like that...

PT: That is true

OT: ...you got all the girls.

PT: Next time you go to a bar, watch them dance. No matter whether it is a fast song or a slow song. Same speed, same moves. The white guys were just jumping all around and doing that. I mean, no girls want that. And so, he taught me. Well, anyways, we went out on the dance floor, and he was like, "Show me what you did on this song." And, like, all the football team was looking on. I felt real stupid. And so he is like, "No, no,

no, no, no. Like this. Do this and imitate me."
He would grab my hands and say, "Put your hands
here." So I was dancing with him.

This joking story exchange begins when the therapist introduces the two men, an ironic introduction which already sets the stage for the stories that follow. The physical therapist reminds the patient that he is "the good looking one," to which the occupational therapist replies "Yes, dream on. That is what John keeps saying about himself." Her retort defines the two men as being alike and includes the patient in her response. Since John is a quadriplegic who has lost both legs, this is an ironic response, but the irony is ambiguous, for she often compliments John on his "beautiful blue eyes" and by his own account he was always quite vain about his appearance. She follows this up with a story about John. She tells John's story, and in so doing, she conveys something about John. The entire story could be seen as an extended introduction of the two men mediated by the occupational therapist as she conveys to the physical therapist and perhaps more importantly the patient, a view of John's identity. The story she tells is about John's boldness and wit, about a quadriplegic patient using humor to off balance a famous football player. The physical therapist counters with a story about his own encounter with the famous football player. In this story, the storyteller is the one who fumbles, a simple inversion of the first theme. There is also, in both stories, a theme about the off-balancing of culturally typical power hierarchies: a

paralyzed man shows up a whole man; a black man shows up a white man. This theme of the fluidity and unpredictability of power is reinforced by the final exchange between occupational therapist and physical therapist as the physical therapist leaves. The physical therapist's name is called over the intercom. He parts with a final joking remark.

PT: They probably want me to tell them my Andre Tippett story. So that is how I learned how to dance. He is a football star and I am...

OT: Making beds.

PT: Cruel, but true.

This exchange on the ironies and unpredictabilities of power is also an episode of bonding in which teasing and tricking are cast in a friendly way. Both are friendship stories with happy endings about the possibility that very different sorts of people can find ways to make real contact with one another. In the first story, everyone laughs together at the end. In the second story, an inexperienced white man learns how to attract girls.

The storytelling which the occupational therapist is so key in initiating conveys multiple messages about the meaning of this patient's disabilities. One clear message is that while such an experience may be devastating, the patient has not lost all of his force as a social actor. In an encounter with a powerful man, he still has resources to equalize the relationship. He may be crippled but he is not powerless. The public identity which the first story gives

to the patient is that he is a strong man, someone who still has some ordinary perspective on the outside world (he can be disappointed that his Boston team lost the Superbowl) and who still has an intelligence which he knows how to use to advantage. Another strong message is that it is still possible for this patient to connect to the world and to other men. This message is given both by the content of the first story, which is about bonding through kidding between a disabled man and an enormously physically able man, and by the placement of that story as part of an introduction between the physical therapist and the patient, itself an encounter between the able and the disable. While the occupational therapist's help as a translator and commentator are essential in informing the physical therapist about John, she also participates in generating an impression that John's powers of kidding exceed in some ways what the physical therapist may yet be allowed to know, for the joking which precedes the storytelling is initiated in part by a remark which John's makes to her which causes her to laugh, but which she treats as a private joke, refusing to communicate it to the physical therapist.

Returning Patients to the 'Real World'

Occupational therapists are transporters; they help patients make transitions from hospital to home, from sick role to active social member. They contextualize the skills which they teach in terms of patient lives back home, lives

which go beyond the "sick role" of the hospital patient. They work at the interstices of the patient's life, treating patients in settings apart from everyday life -- like the hospital -- but orienting patients to the everyday life to which they will return. Therapists work to embed the activities they ask patients to carry out within patients' life stories and they often ask patients to discover connections between therapeutic activities and their personal lives. In all of these ways, their therapeutic activities take on a meaning that goes far beyond technical assistance at skill-building. Therapy sessions become microcosms of life which therapists hope patients will build on and expand in their return to the larger life outside the hospital. It is thus that occupational therapists aid their patients in the journey back from the hospital world and the sick role to the everyday world and the more complex and responsible roles of being father, sister, friend, worker, and the like.

In this role as transporters, therapists deal with the problem of stigma, or what the sociologist Erving Goffman (1963) has called "spoiled identity." The disabled suffer not only a dramatic shattering of life stories through accident or disease, not only the imperative to revise their lives to suit those bodies, they also confront a society which views them as less than a normal member even though they have left the "sick role." When therapists treat the "whole person" they treat a different person than the

outside social world is willing to acknowledge. Goffman notes that the stigmatized person is one who has lost his wholeness in society's eyes. "He is reduced in our minds from a whole and usual person to a tainted, discounted one (Goffman,1963)." Enabling a person to "live on the outside" and take up an active life in society also means helping them to confront the enormous fears which accompany tackling the social world with a "spoiled identity." Competencies at specific activities of daily living become symbols of how to take on that frightening, dismissive social world.

The patients which occupational therapists treat have had their lives seriously interrupted by a disabling disease or trauma. They must imagine new lives for themselves, "begin a new life story," one might say. The attempt to recover as far as possible their former lives requires a radical reimagining of how to go about the simplest daily tasks. While the therapists in this study generally concentrated on teaching patients such simple skills (simple, that is, from the perspective of the non-disabled), skill-building in itself was rarely underlying goal. They tried to organized therapeutic activities not simply to build skills or strength but to provide experiences through which patients might see how they could effect a transition from the hospital and the sick role back to a life of comparative independence. This made it important to listen to patients' stories about their previous "well lives," and

to the concerns they had about attempting to reenter their lives.

All of this is to say that a concept of clinical reasoning as the identification of disease and the planning of disease-specific treatments leaves out too much of importance in the way occupational therapists must think in their work. Their concern to help patients transcend limits is implemented not only in what Robert Murphy calls the long process of restructuring bodies, it is also applied in their use of therapeutic tasks and conversations to advance a necessary restructuring of the self. The occupational therapists in this study recognized, though perhaps fleetingly, how closely one's sense of body is connected to one's sense of self. They constantly structured experiences in ways calculated to allow particular patients to transcend the physical limits which they thought would now govern their lives. This growth often occurred only through an accumulation of almost imperceptible gains gotten at the price of agonizing effort. The intended effect, however, was not only a compensation for earlier losses in physical ability; it was meant to begin a re-construction of the self which recognizes and values those possibilities and qualities of life that remained open.

Blurred Frames

In theory, the biomechanical and the phenomenological frames oppose one another. And it is easy to choose

examples from the practice of occupational therapists in which they function so fully within one frame or the other that this opposition is clear. Therapists themselves feel the tension between these two, as when they discuss the dilemma of needing to both "treat that hand" and "treat the whole person."

But often therapists work and talk with their patients in a way that shades one framework into the other. Therapists and patients tact back and forth between these two perspectives, relying now on one, now on the other. Asking the patient how a hand feels when ranging it may yield, quite naturally, a broader discussion about how the patient feels about therapy or about difficulties he is facing at home. Sometimes when that occurs the therapist may cut off the patient's exploration of these associations. In most such instances the therapist seems concerned to stay within a biomechanical frame. But often the therapist will allow or even encourage the patient to respond to a narrowly posed question with a more wide-ranging discussion of their feelings and experiences.

Sometimes a single therapeutic activity can have meaning within both frames. For example, a therapist may range a patient's hand while listening to him talk about feeling depressed, the physical touch helping to create a context in which the patient can reveal himself.

Some therapeutic activities dwell on the margins of both frames. One example of this would be the example given

earlier in which a therapists talked to a patient about what to pay attention to in their bodies and how to manage direct their care relative to the side effects of medications. Therapists refer to this sort of thing as "patient education" and identify it as one of their prime therapeutic tasks. Patient education often entails directing attention to the patient's physiological body. When this attention serves the therapists' need to gain better information about the patients' physiological status, the interchange will be conducted within the biomechanical frame. But attending to the body as a locus of symptoms and signs can also provide the basis for a bit of education designed to help the patient become more adept at interpreting the biomedical meaning of what he feels. In these instances, therapists teach patients some elements of biomedical language to be used in interpreting their own condition somewhat as a medical professional might. This enables the patient to regain a sense of independence and control over his body which is not only a subjective, but has the practical consequence that the patient can tell others what he needs in terms of professional medical help as his condition changes.

Whether an activity or conversation fits within the biomedical or the phenomenological frame is not determinable by any narrow criteria. It very much depends on the context of activity, especially on how the patient responds to the therapist's intervention. This may mean that patients come

to learn a subtle interplay of these two discourses just as therapists do. Consequently, there may be no simple demarcation between the patient's experiential language for the disability as an injury to his life, and his use of elements of the biomedical interpretation of such symptoms and signs related to the nature of the disease or trauma.

In these ways the patients' mastery of some areas of biomedical thinking can have direct implications for the ways in which they construct the meaning and experience of disability in their lives.

SIX

DOUBLE VISION

THE TWO DISCOURSES OF OCCUPATIONAL THERAPY

Depending on which 'body' therapists consider at a given moment, biomechanical or phenomenological, they describe the patient's disability differently. Not only does the content of their talk change, as is to be expected, the structure of the discourse itself changes. When a disability is presented biomechanically, therapists typically outline a list of general problems which have clustered around a particular patient. The tendency toward an atomistic portrayal of clinical problems is also characteristic of the way treatment modalities are described. Treatment is often pictured as a serial collection of "basic actions," a linear sequence of events. General problems are connected, one by one, to treatment interventions, with outcomes of interventions matched against the initially identified problem categories. When a history is given, either of onset of disability or of treatment process, that history is of the pathology and its course through treatment, not of the person who possesses it. The particular experience of the patient is downplayed or left out altogether.

Alternately, when therapists consider the phenomenological body, their discourse moves into a

narrative mode. They begin to tell stories. Clinical problems and treatment activities are organized in terms of some unfolding drama the narrator sees in the work with a patient. A cast of characters emerges. Motives are inferred or examined. Feelings often dominate the drama, where narrators intersperse descriptions of what happened with interpretations of how the patient felt or their own emotions when certain events transpired. Both the patient's illness experiences and therapist's experience of treating the patient take center stage. Idiosyncratic events occur in many of these stories, unexpected difficulties, or a great success that couldn't have been predicted, though the therapist might have hoped for it. Therapists and patients often get surprised in the story. Usually some suspense surrounds its telling, except in the briefest tales.

Describing clinical cases to colleagues plays a substantial role in a therapist's work day. Therapists spent approximately one third to one half their time in meetings with colleagues or in writing chart notes. This time was spent discussing patients, describing clinical problems, outlining and justifying treatment approaches, citing treatment goals. There was a weekly departmental meeting among the occupational therapy staff, weekly interdisciplinary meetings with medical staff in particular diagnostic wards (neurology, psychiatry, etc.), and supervision meetings between senior occupational therapists who were supervisors for staff therapists.

The main topic in all of these meetings, except perhaps the weekly departmental staff meeting, concerned the presentation and review of case loads. The status of each patient would be reviewed, with discussions around the efficacy of particular treatment approaches, problems the patient was presenting to staff, any new medical complications, or possible discharge dates. Therapists were continually called upon by colleagues to provide descriptions of their work with patients and to evaluate the patient's status.

Therapists also talked to one another casually, over lunch, in the hall or in their offices, about the patients they were seeing. And in the everyday course of treatment they talked to the patients themselves about how the therapeutic process was going or about the nature of the patient's disability.

The dual practice of occupational therapy was visible in the dualistic way therapists described their work and their clinical reasoning to one another, to their patients and to outside researchers. Therapists at University Hospital talked about their work, either in interviews, in staff meetings, at lunch, or to the patients themselves, they drew on two distinct languages. One was a biomedical discourse, a language of "chart talk." The other was a narrative discourse, a language of personal experience.

These two modes of description played a powerful role in giving therapists two languages for making sense of

patients; two ways of envisioning clinical work. The same patient could be described through both forms of talk. This chapter and the following one examine the relation between the "body" the therapist treats and the form of discourse she uses to describe what she is seeing.

This chapter takes a comparative look at the two forms of talk, especially focusing on how each language gave therapists a particular vision of the clinical problem. The chapter following this takes a much closer look at narrative discourse, at storytelling as a way of reasoning about the clinical problem and how that differs from clinical reasoning construed, as it generally is, as a form of applied scientific reasoning.

Framing Discourses

These two forms of discourse provided therapists alternative ways of framing disability. They gave therapists a double vision for construing clinical problems and for reasoning about what kinds of interventions were required. Depending on which discourse the therapist relied on, she set the problem differently. These were more than descriptive forms of talk; they provided a logic for selecting, connecting and synthesizing therapists' experiences with their clients, and for guiding the therapists' on-going framing of clinical problems. The languages revealed -- or perhaps created -- a mode of thought, a way of contemplating and configuring salient

clinical problems. Each discourse reflected a distinct mode of clinical reasoning. The accounts therapists recounted revealed what, quite literally, they saw (what the crucial features were), how they explained what they saw (what the causal connections were) and how they justified and moralized their actions in terms of what they saw.

Bateson (1972), Goffman (1974), and Schon and Rein (1976) have described the role of frames in organizing personal experience. Erving Goffman, building on Gregory Bateson, describes frames as "definitions of a situation ...built up in accordance with principles of organization which govern events -- at least social ones -- and our subjective involvement in them...(1974:10)" In speaking of these two clinical discourses as framing discourses, I am relying on the Bateson-Goffman concept of frames, especially on the idea that we are always plagued in our actions with an intitial sense-making question (What is going on here?) and that the frame we invoke in our initial attempt to make sense determines any more specific answer to that question.

Donald Schon's (1983) work on problem-setting among professionals usefully extends the framing concept proposed by Goffman and Bateson by connecting their very broad conception of a fundamental ordering schema with a more fine-grained recognition that the thinking which a practitioner brings to bear in setting a problem, in recognizing a problem as being of a particular kind, is a more important aspect of practical reasoning than the

techniques and skills the professional relies on to solve the problem once it has been set.

Goffman distinguishes two broad classes of primary frames, one natural and one social. When we see events within a natural frame we see them as unguided.

Natural frameworks identify occurrences seen as undirected, unoriented, unanimated, unguided, 'purely physical.' Such unguided events are ones understood to be due totally, from start to finish, to 'natural' determinants. It is seen that no willful agency causally and intentionally interferes, that no actor continuously guides the outcome (1974:22).

Social frameworks, by contrast, are concerned with what Goffman calls 'guided doings.' Social frameworks construe events as ones which "incorporate the will, aim, and controlling effort of an intelligence, a live agency, the chief one being the human being. Such an agency is anything but implacable; it can be coaxed, flattered, affronted, and threatened...(Ibid.)" Because social frames are organized around a "doer" who could, presumably, do something differently, they also involve evaluation of performance. With the possibility of doing otherwise, and consequently of things being otherwise, moral evaluation enters. "These doings subject the doer to 'standards,' to social appraisal of his action based on its honesty, efficiency, economy, safety, elegance, tactfulness, good taste, and so forth (Ibid.)."

The two primary frames also involve two different conceptions of causality. Within a natural frame, cause refers to general physical laws which are not connected to

the motives and aims of particular intelligences. Within a social frame, cause refers to the intentional work of the agent. Intentions and motivations provide the causal impetus within a social frame because actions are seen as prompted by intentions and these actions result in certain consequences. Social frames causally chain intentions, actions and effects. "We use the same term, 'causality,' to refer to the blind effect of nature and the intended effect of man, the first seen as an infinitely extended chain of caused and causing effects and the second something that somehow belongs with a mental decision (1974:23)."

The marked difference in these two explanatory strategies is elaborated by Jerome Bruner (1986) in a provocative essay in which he draws a cognitive dichotomy which closely parallels Goffman's primary frames, arguing that there are two fundamental modes of thought which provide distinctive ways of ordering experience. One he terms 'argument,' the other, 'story.' 'Argument' is a misleading term since one can argue quite effectively in narrative so I will speak less elegantly of "propositional argument" where Bruner uses argument. Bruner's contention is that propositional argument and story are our two primary ways of turning statements of fact into statements implying causality.

Thus, like Goffman, Bruner believes these two modes of thought involve different modes of explanation, invoke different notions of causality. He adds to Goffman's

differentiating criteria of guidedness a second key difference in their explanatory strategies, their level of abstraction. Propositional arguments find their place in logico-scientific mode which "attempts to fulfill the ideal of a formal, mathematical system of description and explanation (1986:12)." This mode of thinking deals in general causes and their establishment. "Its domain is defined not only by observables to which its basic statements relate, but also by the set of possible worlds that can be logically generated and tested against observables -- that is, it is driven by principled hypotheses (1986:13)."

While propositional argument, as Bruner uses the term, seeks to transcend particulars and strives for abstraction (for truths that transcend any particular situation), narrative is rooted in the particular. Propositional arguments are concerned with understanding phenomena in terms of general causes, narratives are concerned with the likely connections among particular events. Bruner gives a simple example to illustrate the difference. The statement "if x, then y" belongs to propositional argument. Such a statement is aimed at providing an abstract description of a causal relationship. The statement, "The king died, and then the queen died" belongs to narrative (1986:11-12). This narrative statement not only concerns the particular, a specific king and queen, but suggests causes that lead us to wonder about intentions. Did the queen die of grief? Was

the queen killed? We investigate the meaning of a narrative statement by trying out different motivational possibilities -- we search for what guided the action that the statement reports.

Narratives make sense of reality by linking the outward world of actions and events to the inner world of human intention and motivation. To ask in a narrative sense why something happened is to ask what motivated the actors to do what they did. Stories deal in intention and action and the "vicissitudes and consequences that mark their course (Bruner, 1986:13)." Stories locate experience in time and place. In a story, a person's actions are accounted for by placing them in some specific historical context, showing how and why they were begun, what other actions unfolded as a result, how they evolved over time.

Comparing Frames in The Concrete Case

Hand Patients: Two Written Cases

A good example of the significant difference between these two forms of discourse emerged out of an exercise I asked therapists to carry out at the very start of the research project. I asked therapists participating in the study to write out a description of a patient that had presented them with problems, one where they had gotten "stuck." They were to define the problems and write up the case in any way they chose.

Therapists presented their cases in two distinctly different ways. Some wrote stories about the therapeutic process and especially about the experience of treating the disability from the point of view of both therapist and patient. These were the phenomenological accounts. Other therapists described their problem case primarily in biomechanical terms; experiential aspects were minimized. A nice illustration is the quite different way two therapists presented cases which concerned hand injuries. One confined her description primarily to the bio-mechanical body, referring only briefly and as a kind of postscript to the disability and its treatment in an experiential way. The second described her problem in such a way that the bio-mechanical was buried within a narrative description of how the disability was affecting the patient and herself.

First Therapist: The Biomechanical Mode

The experience I've had most often as a hand therapist is a result of the natural cycle of recuperation post injury. That is, maintaining motivation, creativity and dealing with the inevitable frustration, both in myself and the patient, over a long haul of rapid, then slow improvement with many plateaus in between.

This was especially true in the case of a young man who received therapy over a period of a year and a half. He had amputated his right dominant hand in a hydraulic log splitter. The hand was replanted with fractures pinned and soft tissue repaired, after which he started on an aggressive rehabilitation program. The long-term

problems that required multiple attempts at solution (some effective, some not) were:

1. Lack of metacarpal phalangeal flexion;
2. Lack of thumb rotation and subsequent functional opposition;
3. No active motion in interphalangeal joints of the little finger.

What I tried for each problem was:

Problem I: MP flexion.

1. Wrist splint with rubber bands and finger slings for dynamic flexion.
2. Discontinued night resting extension splint since patient was in extension and active extension had improved.
3. Joint mobilization.
4. Coband wrapping in flexion and active assistive range of motion.
5. Ultimately, 11 months post injury - surgical capsulotomy to MP joints and extensor tendon release.
6. Alumafoam splints to concentrate flexor power at MP joints.
7. Flexion assist wrist splint with betapile strap to flex IP joints.

Problem II: Lack of thumb rotation.

1. Wrist cuff with dynamic thumb sling to pull into palmar abduction and opposition.
2. Functional "opposition" activities with decreasing object size.
3. Aquaplast web spacer.
4. Resistive prehension for strengthening.
5. Dynamic thumb sling attached to wrist splint to stretch web and position thumb in palmar abduction.

Problem III: Little finger limitation of motion & limited flexion, all fingers.

1. Massage to break up adhesions.
2. Resistive exercise for same.
3. Flexor tenolysis 14 months post injury (significant improvement.)
4. Splint with finger nail loops for rubber band traction.

Reviewing this case pointed out a few things to me. One was the need to work closely with the physician because well-timed surgery moved the program along significantly, and therapy maintained and built on these improvements. I also had to come to grips with the fact that we can't control all outcomes - for example, sensory return, which has important implications for ultimate functional usage, is generally poor in adults, and there's no way to change that. This patient saw good improvement from all the modalities tried out but some were more effective than others. There were long periods of time with little or no improvement and patient attendance also lagged - the end is sometimes never in sight for them, too. Therapists and patients alike get bored. It is hard to maintain creativity and motivation. And sometimes you just can't find a solution as good as you want!

Second Therapist: The Phenomenological Mode

I was visiting a colleague at her clinic. She invited me to join her as she was treating one of her patients - we'll call her Mrs. Anna Anderson. I introduced myself as an occupational therapist and a friend of her therapist, and sat down beside Anna.

Anna started to ask me questions about my work and my studies, and we found that we had some common interests.

I asked her about the injury for which she was receiving treatment and how her treatment was progressing. She explained that she had injured her middle finger when a window sash fell on it, that there had been a lot of blood and that her two children had been frightened by the accident and the trip to the emergency room of the local hospital. (I observed to myself that the injury look to be a relatively minor one and was responding nicely to therapy.)

Then Anna remarked that her husband had recently been killed in an automobile accident and that there had been a lot of blood. After she made the remark, I felt as though time stood still while myriad thoughts raced through my mind: I sensed this was an important revelation. Who else knew this? I wanted to look at my colleague, but I felt that eye contact might deflect the focus of attention away from Anna's statement. But why would she share it with me, a relative stranger? How did she see me? What did she expect from me? I became aware of my own discomfort; I could feel her pain and horror at having her recent injury be a catalyst for reliving her husband's death. The intensity of feelings was hard for me to endure, and part of me wanted to ignore the remark and go on as though it had never been spoken. But I sensed this moment was an important one and I knew I must acknowledge it.

After what was probably a 30 second pause, I responded to Anna's remark by saying that her injury must have been a horrible time for her if it reminded her of her husband's death and she said no. She said that it was a very hard and lonely time for her and a frightening one for her children. I asked whether her surgeon knew about

her husband's death and she said no. She criticized her doctor for treating her as though she was just a finger and not caring about the rest of her.

I was tempted to lecture her, i.e., if the doctor had known her situation his approach may have been different. I did not lecture her, however, because by this time I had concluded that the role Anna cast me in was one of a sympathetic outsider - a professional, but not one she was responsible to - and that the best thing I could do was to acknowledge that her feelings were legitimate and natural and to hope that this discussion would lead her to separate her injury from her husband's death.

Anna then began talking in generalities about her disappointment with some health care providers.

I asked her whether occupational therapy had been beneficial and she said that she had enjoyed that part of her treatment the most.

While we had been talking, Anna had been exercising. At this point her therapist intervened to bring her back to her therapy and to discuss her progress and her home exercise program.

Then Anna said goodbye and that she had enjoyed talking with me. I said the same and that I wished her continued progress.

When she had gone, I asked my colleague if she knew about the husband's accident and she said no but that it explained a good deal about Anna's worry over her injury.

When I reflect back on why I behaved as I did, I would say that my behavior was in part shaped by my clinical experience in treating

patients with physical disabilities and the importance of helping them deal with their feelings as a way to come to grips with the implications of their physical problems. I had learned in graduate school to check out my assumptions, to make sure that the conclusions I drew were in fact what people meant. Finally, I had learned during my own therapy to endure that uncomfortable feeling that comes to me when I or someone else is sharing a revelation that is filled with strong emotion.

These two cases present hand problems very differently. In the first case, the therapist lists three problems for therapy, and then takes each problem in turn and describes the therapeutic approaches used to treat that physiological difficulty.

Interestingly, these specific physiological problems are framed by problems that hint at the phenomenological domain but these are not taken up as the target issues to which her therapy is directed. The therapist mentions at the beginning and end of her case that a major difficulty was the frustration of the patient at the plateaus in therapy. She also hints at her own frustration at lacking control over the progress of treatment, "I also had to come to grips with the fact that we can't control all outcomes..." This frustration points toward another possible case, an untold case, in which the disability was not a physiological problem, but a problem of loss of control experienced by both therapist and patient. It is

not difficult to imagine that this loss of control might have invaded the patient's life-world and directly influenced his response to therapy and that this could be the subject of a phenomenologically oriented description of the hand injury.

By contrast, the second case gives almost no information about the physiological nature of the injury but only considers the hand injury as it plays a part in the patient's life. In fact, the therapist presents the case in such a way that it highlights the difference between the injury as a physiological phenomenon and as a meaningful lived experience. The narrator notes that "the injury looked to be a relatively minor one and was responding nicely to therapy." Bio-mechanically speaking, this injury posed no major problems. But this was not true of the woman's experience of the injury, which she had connected to the tragic recent death of her husband. The narrated sequence of events thematically connected the patient's description of her injury where "there had been a lot of blood and... her two children had been frightened by the accident and the trip to the emergency room" and her admission that "her husband had recently been killed in an automobile accident and...there had been a lot of blood." When the therapist expressed sympathy, acknowledging that the patient had said something important when revealing that the injury reminded her of her husband's death, the patient

told her "that it was a very hard time and lonely time for her and a frightening one for her children."

One major theme of this case is that the injury held meaning for the patient which her medical care-givers were not aware of. Her surgeon treated her body as a bio-mechanical object: "She criticized her doctor for treating her as though she was just a finger and not caring about the rest of her." The case concludes by presenting the moral that physical disabilities cannot be reduced to physiological phenomenon. The therapist says, "When I reflect back on why I behaved as I did, I would say that my behavior was in part shaped by my clinical experience in treating patients with physical disabilities and the importance of helping them deal with their feelings as a way to come to grips with the implications of their physical problems."

The same dramatic shift in language evident in the case presentations of hand patients just cited also regularly occurred in departmental staff meetings as therapists discussed patients. When therapists gave formal, public presentations of clinical work, in staff meetings or in interviews to the researchers, they often began with a bio-mechanical description of the disability, along with a thin set of facts which attached the disability to a category of person (e.g. a 28 year old working class male). After a description of problem in bio-mechanical terms, as a physiological process, they often then shifted to a highly

phenomenological account of how the disability was affecting the patient's life and how that patient was responding to it. It was commonplace for therapists to move back and forth between the two types of description. The following example illustrates the way that a shift in "body" goes hand in hand with a shift in discourse.

A Parkinson's Patient: Staff Meeting

This example is taken from field notes of a weekly departmental staff meeting where a student intern gave a formal case presentation as part of her internship requirements. Her presentation began with a description in which Parkinson's disease was the main character and then shifted to a narrative mode in which she introduced a patient, his wife and herself -- referred to vaguely as a therapist team, a 'we.'

The presentation divided dramatically. In the first half, the student therapist discussed the general medical characteristics of Parkinson's, with emphasis on the occupational therapy relevant aspects of the disease. Her disease centered discussion was organized as follows:

(a) She began by describing general functional problems characteristic of Parkinson's disease, e.g. "Major dysfunctions which come with the disease are personal changes, depression, drowsiness."

(b) She then discussed management of the disease. She told the group, "The disease is life-long since there is no

cure. The person becomes increasingly inactive, so keeping active as long as possible to keep up general health is essential. Maintenance is really important. Generally patients are admitted to the hospital because of related problems, problems with walking, ADL (activities of daily living)."

(c) She described various ways to assess and rate a patient's extent of impairment. She reviewed a scale developed by a physician for delineating rate of severity along ten impairment dimensions. She said, "Rating is used to show how severe the person's disease is when evaluating him. 1 to 10 is mild, 11 to 20 moderate and 21 to 30 severe."

(d) Finally she returned to her earlier management and treatment theme as she discussed the role of drugs and rehabilitation in treating the disease, with major emphasis on rehabilitation which is the occupational therapists' tool. "It is important to know when a person is on drugs because when they are on you can do the most functional work. Patients have to be put on a 'drug holiday' every so often because of the toxic build-up of drugs in their system. When this happens they go into full-blown Parkinson's. Then probably the most that can be done is passive range." She emphasized certain rehabilitation tasks that were the special domain of occupational therapy. "Things to be done with patients are moving arms in big

circles so that a person can write bigger. This helps in writing. Also passive range for rigidity."

The presentation then shifted markedly as the student began telling the group a story of her work with a particular Parkinson's patient. She introduced her narrative by saying, "It is hard to see a patient dependent at one time and independent at another. This is one of the most difficult aspects of this disease for everyone, the patient, the family."

What was most notable was the response of the audience to this cueing that talk was entering another domain. The affect of the group changed dramatically. There were sympathetic nods and small sounds of agreement from the staff therapists. Several leaned forward or focused more directly on the speaker's face. The structure of conversation shifted. During the first half of her talk the audience was quiet, respectful. Everyone assumed some appearance of listening, if distant listening. The speaker was not interrupted. During the second half, the audience paid increasingly close attention to the speaker, mirroring her facial expressions on their own faces in sympathetic accompaniment to the unfolding story. Talk changed from a strict monologue to an increasingly flowing, overlapping dialogue with nearly all audience participating in the end. The audience became a chorus, first in largely nonverbal expressions which marked their strongly felt participation

in the story, quickly followed by storytelling of their own at the conclusion of the speaker's story.

Here is the story the speaker told to them of her work with a particular patient, as captured by my field notes.

When he (the patient) was on drugs he could do all the ADL. When he was off, he couldn't do anything. He had a mask-like facial expression. His changing ability to function was frustrating for him and for his wife. The only adaptive equipment I gave him was a shoe-horn because it was difficult for him to reach down to put on his shoes. I suggested (...didn't catch) but he didn't want that. He said that something would have to be changed because his bedroom was downstairs in the basement. His wife wanted to keep him downstairs but finally agreed that he could have a bedroom in the livingroom. He progressed rapidly and after a week and a half he was smiling, becoming more social. His wife told me, 'He does nothing at home.' I don't know if she could hear what we were tellin her. We said, 'He is not just sitting around. Many times he simply can't do anything because of the disease.' When the wife heard that he would be on medication and that this would improve his functioning she said to him, 'Good. There's a lot of chores around the house you can do.' I don't know how much she heard of what we were telling her.

The audience followed this story sympathetically. When the narrator said the wife had to be persuaded to move her husband's bedroom from out of the basement, the other therapists look dismayed. They indicated even stronger dismay (grimacing, frowning, shaking heads) when the wife

reportedly told the husband that she was glad to hear he would be able to do chores around the house. By the time the narrator reached this point in her story, everyone was listening avidly, directly facing her rather than facing down, looking out the window or reading the announcements.

When her story was finished other staff therapists began to talk for the first time. This talking flowed into a storytelling exchange in which others around the table offered their own experiences with Parkinson's patients, emphasizing the "feltness" of the disease for patient, family or themselves rather than its objective medical features. Nearly all speakers narrated small stories which picked up and elaborated some themes raised by the initial story given above. Initial narratives followed the themes in the first story somewhat closely while later storytelling tended to follow previous stories thematically in contiguous fashion but did not necessarily remain faithful to key themes raised in the first story. Here are some excerpts from the dialogue that followed the presenter's story:

T1: It's a really hard disease. At one time they can do something, even at one moment. Then the next moment they can't.

T2: I remember there was this patient, when she was on she could talk about how crabby everyone thinks she is. then she would go off.

T3: I had this man. He's alert but he has no way of communicating. No method of communicating at all. (Sounds of horror by listeners.) He's allergic to every medication used. He's the worst case of Parkinson's I've ever seen.

T4: I think it affects the emotions of patients a lot.

T3: This is awful to say but, this man was completely intelligent but his hygiene, he couldn't control himself. It was hard. It must be hard on a family member. (Turning to student presenter) Your example is extreme but often the family doesn't understand.

T4: Or you have an elderly wife. She isn't very able to take care of herself, much less her husband, even if she wants to.

...

T4 told a story which I didn't catch in fieldnotes about a patient who had been given too much medication too early in the disease which caused terrible side effects. T6 followed with an even more graphic story about how this happened to a patient she had seen who a few months earlier had been fine but because of medication couldn't use her hands any longer. Listeners expressed regret, disapproval, "oh no," "umh," "oh god," shaking heads. I didn't capture either of these stories in my field notes because this was the first staff meeting I had ever attended and I had just begun to realize that therapists were doing storytelling. I was noting to myself that this gave them a very different way to think about their patients than the first half of the presentation. I was looking around the room, trying to understand the shift that had occurred and noticing how differently the other therapists were listening and waiting to participate.

T7: Families have an easier time putting people away who have Alzheimer's.

T8: My friend had a grandparent. This guy would take showers at 3 in the morning, wake everyone up. His wife would yell at him. It was terrible. Finally they found a nursing home for him, level one, where next to it there was a self-care home. His (the friend's) grandmother moved into that one next door. It took them three years before they could come to terms with it and finally put him away. The guilt.

T9: With Alzheimer's you get two types. There are the rigid ones and there are

T10: the runners. They are fine until they burn themselves out.

T11: I know a lot of people who are alcoholics with Alzheimer's. I saw this alcoholic. He had a fine memory up until about Kennedy's death. The psychoanalyst took him through his own history and you could just see it. It was amazing. He could remember everything fine until this one point and then you could just see it go. You could just see him making things up.

(Missing here some conversation that connected this to the rest of the discussion that followed.)

T12: There is a big euthanasia issue on our floor right now. The man, his mind is fine but his body is off. He can't do anything for himself. He is a C4. He has to be on a ventilator.

T2: And he really wants to die.

T12: Yeah

T2: Then I think they have to let him do it. I think there is a precedent that's been set in court.

T12: He couldn't even kill himself if he wanted to. That's the thing. He is completely dependent. If he stays on F5 and they take him off the ventilator, I don't know. And you know, you get on F5 and there are these issues of neglect which aren't really neglect. Some patients are just very needy and their way of getting needs met is to just ask for a glass of water a hundred times. So you can't respond to everything.

T2: My friend told me about first being in the hospital and the secretary rings and says, 'A patient is ringing. He wants to be suctioned.' There are a bunch of nurses standing around gabbing. So one says, 'I'll be there in a minute.' And ten minutes go by and they are still gabbing. So the secretary calls again and says, 'The patient is ringing again.' The nurse says, 'I'll be there in two minutes.' And you know, getting suctioned is terrible. No patient would ask for it unless he really needed it, unless he was really fighting for every breath.

T4: This nurse was complaining to me that this patient wanted to get dressed every day, how that

was wasting her time. And I'm thinking, well if this patient wants to be dressed up in the day instead of sitting around in a bathrobe, why shouldn't he? You get dependent because you want things.

T2: But I don't know if I could give that kind of compassionate care day after day.

(Meeting breaks up. Brief announcements about next week's meeting.)

There are two obvious distinctions between the first half of the presentation and the storytelling session: what the therapists talked about and how they talked about it. The difference in how the therapists talked, which has already been remarked, was quite dramatic. Biomedical discourse, which was carried out in an authoritative and highly formalized way, was a different speech act than the highly participative storytelling which followed. These two discourses were performed differently and invoked different rules of appropriate social behavior. The presenter's storytelling signaled to others that consideration of Parkinson's could be a collective affair and even that one thing might lead to another in unexpected directions but this was not a problem.

The reference of discourse also shifted. In the first half, the talk refers to the disease. There is no mention of any particular patient in this part of the speaker's presentation. In the second, the focus is always a patient with a disease. This is evident in the beginnings of the eight recorded stories which either introduce a particular

patient or announce the moral of the story which concerns the experience of a particular patient:

-- "When he was on drugs he could do all the ADL."

-- "I remember there was this patient, when she was on she could talk about how crabby everyone thinks she is. The she would go off."

-- "I had this man. He's alert but he has no way of communicating."

-- "My friend had a grandparent. This guy would take showers at 3 in the morning, wake everyone up."

-- "I know a lot of people who are alcoholics with Alzheimer's. I saw this alcoholic. He had a fine memory up until about Kennedy's death."

-- "There is a big euthanasia issue on our floor right now. The man, his mind is fine but his body is off."

-- "My friend told me about first being in the hospital and the secretary rings and says, 'A patient is ringing. He wants to be suctioned.'"

-- "This nurse was complaining to me that this patient wanted to get dressed every day, how that was wasting her time."

With the shift to patient centered talk comes a dramatic difference in level of abstraction. The disease centered talk, while specific to a particular disease, conveys information through a discussion of general traits and characteristics:

-- "Major dysfunctions which come with the disease are personal changes, depression, drowsiness."

-- "Generally patients are admitted to the hospital because of related problem, problem with walking, ADL."

-- "One out of 40 people get Parkinson's."

-- "Parkinson's patients tend to have mild to severe frozen faces ranging from flat affect to drooling."

These statements describe general trends, statistical truths. They are also descriptions of states of affairs rather than of singular events.¹ The narrative statements made in staff meeting, by contrast, locate the discussion with particular individuals, and usually in a particular time and place as well. "Patients" or "the Parkinson's patient" become "this patient," "this friend," "this nurse." The narratives refer to singular events which occurred, uniquely and specifically, in a particular historical moment.

The speaker's story quoted above is a good example of the way narratives locate what they describe in specific times and places. In the story, the speaker moves toward an increasing level of specificity. Initially she describes traits which are specific to the patient but states them

¹ Interestingly, Hempel (1942) identifies this language of states of affairs as the proper form of descriptive discourse for the nomothetic task of discovering general laws which transcend the particular case. He critiques the narrative language of history for couching descriptions in a language that is too ideosyncratic and argues that all historical descriptions of unique events could be recaptured in statements about states of affairs as a first step to the descriptive level proper to scientific explanation -- nomological deductive discourse.

quite generally ("He had a mask-like facial expression."), then moves to a broad sweeping sketch of the overall historical situation ("He progressed rapidly and after a week and a half he was smiling."), and finally concludes with a much more concrete and vivid portrayal based on remembrances of actual dialogue ("His wife told me, 'He does nothing at home.'...We said, "He is not just sitting around. Many times he simply can't do anything because of the disease.'"). It is as though she has a camera which she propels gradually closer to her subject.

Early in this chapter I began a discussion of the difference in these two discourses as they reflect two different ways of explaining clinical phenomena. The following chapter takes a closer look at this difference in explanatory strategy, concentrating especially on narrative as one of the two modes by which therapists explained themselves, connecting clinical problems, treatment interventions and treatment outcomes.

SEVEN

MAKING NARRATIVE SENSE

Storytelling is treated by therapists as a casual, everyday form of clinical talk. It is that place where therapists describe their work in personal language, where their identity as objective, dispassionate professionals is partly relinquished. Storytelling does not carry nearly the same weight as "chart talk." It is an unprivileged and unofficial discourse. It is not considered appropriate for written communication and so does not find its way into charts. In formal group meetings, storytelling often follows after a more official presentation of a clinical case has been made.

There are many reasons for dismissing narrative as a form of serious professional discourse. Narratives are personal and particular while theoretical, and especially scientific discourse, is intended to be impersonal -- objective -- and general. Professional knowledge is usually characterized as "applied theory." (See Schon, 1983; 1987 for a more detailed discussion of this point.) In the medically related professions, it is characterized as applied science (Elstein, 1976; Kassirer, 1982; 1978). Narratives also do not appear to be a discourse capable of directing reasoning, especially if clinical reasoning is taken to mean, as it generally is, discovering causal

relations between symptoms and underlying diseases. In this chapter, the two discourses therapists use to describe clinical problems are viewed as reflecting two distinct reasoning processes. Therapists use two forms of clinical reasoning. In biomedical discourse, they rely on a form of reasoning which fits a scientific model of reasoning. Here their reasoning is appropriately captured, with some modification, by the discussion of clinical reasoning in the medical literature. But when therapists tell stories, their clinical reasoning is a form of narrative reasoning directed towards understanding clinical problems as personal experiences and these experiences are, in part, shaped by feelings and motives. The major part of this chapter will examine clinical reasoning as a form of narrative reasoning. The initial discussion of clinical reasoning as applied natural science is meant primarily to highlight what makes clinical reasoning as narrative reasoning so distinctive.

Chart Talk And The Biomedical Frame

When addressing the bio-mechanical body, therapists in this study viewed that body as governed by disease processes explainable without reference to the agency of the patient or his caretakers. Even where a disability was initially caused by a willful act, such as a spinal cord injury resulting from a dive into a shallow pool, the description of the disease was not influenced by the human actions which originally triggered its onset. Within this natural framing

of the clinical problem, the problem was cast entirely in light of physiological processes which could be understood and explained as having a life of their own apart from any human causes, even if they originally occurred because of human actions and were influenceable by human intervention.¹

From the perspective of this natural frame, the patient was not an individual with particular experiences and a particular history so much as a carrier or container of a disability created by trauma or disease. The emphasis was on the particular effects of that underlying disease process as it manifested itself in a given patient.

The causes identified within bio-mechanical discourse, by contrast, were natural ones (however unnaturally these were set in motion) and similarly treatment interventions were described in terms of the purely physiological responses they engendered. In official medical talk, therapists described problems and even interventions as though these were manifestations of natural and unguided doings.

Using Bruner's (1986) useful distinction, clinical reasoning among occupational therapists as it was reflected in "chart talk," belonged to the language of scientific

1. To be quite faithful to Goffman's (1974) distinctions, this clinical discourse belongs to a subgroup of guided doings which pertain to "quite physical matters," such as the physical manipulation of checkers pieces as opposed to the social world of making a move in a game. However, so much official medical discourse is concerned to understand and describe natural processes apart from any willful agency, Goffman's nature/culture slicing seems an appropriate division within the medical world.

argument for here the reasoning task involved defining problems in terms of general medical and dysfunctional causes and effects. The hypotheses therapists generated and tested by this reasoning process involved guesses about which general disease entities might be producing the symptoms observed, which general functional deficits were likely given certain medical conditions, or which treatment techniques were most appropriate given the identified functional deficits.

When therapists described clinical problems in the language of chart talk, they thought about the nature of those problems in a way which closely fit the accepted medical conception of clinical reasoning. Clinical reasoning, as the term has come to be used among medical researchers and medical professionals (especially physicians) is assumed to be a form of applied natural science. Medicine is conceived as a diagnostic science in search of the hidden causes of observable symptoms and signs. The assumption that clinical reasoning is applied scientific reasoning underlies nearly all research on clinical reasoning in medical fields, and the informal perception of occupational therapists, at least when speaking in a biomedical language.

Occupational therapists as a profession have become increasingly concerned to identify and enhance clinical reasoning in their field (Rogers, 1983, 1985; Parham, 1987). In the everyday talk of the occupational therapists at

University Hospital, clinical reasoning was often equated with the capacity of a therapist to give a reason for any particular intervention grounded in occupational therapy theory or in generally accepted medical knowledge. In the writing and research among occupational therapists about clinical reasoning, it has largely been associated with formal assessment, the initial identification of a patient's functional strengths and weaknesses which provides the basis for developing treatment goals and a treatment plan. Therapists rely on a wide variety of structured assessment instruments to carry out their assessments. The development of better standardized assessments for a variety of patient populations has been a focus of concern in recent years among educators and scholars in the field. This is significant, for it reveals the concern of the profession to be recognizable as an applied natural science, just as medicine is. Connecting clinical reasoning to assessment makes it possible to see the occupational therapist as a species of physical scientist, developing hypotheses which connect particular observables to general physiological processes or to well articulated, empirically tested theories about the nature of physical and psychosocial dysfunction.

The equation of clinical reasoning with assessment in occupational therapy mirrors the depiction of clinical reasoning in medicine as a diagnostic task. In medicine, this is such a strong underlying assumption that sometimes

researchers use the term "diagnostic reasoning" or "clinical diagnosis" interchangeably with clinical reasoning. To quote from one definitive essay in medicine, clinical reasoning, quite simply, "is a process of converting observed evidence into the names of diseases (Feinstein, 1973:212)." In occupational therapy, the emphasis on diagnosis is modified to fit their professional task. Their job is not to identify underlying disease processes, per se, but to identify dysfunctional problems in carrying out common daily life tasks such as eating, dressing, bathing, writing, and the like.

In medicine, the reasoning process is treated as a quest where the clinician discovers an underlying disease which causes the illness symptoms. The linking of clinical reasoning with diagnosis relies on an assumption that there is a definite something to be known (a disease) and clinical reasoning involves the clinician's ability to detect the underlying biological phenomena. Medical anthropologists who criticize this belief in a definite, unproblematic empirical reality have labeled this the "empiricist theory of medical language (Good and Good, 1980; 1979)." The clinician works from particular effects (signs and symptoms) which are the manifestations of abnormality, to inferences about the underlying cause, the disease producing these effects. Clinical reasoning means detecting a hidden disease on the basis of tangible cues.

Studies of clinical reasoning have emphasized the process by which clinicians select among alternative hypotheses to explain the patient's condition. Clinicians are presumed to use early case cues to generate tentative alternative explanations or hypotheses about the underlying phenomenon which, in turn, structure further interrogation of the case. (Kassirer, 1978; Feltovich and Patel, 1984) The general model of clinical reasoning here is of the clinician tacking back and forth between gathering data and constructing hypotheses until he finally uncovers the correct diagnosis and names the disease. (Elstein, 1976)

Clinical reasoning is treated by medical researchers as a type of problem-solving involving facts, propositions and decision rules which can, in principle at least, be explicitly stated and perhaps even quantified. (Feltovitch 1981; Kassirer, 1978) The ends to be arrived at are considered to be known (an identifiable disease entity). The physician's task is to solve the clinical puzzle by correctly identifying the disease entity causing the symptoms and signs presented by a particular patient. Once having done so, she can then make predictions about the likely course of the disease (based on his knowledge of the general disease entity) and, at times, control the course of the disease through his interventions.

Perhaps the clearest analogy is the reasoning involved in solving a puzzle, an analogy Thomas Kuhn (1962) uses in describing the reasoning of physicists. Puzzles present

simple worlds with comparatively few features that need to be attended to and with a clear right answer that shows itself to be right when you find it. Clinical reasoning within a biomedical frame is like puzzle solving where there exists a clearly identifiable right answer and the player's task is to find the right answer. The expert player is presumably better able to reach the correct answer than then the novice.

There has been a strong impetus in medicine to formalize the reasoning process of physicians. The extent to which clinical reasoning has been associated in the medical world with a form of discourse ideally translatable into mathematical terms -- following the ideal of scientific argument pointed out by Bruner (1986) -- is evident in the direction research on clinical reasoning has taken.

The study of clinical reasoning came into vogue among medical researchers in the early seventies. Most of these researchers have been cognitive psychologists or computer scientists. Interest in it has grown largely from the work in artificial intelligence to design computer programs which could model expert knowledge in a variety of areas. One of the first areas was medicine. Expert systems have been designed to allow computers to make intelligent clinical decisions, that is, to imititate the clinical decision-making of expert physicians. The more successful systems focused on narrow areas of specialization. For instance, one early and well known expert system, MYCIN, was designed

by an artificial intelligence specialist in the mid-seventies to perform clinical diagnosis in the medical area of meningitis. This system was as accurate at clinical diagnosis as competent medical specialists in the area (Feltovich and Patel, 1984:10). One major goal of these systems has been to provide teaching tools for students to help them become better clinical decision-makers.

Clinical reasoning, treated as applied science, is reasoning directed to the practical problems of prediction and control; it is a type of instrumental reasoning. It is assumed that the expertise of the professional is in her capacity to identify and put to use the best means for achieving given ends. Her expertise is not in identifying these ends (e.g. better health through cure of disease) but in her trained ability to achieve them. She is better able to predict the consequences that will follow from certain conditions (e.g. the disease process given current symptoms) and from particular interventions used to control the future (e.g. the effect of certain medications on the disease process). Instrumental reasoning is considered to be value-neutral reasoning about the best means for attaining given ends. Ends can be clearly and explicitly given prior to the reasoning process. While ends are identified by the values of the actor and are not considered something one can reason about (because they are subjective and value-laden), means can be strategically and neutrally identified for reaching those given ends. If clinical reasoning is treated as a

form of instrumental reasoning, it is presumed to be reasoning about how to best reach explicitly and clearly given ends.

Instrumental rationality derives from a positivist understanding of practical knowledge (Habermas, 1968; Schon, 1983, 1987). Schon describes this dominant paradigm of professional rationality:

Technical rationality is an epistemology of practice derived from positivist philosophy...(it) holds that practitioners are instrumental problem solvers who select technical means best suited to particular purposes. Rigorous professional practitioners solve well-formed instrumental problems by applying theory and technique derived from systematic, preferably scientific knowledge (Schon, 1987:4).

Instrumental rationality is associated with a particular form of explanation which subsumes (and in this way explains) particular instances under general laws. The presence of universally or probabilistically applicable cause and effect relations is critical for a strongly predictive practice where effects of interventions can be predicted and controlled. This, of course, is the powerful form of explanation most fully developed in the physical sciences. In explaining particular symptoms and signs by an underlying disease, the clinician is explaining the particular by the general, namely revealing how particular manifestations have been caused by general law-governed physiological processes. It is not surprising that this scientific model of explanation, when introduced systematically into medicine, produced a medical revolution.

The scientific model of reasoning fits a biomedical model of knowledge where, to quote a medical researcher who criticizes it:

training in situations of inpatient care and treatment tends to emphasize technical-scientific skills and the diagnosis of specific diseases; rather than the patient being viewed as a person, the person is viewed as a patient...Physicians are viewed as collectors and analyzers of technical information elicited from patients (Mishler, 1986:9-10).

That is, the whole enterprise of defining clinical reasoning as an applied natural science requires the separation of patient and disease, and with it the identification of disease as an unguided doing.

Story Talk and Narrative Reasoning

When therapists tell stories rather than provide medical accounts, they not only describe a different phenomenon -- an experience rather than a physiological process -- they also explain differently. This section looks at the explanatory structure of narrative.

The commonsense view of narrative might be put something like this. Stories describe action; they tell what happened. A narrative is a simple chronological account of an event or set of events, an account which tells how something came about by describing the linear sequence of actions which brought it about. While theories explain why something happened, narratives tell how something happened. Narratives yield descriptions because the answer

to a "What happened?" or a "How did it happen?" question results in a description, not in an explanation.

There is something right about this commonsense view. Certainly narratives, in providing detailed accounts of particular events, tell what happened and how it happened. Also narratives, being about particular events, seem to lack the ability to provide answers to "why" questions which we associate with explanations. This is especially the case when we assume -- as we often do -- that proper explanations are of a general type. To posit why something happened is to posit a cause and effect relationship which holds in some general (though not necessarily universal) way. Even if narratives tell how doing action X caused outcome Y it would seem that they do not reveal in a general way that X-type actions cause Y-type outcomes, thus explaining why Y-type outcomes occur.

Against this reasonable and common view that narrative is a type of description, not a type of explanation, two arguments will be made. Both of these arguments are elaborated in the following two sections. But they are insufficient arguments taken by themselves. To contrast narrative with biomedical talk as a mode of explanation is to capture only part of the power of stories as things to think with. In Truth and Method, Hans-Georg Gadamer objects that the human sciences are not merely different from the natural sciences in their mode of explanation and understanding but that the very notion of understanding as

method belongs to the natural sciences and is wrong-headed for the interpretive sciences. Natural science equates truth with method but understanding meaning, the business of the human sciences, cannot be similarly equated with the application of a method.

I focus here on the difference between narrative discourse and biomedical discourse as these reveal different modes of explanation, but narratives differ from scientific argument along other key dimensions than their explanatory schemes. One significant difference in these forms of talk is that scientific argument is intended to weed out or neutralize all personal commitments and feelings. But stories give form to feeling, and this is immensely important in communicating and considering the nature of experience. Stories take place on a double landscape, as Tzvetan Todorov (1977) has noted. Their subject matter is not just publicly observable action but an accompanying inner landscape which explores the feltness of life as lived. This is particularly apparent in much of the storytelling therapists and patients do about the clinical encounter and about illness experience. In examining the distinction between scientific discourse and narrative discourse, I only address one important dimension of the distinction which has particular relevance for clinical reasoning about illness experience.

The Causal Logic of Narrative: Explanation By Reason

Stories explain as well as describe what happens and they do so through a very different form of explanation than the covering law model associated with science (Hempel, 1942). Narratives explain what happens by linking a visible world of events and actions to an inner motivating world of thoughts and feelings. Such explanation, though initially built around the concrete case, is not necessarily as historically particular as it might seem. The answer a narrative provides to a question about why something happened, though at first glance seeming to merely identify a causal relation between a quite specific X and Y, actually points to a much more general social explanation. This is because intentions are not merely personal and cannot be divined by others unless they are culturally intelligible given the social context in which they occur.

Stories are about experiences, about a person or group of people trying to get something done somewhere and what happens to them and to others as a result. Stories about a clinical case depict it as something active. The clinical problem is shaped around commitments, purposes, desires which prompt actors (therapist, patient, family member, physician) to act in certain ways. The story describes what happens to them and others as a result of their attempts to deal with the disability in a certain way. The disability becomes a situation which belongs not only to the patient but to all those actors who enter the story, and it becomes a situation around which certain concerns and commitments

form, around which a future is being shaped. In characterizing disability in this way, certain features of the clinical problem become the target for intervention.

Disability as depicted in stories is personal. Not only does it belong to a person when a clinical story is told, the disability poses a clinical problem which generates an intervention process and this is also personally portrayed in a story. Stories show how therapeutic outcomes resulted from a set of individuals working together or sometimes at cross-purposes. They reveal how clinical outcome turn out the way they do in part because of what some concrete individuals did or neglected to do. When the therapeutic process is depicted in a story, the relation between an initial clinical condition and final clinical outcome tends to lose any quality of a simple, rational and straightforward application of a scientifically informed treatment plan; instead it emerges as a complicated and infinitely more quirky interactive process among any number of critical actors (patients, families, other staff) as they come to know each other, try to built up trust and manipulate each other for their own ends.

In the story told by a therapist to a researcher in an interview (and transcribed from an audiotape) one of the major clinical interventions she describes is an experience where the main event is among the patient, therapist and several physicians. The clinical process of the patient, which she describes elsewhere as a "roller coaster" of

progress and set-backs, is far from a physiological process. It is even far from an internal emotional process experienced by the patient. Rather it is the outcome of actions of a series of actors, as this story of the therapist's clash with several doctors illustrates. In this story the therapist has accompanied the doctors on rounds and they have come to the bed of one of her patients, who she has worked very closely with. This patient had shortly before had a respiratory arrest because something had gone wrong on his respirator. He was still quite weak and had barely been expected to live prior to the respiratory arrest. He was unable to speak, because he had a tracheotomy, and, by his own account, only the therapist could understand him by reading his lips. This is the therapist's story.

I'll never forget that Friday morning, after he (the patient) came back. Here we were in rounds -- I walked with the physicians in the morning and there were two physicians and two tending physicians -- and one of the tending physicians said, in the middle of a very casual conversation with him [the patient]. Imagine this guy lying in bed with his machine...People were standing around. I was on his right side. This physician said, very sort of out of the blue, "If you have another respiratory arrest, would you like to be resuscitated?" Essentially saying, "Do you want DNR [Do Not Resuscitate] or to do everything we can?" He immediately, his face lost color. He immediately looked at me like, "What is she talking about?" He knew what she was saying. It is unbelievable to me. He -- oh God it is unbelievable to me -- she was saying, "If it happens again what do you want us to do?" He was freaking out that it would happen again. "Oh God, is this going to be a regular occurrence?" The next two months he didn't know if that thing [unclear -- referring to the tube that connected him to the machine which had come loose and caused

the first arrest] would come off. I said, "Steve, the physician isn't saying it will happen again or that they wouldn't do everything they could." Then the head, another physician said, "Professor, let the doctor do her work." And I'll tell you, if it ever happened again to me, I'd do the same thing because I don't give a hoot.

Narratives accounts, whether elaborate written histories or casually told stories, share a certain strategy for giving an account of actions which renders them plausible and meaningful as part of a unity which one can describe as a single experience. A story can be thought of as a complex whole constituted by elements which are particular actions performed by some set of actors.

In rendering an experience plausible and meaningful, narrative accounts do not merely mirror what happened in some simplistic empirical fashion. Rather the storyteller selects out from the infinite possible occurrences those deemed relevant, orders those selected actions and unifies them so that they can be seen as significant elements of a cumulatively unfolding processual whole. Each element is significant because of its role in helping to bring about the final end, or telos, which constitutes the organizing 'point' of the story.

This cognitive work of selecting, ordering, unifying and rendering significant is done through a strategy of explanation which philosophers of history call explanation by reason (Dray 1980; 1971; Gallie, 1964; Mink, 1987). A narrative, if it is followable, describes actions in such a way that it allows the audience to infer the intentions

which prompted agents to act as they did and depicts those actions as creating the events which the story is about; it offers an explanation by reason. Actors, in other words, do things for a reason, to fulfill some purpose. In simplest terms, they have a certain aim in mind, they believe that doing a certain action will lead toward the fulfillment of that aim, and for that reason they perform the action.

This is a helpful but overly rational and overly conscious account of narrative explanation since narratives nearly always provide clues to a variety of tacit motives as well. Many narratives evoke a shadowy contradictory world of feelings and desires which never find clear expression in action. And of course the narrative may reveal the unintended course of events which followed an agent's actions, connecting intentions to outcomes in a paradoxical and ironic way. But generally a narrative will refer in some way to the conscious aims and purposes of actors, if only to discount or modify them.

Narratives thus not only describe what happened in the sense of giving a concrete account of a set of publicly observable events but also connect them to an "inside world of thought and experience (Collingwood, 1938)." A narrative gives an account of a set of actions, locates those actions in a situational context, and explains them intentionally. The story experience is explained as the result of a series of actions performed by agents. These actions are in turn

explained as a result of motivations (reasons) which prompted each agent to act as she did.

Even if one viewed narratives as mere descriptions, what they describe is action, not behavior. Because of the nature of action, such description necessarily involves interpretation and not a simple rendering of directly observable behavior. By naming an action one has already partly explained it.

An action, as a naming category, is distinct from directly observable behavior because it is intentionally defined. An action cannot be identified from outward appearance alone; it is also necessary to know what the agent thought he was doing in performing that behavior, that is, what he was intending to accomplish by so behaving. Merely to correctly identify a piece of behavior as the action it is requires this attribution of intentionality. Smiles must be distinguished from smirks, winks from twitches. Such basic classification is not possible without attributing to the observable behavior the agent's underlying intention.

Because the subject matter of narrative is action and actions cannot simply be described but must be connected to agent intentionality, even if it were the case that narratives merely described actions by stringing together action episodes into a temporal sequence, a partial explanation is provided in the very telling of a story simply due to the character of action. In narrative

accounts, the reasoning of the involved agents becomes an important causal factor in explaining how an experience turned out as it did, though often the reasoning process is an implicit part of the story. In a narrative, not only are the observable behaviors of actors depicted, they are depicted in such a way that the intentions motivating agents to perform their actions are either explicitly stated or can be inferred from the social context.

There is another level in which an action is explained by reason. Motivating reasons must be shown to be reasonable -- at least from the perspective of the agent. For many narratives, the reasonability of actions is unproblematic because actions take on their reasonable character from a well understood underlying sociocultural context. When narrator and audience belong to the same sociocultural context the reasonability of ordinary actions is obvious. The the more distant the normative backgrounds the more difficult the translation from story context to the context of telling.

The connection of behavior to agent intentions is, in fact, a rather complex interpretive task. Actions are only comprehensible in terms of the agent's view of why the behavior he performed was a reasonable thing to do. Correctly labeling an action such that it becomes a comprehensible action requires not merely categorizing it in terms of the agent's intentions, but categorizing those

intentions in a way which renders them reasonable in light of the situation in which the agent was acting and the beliefs and purposes he brought to the situation. The mere description of action involves a great deal of interpretive work just to place the outward, observable behavior within the appropriate intentional context. This interpretive work is analogous to our on-going interpretive efforts as actors when we infer the hidden intentions behind others' observable behavior by reference to our knowledge of them and of the social context.

Simply in order to give a plausible account of a set of actions constituting an event, even the casual storyteller will provide enough information to his audience to allow this sort of inference. The fact that narratives allow, in fact require, the audience to infer motives from actions is most apparent when the audience lacks the necessary understanding of background contexts and story characters to make this connection in a tacit way. The comparatively more complete stories occupational therapists told to outside researchers as compared to those they told one another or their patients indicates the need for more elaborate and complete narratives as the social distance between storyteller and audience increases.

In written stories, such as histories, ethnographic tales or literary works, much more information must be provided to allow the readers to make the connection between behavior and agent intentionality. Particularly in stories

dealing with unfamiliar social contexts, the intentional character of the actions must be much more explicitly drawn -- or skillfully evoked -- in order for readers to follow the story in a way which makes it comprehensible. This is because a social context provides a normative framework, a shared set of values and assumptions about what constitutes appropriate actions. When operating within a shared normative framework, it is not difficult to infer why a person is doing what he is doing -- at least at the level of rendering the action intelligible. When crossing social contexts which are considerably different, interpretive trouble arises. It becomes much more difficult to understand a person's actions in the sense of correctly identifying the intentions motivating him (and, especially, why those intentions are intelligible ones to have) because his beliefs and values are unknown or too strange to be compelling. The bare narrative of unfamiliar events, devoid of information about and evocation of background contexts will leave an audience puzzled. The narrator must supply this within the narrative as a kind of reader's guide to help the reader follow the actions and sufferings of the protagonists.

In stories about strangers and storytelling to strangers, what is highly implicit in much oral storytelling is made explicit. But whether explicitly drawn or taken for granted as in so much everyday storytelling, a story can only be followed when listeners can make connections from actions

to motives. The capacity to infer the motives of others may connect to our ability to tell stories about them. When therapists talked about patients, it was striking how much more able and interested they were to convey their experiences with patients they felt close to through stories. In those stories they conveyed the experience the patient had of the disability, as well as their experience in treating the patient. When describing their work with patients who they felt distant from, or who felt alien to them, their talk became much more abstract, more clinical or stereotypically descriptive.

In the two stories that follow, the same therapist talks about her work with two different patients, one who she felt she shared a background culture with, a girl about her age who "likes to wear my kind of clothes" and a Hispanic patient she had become very frustrated in treating. The stories emerged in the course of several interviews about her work with the Hispanic patient. During two successive interviews she interrupted her account of her difficulties working with the Hispanic patient to tell a story of the patient who was very much like her, and who was a great treatment success. The difference in quality of the two stories given below is striking. The first is a story about not being able to tell a story, about never getting a relationship started which she connected to never getting a treatment process going. This story conveys a dismayed puzzling about a patient whose motives, that is, whose

deeper commitments and feelings, she is never able to discover. The second story is vivid and dramatically powerful. It relates a patient's conversion experience, a moment of coming to trust the therapist. The story is told from an insider's point of view; the therapist is an insider to the patient and to the experience the story is about. The motivations of the patient are not displayed in an explicit way so much as evoked through the dialogue between therapist and patient.

The Incomprehensible Patient

I feel frustrated, because I'm an outgoing person and find it difficult to sit in a room with someone 45 minutes to an hour, three to five times a week and not say anything...I've tried even -- you know, you run out of approaches to "Hi, how are you today?" And, you know, "Is it hot out?" I mean, even little innocuous things like the weather and, if you say, you know, "Is it hot out?" "Yes." You know (laughs) I almost enjoy the distraction of the kids out here (referring to adjoining pediatrics room). As a matter of fact, even to motivate him we attempted, we had a patient who did not speak English really, at all. We, I tried to team them together and use his expertise. I felt, try to give him a good sense of himself by saying, "I know your English is very good. Could you help us working with this gentleman?...He wasn't able to talk with, I thought that could generate conversation between the two of them. Maybe he had a hard time

because, you know, maybe he felt uncomfortable with his English. That didn't work.

A few minutes after giving this account of what it was like to try to connect with this unfamiliar and uncommunicative patient, the therapist volunteered a contrasting story which follows about what good contact with a patient is like. These are more than contrasts in relationships to patients, however. They are stories about the difference between therapy which fails and the shape of a successful therapeutic experience.

The Girl Like Me

"If the patient doesn't trust, the patient doesn't give you their hand. And they're not going to understand that if you work through the pain, it gets better. I mean, [the Hispanic patient] aside, I had another patient who I'm finishing up treating on Friday and I said to her, we were talking about how we had developed a very, very nice relationship during the time I've been treating her. She's a real lovely girl, you know. She's a couple years younger than me, so there's a lot of, you know, and I said, "I, you know, you didn't feel that you could trust me, we never would have gotten past this." And, one day she sat there and cried because it hurt and I said, "I didn't think you were going to come back." She goes, "well, I wasn't, but, then you were right, you know. One day, I woke up and you were right and I knew you weren't lying to me." So I was able, but every time she had more subsequent pain she knew, "OK, I remember Joanne [the therapist]

told me that and look. It worked on this finger. So I know it will work on this." And slowly she was able to trust me and work though it. And she's got a pretty functional hand and her hand was very bad, awful. So you have to learn to trust and you have to have some level of comprehension of the illness.

In the full sense characterized by Geertz' (1973) term "thick description," narratives explain why a final outcome was reached by showing how the agents acted, why those actions were contextually intelligible, and how they were reasonable responses to previous actions and thus appropriately described as part of the same sequence.

A full explanation of an action's intelligibility turns out to not merely answer the question "Why was this action done?" but to depend on an account (implicit or explicit) of the practical reasoning which informed the intentions of the acting agent. Any account of such a reasoning process which explains why an actor thought it made the most practical sense to intend one thing rather than another must describe the relationship of the action to its surrounding action context. The narrative answers the question "Why did it happen?" by revealing the interplay of practical reasoning, context and action.

Narratives Move Through Time: Explaining Why By Showing How

Kenneth Burke has a small chapter tucked near the end of A Grammar of Motives called "The Temporizing of Essence."

There is a "double vocabulary for the expression of essence," he writes. By essence Burke means an underlying or initial causal term. One vocabulary is logical, the other temporal. That is, "the logically prior can be expressed in terms of the temporally prior, and v.v." (1945:430) In Burke's vocabulary, an argument is a logical expression; a narrative (a drama) is a temporal one. When occupational therapists tell stories, they are temporizing essence. They are identifying what they see as essential, as causally basic, through the temporal structure of narrative. In a story the causal logic works so that one thing after another means one thing because of another. This is why the ending is so important. It names what the story explains and identifies earlier narrated events as causally relevant in bringing that ending about.

Clinical problems characterized in stories are construed as processual and dynamic. Stories depict the disability not in a static way, as a medical condition, but as a contextually responsive process -- an unfolding succession of events. In giving a diachronic view of disability, stories also give a particularizing view of it. The structure of a story, its sequential logic, is context-dependent. The story's structure depends on the unique, unfolding set of events that crystallize around a particular patient. So while an initial assessment, treatment objectives and treatment plan may look the same from patient to patient, a treatment story will not.

For instance, doing relaxation exercises with one patient will -- when looked at as a story -- have a different structure, a different beginning, middle and end, than doing relaxation exercises with a different patient. The relaxation techniques may be more or less the same but the reasoning behind using them may differ depending on the situation and a story will bring this out. Doing relaxation exercises with an angry patient may be a way of calming that patient down in the hope of putting the patient in a cooperative mood. Doing relaxation exercises at another time may be a way of helping a dying patient cope with the stress of impending death. If relaxation exercises are looked at as an example of a technique developed to address certain physiological conditions, this difference in meaning does not become apparent. But to ignore this is to ignore the reasoning process the therapist is using in deciding to use a particular technique at a particular time. It also overlooks the subtle changes in technique as the therapist modifies it to suit her present purposes. Even when techniques and overall goals are the same -- doing relaxation exercises with cardiovascular patients to teach them how to handle stress -- the particular meaning of the exercise will differ from patient to patient because their illness and their experience of stress holds personal significance shaped by their particular life experiences. Because stories are not only about what happened and how it happened but how it felt when it happened, the story's

shape, its dramatic structure, depends on this uniqueness at the level of meaning.

In ordering actions in a (more or less) chronological sequence, narratives do not simply list those actions but unify them. The apparently simple sequencing of actions found in any ordinary story involves more than straightforward cataloging. Stories have a 'point.' There is unity to a story and this means that a narrative is more than 'brute sequence,' it orders the actions it describes into one whole. Put differently, actions in an narrative sequence are cumulative; they add up to something.

This underlying cumulativity is especially striking in cases where every event is, biomedically speaking, a move backward but is narrativized as progress, as in the following story told by a patient with bone cancer who was deteriorating rapidly. In many of the stories told by both therapists and patients, it was evident that each worked very hard to try to see the therapeutic process as cumulative in a good sense, that is, as progressive. The negative cumulativity which was so often the nature of illness, the inexorable movement toward death, was often underplayed or ignored entirely as narrators sought to find some purposes or goals toward which they could work, where they could mark a hopeful path. Their stories were often built around these goals.

In the following story, the progress of the cancer through the patient's body necessitates a series of

operations. The operations are likened by the patient to "hurdles" and through this athletic imagery, the patient tries to convey a movement through an illness which she will somehow overcome. Her need to wrest meaning from her illness experience and to find a place where events lead somewhere hopeful is painfully illustrated in the story she tells about the series of operations she had recently undergone.

Well, I was scared to have that operation. Like I said, I had a tumor on my hip that was pressing on my spine. They operated on that (voice fades almost totally) and I got scared because that I'm scared of operations. I got scared but I got over that. And then another hurdle and they operated on my breast. I had breast cancer (whispers) and then I got scared I'm gonna be operated on. And then I went over the second hurdle, right? And then the third hurdle I had alright, they operated on my shoulder (whispers) because it was broken here. So I got over that. Each day I got over, I was scared but each day I made pro uh improvement, you know what I mean? Every day I am trying to improve little by little. It takes a while but at least every day you are getting something done. That's the way I feel. You get a little bit done and the more you get done, the less you have to do. Right? That's already what you have did before, that's already done, right? That is the way I feel inside.

The cumulative property of narrative is connected to the cumulativity which is part of doing something. Cumulativity is a feature of action, not merely of the narratives which explain it. The agent's interest in effective action gives to action sequences an internal continuity. Actions, as responses to prior actions, build on what has gone before. This makes of action a cumulative process. Because an agent takes previous actions into

account in deciding how he will act, his action is not merely another link in a random chronological chain but is a conscious addition. Even in the story told by this dying cancer patient, she focuses on her fear of illness, and especially of surgery, which allows her to tell a story that conveys a growing courage to face the devastating 'hurdles.'

In emphasizing a cumulative unity underlying a chain of actions, narratives are not simply imposing a teleological unity on what is otherwise brute sequentiality. Rather, as Olafson (1979) carefully shows, agents have their own interests in unifying action sequences to accomplish their own ends. Effectiveness entails this concern for cumultivity because it is almost always the case in practical action that the agent's primary purposes can only be achieved through performing a series of actions over a relatively long period of time. Successful achievement of ends depends not only on the agent's actions but on actions of other agents as well.

Agents then, for their own purposes, intend that their actions will be a coherent response to what has gone before. This is true in the most individualistic case, assuming agents have no collective purpose. In the case of collective action, each agent attempts to add to what has been done in such a way as to achieve collective purposes.

By placing an action within its action sequence, narrative shows how the actions maintain internal continuity with actions that precede and follow it. The unity of

narrative as a whole accrues, in part, from the continual building of actions on previous actions. By describing actions as part of a sequence, narratives not only show the intelligibility of actions but also show how they contribute to a process which unfolded in such a way that the final event or the overall experience was a cumulative outcome of that historical process.

The notion of cumulativity, like that of intelligibility, points out that actions cannot be treated as isolated events but must be understood contextually. Actions often cannot be meaningfully isolated from other actions because the agents themselves, in doing what they do, take into consideration the situational context as it has unfolded thus far in assessing how they can most effectively achieve their purposes. This is a very ordinary feature of practical reasoning. Agents construct their intentions in light of both what they want to accomplish and how they might best achieve their goals given what has already occurred.

Narratives emphasize the teleological character of social actions through a principle of selection. Actions undertaken by agents unrelated to the purpose or experience which is the 'point' of the story are not part of the narrative sequence and cannot coherently be included. They have no logical place within it. Even simple narratives express an order more dramatic than life-as-lived just because the requirement of teleological connectedness is a

selection criterion for the narrator. The storyteller wants to show how something came about. Of course, this something need not be a goal. It might be a tragedy quite unintended and unwished for. Even so, the events that make up the story will be linked to the agent's motives and also to the consequences, however little the agent ever meant to bring those particular consequences about.

Like practical action, stories are ordered by the endings. But because the story is a backward glance on an experience, the ending of the story may not be the ending the storyteller, when he was living the experience, ever meant to bring about. While particular actions are given meaning (in fact are identifiable as the actions they are rather than others) by their role as means to the identified endings, these endings may not be those the agent had in mind. Very often, the real drama of the story is just this difference between the ends the agent had in mind and the ending his actions in fact brought about.

Personal narratives rarely impose a teleological order on events that is not connected to the intentions of agents, but they do bring the teleological ordering of practical action into sharp relief. Unlike real life, where many different actions occur within the same temporal and spatial context and where only some have a bearing on any one identified ending, stories select out from a myriad of actions those which bear on the outcome which serves as the ordering 'point' or 'moral' of the story. Because of this

stringent selectivity feature, narrative is described as organizing events not through abstraction but by a kind of pure consistency of presentation Kenneth Burke calls 'idealizing.' Idealization is "the elimination of irrelevancies (Burke:1966)." Or, as Roland Barthes puts it, nothing is wasted in a story. It admits no noise.

The following story, told by a patient about the car accident which resulted in his spinal cord injury, illustrates the economic selection of relevant events to bring out the point of the story. He mentioned earlier in the interview that the cause of the accident was "sheer stupidity." He later told the story of how it happened, underlining the "sheer stupidity" of the incident. His story also illustrates the difference in perspective between himself living the experience, when his goals, such as they were, were directed to hurting others, and his perspective as narrator, where he is the one who is hurt.

First thing I remember, all I remember about the accident, the place it was at. I had gotten there real late and a guy that was there had hit my car with a baseball bat. And I got pissed off and I left actually. And I came back later. I was going to shoot him or do something, I don't know what. I came back and everybody was gone. So I left and I was pissed (?unclear on tape). I took the long way home. Last thing I remember is pulling out of the parking lot and the next thing I remember is waking up in the hospital in Rhode Island and I was in a stretcher or something and I was all packed up. And I looked up and I saw my mom. She was crying. And I said, "Mom, what happened?" And she said, "You had a pretty bad car accident." And I looked up and I saw my father. And I said, "Hey Dad, I done screwed up this time."

One of the most important senses in which narratives may be said to explain as well as depict experience is by revealing the dialectical interaction between agent actions and contextual structures and showing how this dialectical interaction evolves in such a way as to achieve some ending. The narrative telos is both distinct from and an extension of the purposive actions of the agents themselves. A story extends or enlarges the meaning of the actions it recounts by showing them to be describable as episodes within a larger narrative. The narrative does not simply assume the perspective of the storyteller or key character. Narratives often locate the meaning of actions in terms of structural or historical contexts, in or in juxtaposition to the variety of meanings those actions hold for some set of actors. Thus the intentions and beliefs of the protagonist will not necessarily coincide with the deeper meaning of his actions as conveyed by the narrative.

Deeper meaning is gained through assuming a different, generally a broader vantage point than that held by the actor who set the events in motion. This is the perspective the narrator offers on the events. In personal experience narratives, the narrator is generally the main protagonist in the story. The difference in perspective is the difference created by the narrator's privileged retrospective glance which the protagonist is deprived of. This is the case even with personal storytelling, where the narrator is also the story's main protagonist. Just having

lived through something, having seen it to its conclusion, and having stepped outside of the action as spectator in order to tell a story about it, often gives the narrator a broader and more critical perspective than she had when she was living the experience. Narrative explanations and immediate agent explanations of the same events will often differ because of this difference in vantage point. The narrator always stands at comparatively greater distance from the actions she recounts.

Narratives describe actions by placing action sequences within a set of larger contexts. Depending on the narrative, these contexts may include life histories of agents, social practices, formal institutions, or broad cultural traditions which provide the background in terms of which agent intentions are formulated and become intelligible to others.

Narratives connect particular actions to underlying social traditions and practices by a process of what Alisdair MacIntyre (1981) describes as "embedding." Narratives explain particulars by embedding them within larger social wholes. Particular actions are placed within an immediate interaction setting -- a longer chain of actions which constitute the episode (or series of episodes) that make up the story events. These episodes are in turn made understandable by reference to personal histories and social traditions. This embedding at the level of personal and cultural contexts is often quite sketchy, especially in

ordinary oral storytelling where listeners so often share similar social contexts with the narrator and are only provided clues in the story which they are expected to fill in. In written narrative histories, at the other end, where the personal and cultural contexts surrounding the recounted events are not presumed to be shared by readers, much of the explanatory work consists precisely in the embedding of the narrated events, the "drama," within longer chains of actions that constitute social traditions and practices.

Sometimes therapists recounted dramatic or clinically significant episodes with their patients in a way which revealed how they were significant in a larger clinical process. They drew attention in their stories to the larger significance of the story events. This was especially the case in "taking a risk" stories, a popular genre among the therapists. The following story is one of these. The storyteller is a therapist who describes an upsetting fight she had with one of her spinal cord patients. She described this fight as a turning point in their work together and in the patient's whole perception of his disability, embedding the fight episode within a much larger temporal frame and assigning the significance of the fight in light of the larger clinical story of which it was a part. It is not unusual for a whole story to be depicted as meaningful in terms of a much larger and largely untold story. The narrated events are shown to be significant

because of the part they played in a story which may never be told but which is clearly alluded to in the storytelling.

I had a talk with Rob (the patient), telling him that basically I was very upset with him and he wasn't working up to his potential. That he was acting like a much more severely disabled person than he was. And that I didn't feel like he was utilizing our services, and that basically when he went to this chronic care facility, he could either make it or break it. He could either be a very dependent person and accomplish absolutely nothing and maybe have people do things for him, and maybe have his pain get worse because the strength that he had he wasn't utilizing. Or he could take what he had and really go with it. So...I told him I wasn't proud of my work with him and that I hoped it wasn't indicative of my work with other people on the floor. It was pretty harsh, considering I really took a chance on our relationship there and blasted him out and put the responsibility back on him. I didn't want him blaming me on his disability, which it would be easy to do because I hadn't taught him a whole lot of anything. And he was certainly able to do more. And so I put the responsibility on him, and blasted him out on the mat one day. And the next day he came up and I was really afraid of what he would say to me. And he apologized and said he was ready to start work and that he wanted to make it at the nursing home. And so we started ADLs which it's like 5 months post, and for a C5 that's ridiculous to wait that long. He started to brush his teeth and feed himself, and so he still whines about it, but he is starting to move on. He was going to come to therapy quite regularly, and the responsibility was on him and he did very well with it. He felt good about what he was achieving and was expressing it to everybody on the staff about what he was able to do for himself. And he started to integrate with the floor a little more and his social being kind of emerged and he was smiling a lot more and feeling a lot happier.

In embedding an episode within a larger framework, the therapist alludes to a much larger time slice of which this experience is one key episode, e.g. a patient's one year therapeutic process, but she evokes in her language the much

broader professional culture of which her interventions and her frustrations are a part. The moral language in which she remembers "blasting him out" reveals the cultural world in which this event occurs, a world of rehabilitation where doing for yourself is very highly valued. She tells him he "wasn't working up to his potential," wasn't "utilizing our services" and was "acting much more severely disabled...than he was." She reinforces the lesson that doing for yourself is fundamental to successful rehabilitation in the very way the story is structured.

The story is an object lesson about the very same moral points she makes to the patient in the narrated episode. For she has told a success story where the patient is confronted, recognizes that he has been in the wrong, and changes his ways. He begins to do the work in self-care that he should have done months earlier and as a result, he becomes a much happier, more social patient. "He still whines about it, but he is starting to move on." Lack of will and cooperation is linked to failure and the potential for more pain; working hard on self-care activities is linked to personal pride, happiness and increased social integration. "His social being kind of emerged and he was smiling a lot more and feeling a lot happier."

Whether sketchily or meticulously drawn, narratives depict the actions they describe as part of a world (Ricoeur, 1978) and that world consists of the larger personal and cultural histories in which the story events

took place. But the relation between the drama of the story, that is, the particular events which comprise it, and the background cultural and personal contexts which make it intelligible, is potentially always a dialectical relation. An action can have a potentially active, even transformative role vis-a-vis a social tradition. Any particular episode may modify the narrator's perception of the traditions which make it up. Even if the story is not about a change of perception, the events of a story, especially if it is a vivid story, emerge as more than mere instantiations of social symbols and social systems. Not only does the background context explain the intentions and outcomes of agent actions, but in recounting what agents were intending and experiencing within the context of background traditions and practices, the social context is explained as an outcome, as a creation, of actions. The reframing stories recounted in Chapter Nine often have as an underlying lesson the potential of a powerful event to throw into question a whole network of background values, assumptions and practices.

Narratives reveal the implications of the intentional actions either as instances of enduring sociocultural contexts (Geertz' (1973) essay on the Balanese cockfight is an excellent example of the revelation of structure through a narrated episode) or historically, by showing the implications of the narrated events in light of changes brought about in a social structure (many traditional

historical narratives exemplify this). Or, somewhere between the two, a story may reveal and illustrate strongly held cultural meanings and yet at the same time reveal an unease with the settled view of things, a sense that perhaps something has been left out.

Stories are a form of discourse which have the peculiar property of being both extremely particular and extremely general at the same time. While Bruner is right to emphasize the drive toward particularity in narrative when he distinguishes it from propositional argument, Burke perhaps sees an even deeper truth when he attends to the symbolic nature of the "dramatistic" languages. Powerful narratives concretely, metaphorically point toward general truths. While it may seem that stories just are about singular experiences because they individualize experience. This is rarely, if ever, the case. The particularity of stories make them powerful objects to think with. This is evident among the occupational therapists in listening to their storytelling sessions at meetings or with patients. When a therapist tells a story about some particular clinical event, she is almost always after something she considers essential or, at the least, of general interest. Other therapists will follow, conversation become a series of one story after another. In this serial storytelling, therapists easily see themselves by analogy in a story that was just told by someone else. These highly singular accounts -- and the better the story the more unique the

characters and experiences become -- are no barrier to generalization, though generalizations may not be stated abstractly but are more likely to be built, particular by particular, into a thematic vividness. The story functions as a concrete generalization.

In telling stories, therapists offer clinical explanations which emphasize a certain practical "know how" required to adapt general strategies, rules, theories, and scripts to the idiosyncratic contingencies of the particular situation. Stories explain why something happened through a processual description of how it happened. This is a significant addition to social explanation because to know why something happened in the scientific sense of isolating generalizable causal relations among isolated elements is often insufficient for understanding how to achieve the desired outcome in future situations which will be similar and yet significantly different. The critical importance of answering "How?" as well as "Why?" lies in the nature of social reality itself, namely that each situation we find ourselves in is in important respects new. Therefore knowing how to bring about outcomes we desire requires knowing how to subtly adapt and modify our actions in light of the next context.

Of course the physical world which provides the paradigm for scientific reasoning is also contextually unique as well but for purposes of prediction and effective control, this uniqueness can generally be ignored. Such is

not the case in the social world. Acting effectively in the social world requires much more attention to context-dependent features of each situation we are in. A smile to person P in situation S will increase trust, signal friendship, but a smile to person P in situation R (when he has just tried and failed to eat his lunch with an adaptive fork) may be interpreted as sarcasm. The same actions will lead to quite different outcomes, will even communicate quite different meanings, depending on the context. Since effective action requires contextual knowledge, the effective actor is one who knows how to "read" the contexts he is in and adapt his actions accordingly. This practical ability is built on an understanding not only of certain context-free general (i.e. cultural) maxims of the form: X generally causes Y but on the capacity to imagine what the interaction of action X in circumstance C is likely to achieve. The effective actor is able to read new situations and construct models or scenarios which project what is likely to happen if he acts in one way rather than another. Because effectiveness depends on the ability to read and respond to specific contexts with appropriate actions, what the agent really needs to know about a particular event is not merely why it happened but how the causally effective actions interacted with a particular context to provide the outcome they did.

Practical reasoning or "know how" differs from propositional reasoning or "know that" (to borrow Gilbert

Ryle's (1949) terminology) precisely because it involves the practical wisdom required to innovatively apply knowledge about past contexts to new settings. "Know-how" in the sense used here involves more than drawing on one's tacit knowledge if tacit knowledge is understood, as in Peter Winch (), as knowledge about tacit rules. The distinction between know that and know how is not the distinction between a formal rule system which people espouse and a tacit rule system which they actually follow. This distinction does not address the practice problem of the continual innovation needed to successfully act, whether such knowledge is held tacitly or explicitly. Because the practical reasoning involved in knowing how to effectively carry out a practice is innovative, the practitioner needs explanation of social action which models such conceptual innovation.

The following two chapters consider the role of story in clinical practice from a very different perspective. I turn from the stories therapists and patients tell to the stories therapists project and try to create in the context of their work with patients. I also explore very different functions of story than as an explanatory scheme. I examine story-making as a form of sense-making but not primarily as it is linked to creating intelligible explanations of clinical experiences. Making sense narratively takes on a quite different meaning, referring to the need therapists

(and sometimes patients) have to create significant, personally powerful experiences out of therapeutic activities.

EIGHT

THERAPEUTIC PLOTS

In each new situation, the therapist must answer the question: What story am I in? To give an answer is to make some initial sense of the situation on which the therapist can act. Discovering what the story was might be helped through analogy. Therapists might say to themselves, How is this situation like others I have been in? Or, put narratively, How could I retell, in a new way, an old story? As a way of framing a practical decision about what to do, stories give an account about what has happened which gives a view of which actions make sense as appropriate next steps. The descriptions therapists made of contexts in terms of which they decided what to do next were very often stories. Stories place events within a temporal context and in order to know how to act therapists often needed a historical sense which located them in relation to some past and some anticipated future.

This need for narrative framing as a guide to practice is suggested by a nurse quoted in Benner's study of clinical reasoning in nursing. This nurse, who works in an intensive care nursery, describes what she considers the most essential kind of thinking she wants her newly graduated students to evince at the end of their three month affiliation with her.

To my mind, moving the child from Point A to Point B is what nursing is all about. You have to perform tasks along the way to make that happen, but performing the task isn't nursing...I wanted to see a light going on - - that OK, here's this baby, this is where this baby is at, and here's where I want this baby to be in six weeks. What can I do today to make this baby go along the road to end up being better? It's that kind of thing that's just happening now. They're [her student nurses] just starting to see the whole thing as a picture and not as a list of tasks to do (Quoted in Benner, 1984:28)."

The process of treatment encourages, perhaps even compels, therapists to reason in a narrative mode. They must reason about how to guide their therapy with particular patients by images of where this patient is at now, and where this patient might be at some future time when the patient will be discharged. It is not enough for the therapist to know how to do a set of tasks which have an abstract order. Therapists need to be able to picture a larger temporal whole, one which captures what they can see in a particular patient in the present and what they can imaginatively anticipate seeing sometime in the future. This picturing process gives them a basis for organizing tasks.

The nurse quoted above is interesting because she emphasizes both the imagistic character of what the clinician needs to know, contrasting it with the knowledge of tasks, and because she emphasizes the context-specific nature of those images. The therapists in this study spoke in a similar language about picturing the patient, and especially about having "future images" of who the patient

could be. They felt that what they often held most vividly in mind when treating patients were not plans or objectives but quite concrete pictures of the potential patient, the future patient. One pediatric therapist said, "You know when I treat that eighteen month old child, I see the child at three, then I see the child at six, learning to write her name. I mean I have all these pictures in my head." They described their difficulty when the patients or their families held different images of the future their own dilemma about the extent to which they should give patients or families their own pictures, which were often more pessimistic. (Therapists were often in the difficult position of trying to give hope to a patient while also gradually letting the patient know a very dark probable future. Patients and families were often extremely depressed about conditions which were worse than they imagined.) Therapists spoke of these images as necessary but dangerous, necessary because therapist and patient needed some guiding pictures, dangerous because these could blind therapist or patient to what was realistically possible.

Therapists in the study were also, like Benner's nurse, conscious of the need to create quite specific images which were appropriate to a particular patient. General treatment goals devised from general knowledge of functional deficits and developmental possibilities were insufficient guides to practice, in the therapists' view. They worked with much

more concrete guides, images and stories which were the "wholes" that allowed them to selectively choose what aspects of their knowledge base were appropriate to the situation. These images were organized temporally, teleologically, giving the therapists a sense of an ending for which they could strive.

Medical histories are also organized temporally and also provide therapists a larger temporal context of past and future in which to locate their interventions. The particularly narrative character of this temporal placing is prompted by the therapists' need to understand not only the history of the physiological body but to locate their interventions within a history of illness experience and of the on-going clinical experience.

Even if the therapists' general goals remained fairly constant from patient to patient or from session to session with the same patient (e.g. increase range of motion in a hand patient or improve trunk balance in a stroke patient) the concrete embodiment or playing out of those goals depended on the context. Increasing range of motion for a working class young male hand patient who had a good relationship with the therapist did not necessarily translate into the same set of therapeutic actions as increasing range of motion for a hand patient who was a worried middle-aged physician who was not sure the therapist knew what she was doing, to pick an extremely simple case. The therapist was much more likely to be aggressive in her

therapy with the first than she was with the second. The nature of the injury itself might be quite similar between the two cases but if the patients' interpretation of the nature of their injury and their view about the role of therapy in treating that injury were different, therapists modified their interventions accordingly.

The structure of treatment as "doing with" the patient prompted therapists to construct and revise their clinical stories. This revision often took a particularly narrative form because it was so often created by a surprising response from a patient that, in turn, set the therapist puzzling about the patient's motivations for acting in that unexpected manner.

Therapists were continually interpreting the intentions of their patients. A typical case was of the sort where a patient resisted working on an activity the therapist had planned and the therapist then began hypothesizing about the intentions of the patient which triggered the resistance. To take an example from field notes, a therapist brings a chronic respiratory patient into the treatment room. The patient is on a ventilator. The patient becomes extremely upset and says she wants to go back to her room. The therapist must hypothesize what the patient means by this. Is she becoming anxious about her breathing? Is she uninterested in the therapy sessions they have been having? Is she angry at the therapist for not taking her to chapel the day before when she requested it? Is she asking that

more attention be paid to her? The interpretation the therapist makes of what the patient is intending by saying "I want to go back to my room" will directly bear on the intervention she makes with the patient.

In the session just related, the therapist made a series of interventions to try to calm the patient down. When she discussed these later in interview, she described how different interventions were based on different interpretations of what was creating anxiety in the patient. As the therapist described these interpretations in interview, she often gave different bits of a longer story she had constructed about this patient's anxiety attacks on coming to therapy. The therapist drew on aspects of this longer treatment story of her several month acquaintance with this patient in trying to assess the immediate intentions "behind" the patient's responses in this particular session.

Schon's (1983, 1987) notion of expert reasoning as a form of "reflection-in-action" is helpful in understanding this process of "conversation" in which each "move" the therapist makes results in a new situation (produced here by moves from the patient) and successive therapeutic moves must take account of that new situation which has been created. On-the-spot reasoning is particularly required when earlier moves result in some surprising result, as for instance when the patient responds differently than the therapist anticipated. The surprise necessitates an

immediate reflection about what to do next since any earlier plan will not have considered the surprising response. The therapist who faithfully follows an earlier treatment plan in the face of surprising results will be unlikely to provide effective treatment.

Narrative Emplotment

Clinical reasoning among the occupational therapists was so often narrative in character not only because it concerned assessing motives behind observable actions but because it concerned construing and connecting clinical actions into a larger, cumulative process -- making a larger story out of a series of on-going actions. This is the task of emplotment (White, 1987; Ricoeur, 1983).

Therapists worked to create significant experiences for their patients because if therapy was to be effective, therapists had to find a way to make the therapeutic process matter to the patient, to make it meaningful to that patient. Each therapist faced the problem of constructing therapeutic activities which were meaningful enough to elicit the patient's active cooperation.

The patient had to see something at stake in therapy. Why should he bother to try? If the patient did not try, therapy did not work. Partly, this was because therapists required patients to do things in therapy that patients did not necessarily feel ready to do or believed worth the effort. But more important, the patient had to become

staked because he had to 'take up' the therapeutic activities. Therapists were with patients only a short time, often a few weeks or less. They might teach a few skills or improve the patient's strength a bit but generally their effectiveness depended on using therapy as a catalyst to help patients begin to see how they might "do for himself" even when the therapist was no longer there.

An example of this is a therapist who was working with a spinal cord patient, being taught to move checker pieces using a mouthstick. It is not enough for this patient to learn to move these checkers pieces for the therapy to be successful. He must also take up a point of view that comes with being committed to the tremendous concentration it takes to perform this trivial task -- trivial, that is, if you are not a spinal cord patient. He must absorb a vision as well as a few new skills. The therapeutic time together itself has to provide a kind of existential picture of how he might live his life in the future with his disability. The therapy will not ultimately work, not in any catalytic way that the patient will take home when he leaves the hospital, if he is not strongly committed to the process. Without experiencing his treatment activities in a from a committed stance, he won't see any future in them. He won't see the point.

If the patient is to become committed to the therapeutic process, both patient and therapist must share a view about why engaging in any particular set of treatment

activities makes sense. Coming to share such a view requires the therapist and patient to see how these treatment activities are going to move the patient toward some future he can care about. Such a view is not reducible to a general prognosis or even to a shared understanding of a treatment plan. Therapist and patient must come to share a story about the therapeutic process, must come to see themselves as "in the same story." This is a kind of future story, a story of what has not yet happened, or has only partly happened, an as yet unfinished story.

How is such a story constructed? Generally not through any explicit storytelling. Rather it is constructed through sharing powerful therapeutic experiences which point to a prospective story -- a path therapy will take. Clinical reasoning involves seeing possibilities for creating significant experiences in which the patient will be staked, making moves to act on these possibilities, responding to the moves the patient makes in return, and, if therapist is lucky and can get something started -- can get the patient 'in' -- building on the experience by showing the patient a future in which this therapeutic experience becomes one building block. Or, in the language of narrative, the experience becomes one episode in a much longer story. The therapist tells the story not in words but in actions that create an experience the patient can care about.

The clinician's narrative task is to take the episodes of action within the clinical encounter and structure them

into a coherent plot. A plot gives unity to an otherwise meaningless succession of one thing after another. Quite simply, "emplotment is the operation that draws a configuration out of a simple succession (Ricoeur, 1984: 65)." What we call a story is just this rendering and ordering of a succession of events (say, a series of treatment activities) into parts which belong to a larger narrative whole. When a therapeutic process has been successfully emplotted, it goes somewhere, it is driven and shaped by a "sense of an ending" (Kermode, 1966). To have a (single) story is to have made a whole out of a succession of actions. Those then actions take their meaning by belonging to, and contributing to, the story as a whole. A story, Ricoeur writes, "must be more than just an enumeration of events in serial order: it must organize them into an intelligible whole, of a sort such that we can always ask what is the "thought" of this story (Ibid.)."

Narratives give meaningful structure to life through time. The told narrative builds, to borrow from Ricoeur's argument, on action understood as an as yet untold story. Or, in his provocative phrase, "action is in quest of narrative (1984: 74)." Therapists use in their quest to transform their actions and the actions of their patients into (as yet) untold stories.

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This can be translated into more familiar clinical language through a narrativized reading of treatment goals. When an occupational therapist makes an assessment of the

patient, the outcome is a set of treatment goals. Goals, to follow Ricoeur (1984) are not predictions of what will happen but express the actors' intentions of what they prefer happening and intend to try and bring about. These goals express a therapeutic commitment. They capture what the therapist intends to accomplish over the course of therapy. Treatment goals are an expression of what the therapist has committed herself to care about with a particular patient.

As occupational therapists have argued (e.g. Rogers and Masagatani, 1983; Rogers, 1985), a primary task of clinical reasoning is the individualization of treatment goals. To speak narratively, individualization involves constructing a particular story of the treatment process rather than relying on a generic line of action which strings together standard goals and activities.

The remainder of this chapter considers the conception of emplotment in occupational therapy through two cases. These cases, taken by themselves, paint a rather skewed picture of how therapists create stories "in action" as they work with their patients. They portray therapists as improvisational artists, craftily handling the odds and ends of a patient's actions and the accidents of the clinical situation to produce a well wrought plot. The following chapter, which has to do with how this story-making process goes wrong, is a necessary partner. For if stories are

about acting and suffering, then this chapter tells stories which mostly show therapists acting and the following chapter tells stories about therapists suffering.

Or, to follow another line of narrative theory, if a story incorporates the multiple perspectives of narrator, characters and audience, this chapter construes clinical practice as though therapists were the narrators, confidently plotting a story out of individual clinical events as though they knew the ending and the narrative shape they wanted those events to assume and had the power to make their wishes come true. The case examples here are about therapists configuring clinical events, masterfully steering their own actions and the actions of their patients so that a coherent, cumulative and well formed beginning, middle and end unfolds in the course of a clinical session. This well-formed narrative structure has not only a formal elegance and a pragmatic result (it gets the therapist somewhere), it carries moral weight. Therapists have moral messages they want to convey to their patients (often this is called "patient education") and they try to shape clinical sessions so that these messages "tell themselves" through the experiences they provide patients.

The narrative perspective changes radically in Chapter Nine. Therapists are no longer narrators with their images of the ending well in tow. Through difficult and unexpected turns in the therapeutic process, therapists become readers of the story which appears to unfold in front of their eyes

as though of its own making. Having lost their place in the story they were trying to play out, they struggle to understand what has gone wrong and, sometimes, what another story might be that could substitute for the one they have had to abandon. Here we see the clinical situation presenting puzzles, dilemmas, impasses in which there is no graceful exit. Therapists, like the hermeneutic reader confronted with a foreign text, are presented with a baffling clinical context in which previous tricks and maneuvers, stories and theories are not helping them find their way about. They are not charmed by the foreignness of the text but frustrated and angry -- at best intrigued. Often things are just muddled.

Sometimes things stay muddled, as some of the case examples in Chapter Nine describe. Therapists find themselves with prejudgments thrown into question but without any subsequent "widening of horizons." No meaningful sense can be made, except some unsatisfactory, uneasy and ad hoc stigmatizing of patient, family, or "the system." But sometimes the therapist's confrontation with the puzzling clinical situation provokes a revision of therapeutic perspective. This revision may even be of such a deep sort that it is fair to declare the clinical encounter an "experience in the emphatic sense" as Gadamer says. This is when the collision between the therapist's prospective story and the clinical experience that actually unfolds leads the therapist to a deep reconsideration of

values which have implications beyond the particular clinical experience that first triggered the revising.

In Chapter Eight, things go well for the therapist. There is nothing rote about the clinical encounters described in this chapter. Therapists are constantly on the move, looking for opportunities, building on whatever happens to lead the session in a direction she believes is meaningful. When things go well, therapists look like artful shapers of clinical time, creating therapeutically meaningful events out of clinical activities. Most therapists I studied worked to create therapeutically significant experiences for the patient. From the therapist's point of view, experiences were significant not only when they provided the patient time to develop skills but when they carried rhetorical force, when the therapist has conveyed a message through the therapeutic effort. Significant experience was meaningful in the sense that White refers to, when they carried moral messages which the therapist wanted to convey to the patient.

The clinical examples in this chapter look at storymaking as a rhetorical strategy therapists use to create experiences for their patients which give the patient a way of "reading" the meaning of their disability. However, it is not clear, particularly in the second example, that the patient has not played a key role in helping to shape those messages the therapist feels it appropriate to convey.

Case Example: The Head Injured Patient

The following example illustrates the narrative reasoning of an occupational therapist emplotting a set of actions, weaving them into a meaningful sequence. The session is especially striking because it illustrates perfectly the difference between treatment as a mere succession of events, just one thing after another, (which is the form the treatment takes during the first half of the session) and then a dramatic shift during the second half in which this succession is transformed by the two occupational therapists into a narratively structured set of actions.

The shift is from a series of interactions in which therapeutic time is treated as mere succession of activities, as a procedural movement ungrounded in context or in a picture of the patient, to narrative shaping of the therapeutic interaction in which therapeutic time has been emplotted by the clinician's picture of how to create a significant therapeutic experience for a patient. This meaningful sequence which they construct, it is important to note here, is not the carrying out of any treatment plan formed prior to the session. The "untold story" which emerges is structured from unanticipated responses by the patient to their interventions.

The session is with a twenty year old patient who has just come out of surgery a few days earlier. He is between one and two months post trauma from a car accident where he

suffered a brainstem contusion. He is a twenty year old man who was in a car accident and who has just come out of a coma a few days before. He has suffered brainstem contusion. He cannot talk but communicates through signalling and writing. The therapist has seen this patient only twice before very briefly.

As the second occupational therapist comes into his room, she finds the physical therapist and a nurse transferring the patient from his bed to a wheelchair. This is the first time he has been out of bed since the accident. (This session was observed by a research assistant on the project, Terry Sperber. Her field notes form the data for the interpretation that follows.)

When the session begins, the patient is lying in bed surrounded by four medical professionals, one nurse, one physical therapist and two occupational therapists. During the first several minutes the patient is simultaneously treated by each of these professionals. He is: (a) given a shot; (b) introduced to a new occupational therapist who puts on his sneakers; (c) has his lungs listened to by the physical therapist; and (d) asked questions about his height by the second occupational therapist.

The occupational therapists, nurse and physical therapist have previously decided that he needs to stand up and then spend an hour sitting in a wheel chair. They are all there at the same time to help in transferring him from bed to wheelchair. The patient cannot speak but he is given

a pad and marker and writes notes to them. One of the occupational therapists and the physical therapist tell him they realise he does not want to get out of bed. When given a pad and marker, he writes "Be careful of my back." All four medical professionals work together to stand him up. They give him instructions about how to help, e.g. "Don't forget to put your elbow down and lean" or "Lift up your head. Straighten up your knee. Bring the right foot up." Two of the professionals congratulate him on how well he has done, the physical therapist does some more checking of his breathing while one of the occupational therapists tries to help him get more comfortable in the chair and asks him questions about pain. (Most of the questions directed at him are yes or no questions to which he simply puts thumbs up for yes, thumbs down for no.) The nurse and physical therapist then leave the room while the two occupational therapists stay behind.

The initial medical checking of the patient and the transferring to the wheelchair form a sequence of actions with little narrative integrity. This is most evident during the first minutes of medical check where each professional is doing something different, paying as little attention as possible to what the others are doing. The patient is treated primarily as a patient, that is, as an injured body, and is often referred to as "he," as in, "He is writing with his right hand. Was he a leftie? That's good writing." The here professionals are primarily doing

"to" the patient rather than "with" him. Minimal cooperation is required on his part during this phase. Neither do the professionals need much cooperation from one another since the tasks they are carrying out are quite discrete and distinct from one another. They make no effort to build on what the others are doing because accomplishing their task does not require cooperative action. They are quite simply carrying out a pre-planned set of fairly isolated activities. Their tasks are certainly not meaningless and the physical therapist in a minimal sense "emplots" her actions by informing the group, including the patient, that he is improving in his breathing capacity and his ability to help transfer himself to the wheelchair. She says to him, once he is seated, "That was so much better than yesterday, excellent." And, when instructing him to breathe she says, "Yes, good breathing. A little more. That's better than yesterday. We want to get up this high. To the red line. See how close you can get. Two more times. Good."

But this bare chronicling can be contrasted with the more fully narrative emplotting which occurs in the next phase between one of the occupational therapists and the patient. When the nurse and physical therapist leave, the following dialogue ensues.

The occupational therapist helps in the transfer and then physical therapist and nurse leave. She hands him a comb and says "Try to comb your hair." He doesn't want to

do it and hands her back the comb. She then tells him this will help him improve balance; It's a kind of exercise. She says, "It's good for balance practice." At this medical explanation, he combs, but with great effort. When he stops, the therapist points to places he has missed. "Try here," she says, "Nurses can't do back here when you are lying down." As she touches spots on the back of his head for him to comb she says, "I'll guide you a little bit." She compliments him several times as he is combing. "Great job." "Nice." "Great."

Finally, they are done. The patient motions for paper. He writes, "Mirror." The therapist gets a mirror and sets it up on a table so he can see, correcting the angle just right. She asks him jokingly, "Going to make yourself look good for your girlfriend?" He signals for paper again. This time he writes "Want to go for a ride." The therapist agrees enthusiastically. "Great! You want to check out your new place." Their tour begins. She takes him directly to the main occupational therapy room and she wheels him in. "This is the OT room. You will be spending a lot of time here," she tells him. She points to the mat and tells him that they will be working together there. She says, "You will learn to strengthen your trunk."

As they are about to leave, the patient expresses discomfort and the therapist stops to investigate. He indicates that he has pain in his left shoulder when he moves his head. The therapist supports his arm and begins

moving it. She explains the movements she is doing, asking him to hold and then let his arm go again. She notes, "Your left shoulder seems OK but that pain makes you not want to move it. But moving it is good. Moving will get it stronger and reduce the spasm."

They leave the occupational therapy treatment room, and the patient writes "I want more of a tour before I go back to bed." The therapist says, "You've got it. This is Boston University Hospital." As they wheel down the hospital corridors the therapist says. "Today is Friday. Saturday and Sunday I am not here. But as you get stronger, your family will take you out."

They come to a large window looking out over the city. The therapist stops to let him look out. She says, "Do you recognize the Prudential?" He motions for paper and writes, "Open window." She explains that the windows can't be opened, which she also demonstrates to him by going over to the window. She takes him past the nursing station and looks around to find any nurses who know him. The patient writes, "Is Beth here?" Beth comes out and they have a quick, warm conversation. The nurse tells him she's glad he is up. He writes down "Please visit" on a note to her. Then the occupational therapist and the patient proceed on their tour for a few more minutes. The therapist asks him if he is getting tired. He indicates yes, thumbs up. As they return to his room the therapist asks, "Do you remember

which is your room?" The patient indicates thumbs up when they reach his room. And that's the session.

This story was familiar in the practice of the occupational therapists I studied. I see it as an everyday example of how the therapist makes a series of decisions which lead to the creation of a significant experience for the patient and how she uses that significant experience to sketch out to the patient a larger therapeutic story, a whole therapeutic process, they might carry out together.

The "OT" session opens after the wheelchair transfer when the therapist asks the patient to comb his hair. He doesn't want to do it. She persists, giving him a medical rationale -- improving balance -- that he buys into enough to agree. When he finishes she pushes him to continue combing, pointing out missed spots. In pointing out spots, she subtly changes the meaning of the task from a balance activity to a self-care activity by telling him that "Nurses can't do back here when you are lying down." It may be more accurate to say she adds a meaning, giving the activity a polysemic character. Hair combing becomes both a balance support exercise and self-care. And she decides to push him along so that by the end he hasn't just carried out an exercise, he has combed his hair. By the end of this activity, he seems to accept this meaning of the task for he asks for a mirror to see himself, as one might do after combing one's hair but not after doing an exercise for

balance practice. The therapist builds on his request in not only getting him a mirror but in carefully adjusting it for better viewing while simultaneously joking to him about fixing himself up for his girlfriend.

The therapist "emplots his action by defining it as part of a therapeutic story she wants to carry out. The meaning of combing his hair as preparation for being seen by others, a meaning he acknowledges by asking for a mirror, is reinforced by the therapist's joke. If you are able to comb your hair, her joke implies, you can feel ready to be seen by people you care about.

The patient initiates the next phase of the session by requesting to go for a ride. Again the therapist not only agrees but builds on his request by telling him the meaning of his request. She tells him he wants to check out his new place. She thereby turns a ride, which might have meant going up and down the hall into a chance to see his new surroundings, a chance to see and to be seen.

You could say that this whole session is about reentry into the public world. The therapist builds on her success at getting the patient to comb his hair, which succeeds not only in that he does it but that he then asks in succession to see a mirror and then to go for a ride. In her response to both his requests she not only enthusiastically agrees but explicitly marks them as requests to move out into the world. She "reads" them as moves within a story of reentry, and does so aloud so that the patient hears her

interpretation. To his request for a mirror she replies by joking about his girlfriend, signifying that he is getting ready to be seen. She interprets his second request for a ride as his wanting to see and in seeing, to take ownership, to "check out his new place." She "emplots" his requests with a plausible but strong reading of the desires motivating them.

And she emplots his requests through her actions, not only bringing him a mirror but adjusting it, not only taking him for a ride but giving him a tour which includes stopping by the occupational therapy treatment room and stopping at the nurse's station to find a nurse he is friends with. She is personalizing the hospital. She is showing him "his" particular version of the hospital, the version that includes a visit to a friend and the occupational therapy room where he will be working with this therapist to get stronger.

She also uses his request for a ride to give herself the possibility of showing him what he will be doing with her. While both gaze toward the mat in the occupational therapy room, she quite literally points to a future story. She sketches, in the barest phrase, what kind of story they are in. In this prospective story they work together and he becomes stronger. She reiterates this same prospective story when he complains about his shoulder. She says that working, even working in pain, will make him stronger:

"That pain makes you not want to move it. But moving it is

good, will get it stronger and reduce the spasm." Working, and working through body movement, will make him stronger.

She uses his requests as places of possibility to tell a second story in which work, work which will take time, which will involve movement and which will cause pain, will finally make him stronger. She links the two stories, the subplots, into a more complex causal chain. First there is work, work which may even be unpleasant, work he may not want to do, but then there is strength and along with strength, there is the possibility of seeing and being seen, of re-entering what Arendt describes as the public world of appearing.

The figure of the session itself opens with the patient combing his hair, against his own wishes, and ends with a hospital tour reinforces this story. By the end of the session, everything that has happened, from the initial taking of the comb to the end of the tour, becomes an extension or elaboration of this story of making himself presentable and thus reentering the public world. And by doing the tour after he combs his hair, the therapist also extends the meaning of that hair combing. What can look trivial to him becomes the very thing that makes it emotionally possible for him to leave his room for the first time.

One thing after another becomes, in narrative logic, one thing because of another. In what Kenneth Burke calls a "temporizing of essence," earlier events become the causes

of later events. Because the session links one small activity -- hair combing -- to another activity which the patient requests and clearly cares about, leaving his room for the first time, the session becomes an argument in story form about why occupational therapy activities should matter to this patient. The therapist is saying, through the experience, that something that might seem to him small for a large amount of effort on his part is really worth the effort because it makes it emotionally possible for him to feel presentable and to go out in the more public world of hospital hallways. She gives him an experience of the importance of occupational therapy.

This male 20 year old patient would be very unlikely to attach any significant commitment to relearning how to comb his hair as an activity in itself. But the therapist finds a task she believes he will succeed at and uses his success at this ordinary task, which leads him to want to see himself and then to want to leave his room. The session itself links the occupational therapy task to a possibility he cares about, moving out into the world. The therapist creates significance out of his reluctant willingness to make the effort to comb his hair -- in the name of a motor exercise. She then uses this tour, his reentry into this more public world and his pleasure at the tour to show him the occupational therapy treatment room and paint a picture of their future work together. In sketching this prospective story in which she tells him how he will be

getting stronger as they work together, she is also, then, placing the experience of haircombing which led to the experience of the tour -- a significant and desirable experience for him -- within a future story of how he will be working with her, becoming gradually stronger so that he can reenter the real world outside the hospital.

The powerful experience of the tour, which was initiated by hair combing, is thus emplotted by the therapist as early episodes of an as-yet unlived story which will eventually lead to his reentry into the outside world. She emplots this therapy session for the patient, showing how what they did that day are just early episodes of a larger whole, a larger story, which is yet to come. She makes it easier for him to believe in this future story and therefore to be staked to do his part to make it come true because he has just had the experience in a partial but powerful way of reentry into the public world and of succeeding at one task which helped make that partial reentry possible.

Case Example: The Spinal Cord Patient

This example is a useful counterpart to the first because it also depicts a typical interaction between therapist and patient but one where it is less clear that the therapist is the primary creator of the story. Like the last example, this case concerns one therapeutic session. But this is a much more complex case. The relationship

between therapist and patient is well-formed and a great deal happens in this session. The case reveals how the therapist is both open to the contingencies she happens to meet during the session, and yet has certain underlying concerns which appear to lead her to act in ways that allow a certain kind of clinical story to develop.

The data used for this case is quite thorough. The session was videotaped and transcribed and the therapist was interviewed afterward and asked to tell her story of what happened. The data from the video transcript and from the transcribed interview are both used in examining how the therapist emplotted the clinical incidents to create a coherent story with beginning, middle and end, and one which communicated messages she felt it important for the patient to hear.

The patient in this case is a quadriplegic paralyzed from the neck down. He is very depressed at the time of this session because he has had several severe physiological set-backs and has again been confined to bed. The session takes place two months post injury.

Like the therapist with the head injured patient, this therapist does not begin the session with a well worked out script in hand. Whatever it means to have a prospective story, it does not mean a script. The particular exigencies of the situation are too difficult for the therapist to anticipate, both in terms of how the patient is physiologically and emotionally and a miscellaneous

assortment of other important contingencies, as in this case where it turns out that the nurses have not gotten the patient out of bed yet.

The flexible sense in which the therapist organizes what she will do in a session is quite apparent in this case. When interviewed about this session, the therapist in this case said she had no real plan before seeing him. The therapist walked into the room without knowing what she wanted to happen except in a most general way. She decided to range the patient and to "touch base." She also didn't know until she entered the room whether the patient would be out of bed or not. If he had been in a wheelchair she would have done something different with him. However, she was not particularly thrown off by this because she had not devised any plan of activities that depended on his being out of bed. Her open-ended sense of what would happen was reflected in her surprise after the session when the interviewer asked her if anything that had happened was different than what she had planned.

T: Well, I actually didn't know what my pre-plan was until I knew that he wasn't going to get out of bed."

I: OK

T: Jack is a pretty damn, I mean my goals are limited in a sense, but it is more directed to where he is at.

I: They are limited to what?

T: To what I could do with him in bed or in the wheelchair when I can move. We go down the halls and (unclear)

I: So he is either in bed or in the wheelchair.

T: Yes.

I: Who makes the decision as whether he is in bed or in the wheelchair?

T: Nursing. I mean, he will get up today. He will probably get up after lunch.

I: I see.

T: I also mark it saying that I want him up.

I: Yes.

T: That is part of it, but it was already eleven o'clock and that would mean confusion and so forth.

I: And you had, well I guess once you saw, once they decided to keep him in bed, then that is what they decided to do.

T: Since it wasn't like I have been ranging him for four days straight in a row and said, 'Oh gee, another day of him in bed.'

I: Yes.

T: I kind of wanted to connect with him, so the idea of doing (unclear -- an activity which requires him to be in the wheelchair) again wasn't necessarily urgent.

I: Yes. What would you say was the focus of the treatment session in reflecting back on it? What was your purpose behind and objectives for the treatment session?

T: To touch base...Find out where he was emotionally and what was happening and how he was doing yesterday. Nick (his roommate) left...So Jack is eager to see if he will come in. And he didn't. And I wanted to range his hands so (unclear)

The therapist's plans depend on what the nurses have done that morning, something over which she has little control and which she cannot predict ahead of time. This session is essentially all talk because the patient is too

sick to do much therapeutic activity. The primary reason for the therapist's visit is to find out how the patient is doing because she knows he has been very depressed. However, the reimbursable "medical" reason for the therapist's visit is passive range of motion, that is stretching and flexing the patient's hands to prevent stiffening and swelling.

When she gives her objective for the treatment session, she says she wanted to "touch base with Jack," a perhaps unconscious double use of the term "touch" since she touches both a physiological and a phenomenological body. Here the task of treating two bodies are not at war with one another. Her physical touch, although he cannot feel it, appears on videotape as a kind of signal to him that she is there, paying attention. attending to him. This touch certainly does not interfere with their intense discussion of his illness experience and it may very well facilitate it, her own ease touching and handling his disabled body may signal a level of acceptance to him that makes him feel safer to talk as freely to her as he does.

While the therapist appears to have no particular planned story she wants to enact -- she does not view the session as a place to simply enact a pre-given story -- she does seem to have in mind a kind of significant story structure, or perhaps a small set of them, which she wants this particular session to imitate. She (or in this case, possibly she and the patient) have been developing a picture

of the patient's illness experience, which is that the illness goes up and down like a roller coaster, both physiologically and emotionally. She says in the interview, "He has been up and down on this roller coaster with the withdrawal stuff. Sometimes he is like, 'I am going to get off this vent, or I am going to (unclear) and get in my chair.' And other days he is like, 'I will never see that.'" She points out, as does the literature on chronic illness (e.g. Kleinman, 1988), that this is very typical of the experience of chronic illness because, physiologically, patients do have multiple set-backs.

The therapist tells the patient her reading of his illness experience as an "up and down movement" very near the beginning of their session.¹ She does this as part of an opening conversation in which she asks him how she is doing. This opening segment begins to give the sense in which the therapist has an overarching view of the shape of the illness experience (as a roller coaster) but is also open to hearing particular concerns, the particular shape of things, that the patient might tell her.

1. The transcript of their conversation during the session is difficult to follow for the patient cannot speak aloud. The therapist reads his lips and often repeats aloud what she deciphers of his words. In the transcript taken from the videotape and given below, I distinguish when the therapist is repeating the words of the patient and when she is speaking for herself. After sentences which are a repetition of what the patient has said, I note "repeat" to indicate that. A few times the patient becomes audible. "T" is therapist; "P" is patient.

As the session begins, the therapist is leaning over the patient's bed. She speaks jokingly to the patient but more gently and softly than the words alone imply.

T: Hi sport. Whadaya want? Want some water?
(T goes for water.)

T: (To camera person) You need light? (Back to patient.) Thirsty? Is it cold enough? (Gives patient water.)

T: How are ya buddy. Buddy boy. You OK? I'm going to start on that hand since the osimiter is on is on that one. How you doin? (Ranging hands.) Better today?

P: (inaudible)

T: Yesterday was a lousy day. (Repeat of patient's words.) What was wrong about it?

T: Say that again?

P: (inaudible)

T: Not a one? (Repeat.) These spasms are really, it actually seems a little better today. The other day, when all I had to do was touch you. (Ranging.) So where are you on the O2? Still on 28? (Repeat.) They bringing you down? Hows your pneumonia? You don't know? (Repeat) How's your secretions? You have a hell of a lot of scretions? (Repeat) Last night? (Repeat) Are they green or white or what? A lot of water in it?

P: (inaudible)

T: Oh man, I feel great today. Huh?

P: (inaudible)

T: Really? You didn't need it?

P: (shakes head.)

T: Well then, up and down, huh, in a big way.

The therapist's words here, "up and down, huh, in a big way," foreshadow a major theme of this session. That phrase

is, at some level, the moral of the story. It reflects the therapist's -- and perhaps the patient's -- way of understanding the patient's illness experience. The moves the therapist makes to guide the conversation that follows, which consists primarily of a series of stories, creates a therapeutic experience which mimics, in a condensed form, this larger illness experience of which this therapeutic encounter is only a small part. The patient's illness goes up and down. He gets sicker, he gets better, he gets sicker again. His depression goes up and down. He feels hopeless, he begins to have some hopes, to see some possibilities, he loses hope. The meaning he makes of his illness goes up and down. And, remarkably, the series of stories which are shared in this session go up and down. Despairing, angry stories follow on hopeful stories and precede other angry stories.

The exchange of stories is preceded by a series of interchanges which are directed to the patient's physiological body. In interview, the therapist describes what she is doing as "patient education."

PT: (inaudible)

T: You can swear. (Grins. Patient grins.) Uhh. I need to lean against something. My stomach. Ever since I came back from Mexico, hasn't been great. You're tight today. (referring to his hands) You know what happens, because your spasms go this way (she illustrates) it makes your joints tight coming in. That make sense to you? That's called flexion, inner flexion. Do you know the names of the joints in your hands?

P: No but I bet you do.

T: I do indeed. Do you want to know them?

P: (inaudible)

T: Start from far away. There's a little teeny bone here. Your joint between here and here is the distal fangeal bone, does that make you (inaudible)? I have them too. (laugh) This is called proximal. Distal means further away, your proximal means farther away. This is called the DIP, this is called the PIP joint. This is called the metacarpal, which is connected to your falanges.

T: Next week we'll do the thumb. (laugh) So is anyone coming here today? Who's coming? (Coughs) Oh scuze me, right in your face, that was nice.

The therapist gives a justification for educating the patient in which she directly connects teaching the patient about his body physiologically to a phenomenological problem, helping the patient feel some control over his disability when it is difficult for him not to feel completely out of control.

I think ultimately he is going to (need to be) in tune with his body. And to know his body and to be educated about where he is tight or, For some reason it gives me the idea that it gives him more control to at least know whether this guy is. I like for him to know what the ocsimiter lever should be because on a spinal cord unit, so much of the focus is being able to direct your own care. Not that he could direct his care...but I think it is more just so he knows what it is."

Although she does not explicitly mention this, I would also say that this patient education, this familiarizing the patient with his new strange body, also provides the basis for a more hopeful narrative which transcends this immediate rise and fall. With greater knowledge he will be able to observe his body as it makes its progression (albeit a

roller coaster progression) toward getting increasingly stronger. He must know enough about his body to follow the narrative.

The rest of the session is devoted to talking about the patient's feelings and it is nearly all narrative. It is given below in its entirety. The patient is doing most of the talking and the content of what he is saying is only elusively inferrable from what the therapist says back. The discussion of these stories that follows is filled out by the therapist's retelling of some of them in the post-session interview.

The therapist introduces the topic of the patient's experience when she ends her "patient education" and asks him who is coming to visit for the day. The patient does not answer her question but tells her he is bored.

P: (inaudible)

T: You are bored. (Repeat) Well not all the time. (Repeat) Sometimes you put on a good act. (Repeat) You missin it? (Repeat) I know. We don't even have admissions in the near future. So I don't know.

T: Jack, did you ever? Is this an old scar on your thumb? Your pinky? Yeah had that a long time? Where did you get it? Yeah?

P: (inaudible-- tells her a story about giving away his hockey equipment)

T: What? You're getting rid of it? (Repeat) Who? One of the patients? No, that's why I was surprised.

P: (telling a story)

T: (listening and ranging his hands) Yeah. (laugh) Yeah. Scuse me. Time off. YOU have a lot of it? He doesn't know it? What a nice guy you are.

That's a nice thing to do? Really? What does he need to ? Pads? Pants? Is it really? Who gave it to you?

T: That's nice. (Jack smiling.) Tell him to be careful. What that's nice of you. (Jack keeps talking.) Two hundred bucks for skates? Have you been using your widgets lately? So we have our student here, who just started yesterday.

T: So where's the picture of you on the boat that looks like your dad? I've been waitin for that one.

P: (inaudible)

T: Sandra? To come in or to bring them in? Oh ok, I know what you're sayin. (serious face) Ohh boy. So are you still convinced, are you still determined to help her out? (Jack shakes head no.)

T: (Liz walking to get a pillow.) But remember last week you were sayin maybe that she could learn? Ohh, that's really, I'm gonna turn off the exmeter.

T: Scratch your lip? The top one? Keep purrin. (She scratches his head.) Looks like you're in pain when I do that. (He tells her it feels like an orgasm. She laughs and turns slightly red.) How's that? Not bad? Oh, I'll keep working sir. (They grin. Jan begins to range his left hand.)

T: Has Suzanne been in yet this morning? (Yeah) (He spasms.) You alright? (He nods. Looks grim.)

T: Did you have an infiltration? Two?

P: talking upset to her about -- probably -- the infiltrations. Some talk about blood.

T: Was that blood on the floor? It's this little butterfly thing on your skin. There is a needle inside a thin plastic tube but then they pull the needle out. The needle goes in and then they pull that needle out. Then what happens is that when it gets dislodged, you get swelling. But that usually goes down in no time. (Seems to be explaining a swelling problem with his arm.) You remember how swollen you were? No? You don't remember up in the unit? You were a big boy. You were huge. Your neck was like this (gestures with

hands). Your face I mean you looked obese. Yeah, remember I told you that joke up there? Remember, I went up to see you, Cathy (person videotaping) came once. And we did that when you were really stressed out. And I asked you if you wanted to do some relaxation and we did that thing to Hawaii. Remember that? I told you to close your eyes and relax and feel the warm sunshine. Remember that? (He nods.) Do you really or are you just saying that to be nice? And then I was telling you the joke about the bear and the rabbit and you knew the punchline. So I told the other joke about the

P: (interrupts -- inaudible)

T: No you didn't see yourself. (He talks.) About when you were in there? Pretty funny? Confused? Were you nasty?

P: Sometimes. (smiling -- keeps talking)

T: Still ranging his hands.) You winked at Sandra? That was the first thing you did? First time you responded. (He nods and starts to cry. Says something.) What makes you sad? (She leans forward and he keeps talking.) Yeah. Hard to believe all that time has passed. The members of your family were so determined for you to survive. And obviously they knew you well enough to know you would have been so determined. I mean people really didn't know if you were going to survive. As soon as you came to the determination really . What gives you the courage to do that?

P: replies.

T: What do you look forward to?

P: shakes head

T: Something, anything. What's a real small thing? (Meanwhile wiping his eyes.)

P: Suddenly grins. I can't tell you.

T: laughs. Well, whatever it is, it must be pretty good.

P: (inaudible but clearly talking in serious voice)

T: But I don't think you need to block it out. I mean I don't have to tell you, we can do whatever you want to do, but I think, there's a difference

between blocking it out and ignoring that it ever occurred but you did a lot of talking to me the other day about getting past it and learning from it. That's a lot different from blocking, you know?

P: (inaudible)

T: Yeah, you talked about a lot of fun things.

P: Let's change the subject.

T: OK, what shall we talk about? The Lakers game on Sunday?

P: shakes head

T: Who cares? OK, umm You care? (laugh) Was the benefit for Michael last night?

P: Nods

T: It wasn't on TV was it?

P: shakes head. Then talks (about the benefit for Michael. Looking upset.)

T: (listening) Wow. I wonder how much money was in it? Channel 4. Is that the one that always has the

T: Oh sir. Too bad you don't have any friends to do anything for you. (They both grin.)

T: Now this range feels better. You know it's funny because initially you feel very tight. But it doesn't take much to stretch you out. I think your spasms are better. Because the other day I did this and you were all over the place. Did they tell you, I'm sure they told you that the presence of infection makes the spasms a lot worse. So it's often a good thing to monitor before you know you have an infection.

P: (inaudible)

T: right. And you're all upset. One day I'll give you my whole lecture about the relation between your emotions and the immune system in your body.

P: (requests water. T gives him sips from cup.)

T: Anything else you need? (Some discussion about anything he might want before she leaves.)
Now, OK. Ocsimeter? Wench? (Sets up his finger back on platform.)

These stories move as point and counterpoint on the themes of hope and despair. The first is a hopeful story. Jack discovers a way to be a moral actor. He will not sell his hockey equipment, after all. He will give it away and therefore honor an act of friendship because it was given to him and, as the therapist paraphrases Jack's words, "that it would be just cheap of him to sell something that was given to him." He will also have good news to tell the man who wants to buy it. The therapist notices that this decision is an important event for Jack. "He was pretty excited about that. He focused several times on the fact that he really couldn't sell it." The therapist noted that it was clear that the hockey story held special significance for Jack because his accident as he was hit by a car after being thrown out of a Bruin's hockey game very drunk.

The second is a hopeless story. His sister did not come to visit. He tells the therapist that he has told his mother not to say anything to her, just to wait for her action. The therapist filled in the background of this story in interview. He had been trying to help his sister, also a drug addict, and had been hopeful that he was going to be able to persuade her to seek help about her addiction. She "was supposed to come in and bring this picture of him in his boat that looks just like the picture of his father in his boat." She didn't come by. "And so he told his

mother not to ask her to do anything anymore, just wait til she offers."

In the interview, the therapist fills in the background to this on-going story, noting that it started "several weeks ago" when "he had said that...he could never change her [his sister]..." His attitude changed, when "last week or two weeks ago he was pretty good and he said how much he had learned about the (unclear) and all this stuff he read about, and how he was hoping that he could change her now." During this session, he has again reversed his view, for she has not come with the picture as promised, and he expresses hopelessness about changing his sister. The therapist commented, "And then he says he could never change her. So I think there is some sadness or some mourning relating to that loss." This story about his sister is characterized, as narrated by the therapist, by the same roller coaster ride that shapes his illness experience.

Both these stories are morally laden. In the first, Jack is recounting a story of taking a moral stance. In the second, he is mourning a loss of a moral stance, telling a moral story about loss of faith. He cannot perhaps hope to save his sister from some fate similar to his own. Not being able to hope to transform others, he suggests a sense of despair about his own capacity to be an active agent in the world. This may be what the therapist thinks he is mourning, another loss of the possibility of action.

The third story, unlike the first two, is one Jan characterizes as jointly told. She is clear that ownership of first stories belongs to Jack and gives a detailed account of how he begins storytelling sessions with her. "He was telling me about how he decided to sell his hockey equipment. He said, 'Guess what?' which is kind of an interesting way for him to start telling me something." She introduces the second story with "And then he started talking to me...He said how he didn't have any visitors yesterday." The third story is introduced with "Then we started talking. Oh, then we talked about when he was up in the unit. We were talking about being swollen."

Despite the "we" by which Jan indicates that the story is jointly told, the moral of this story seems more clearly hers for it is told to combat hopelessness. This story is about surviving despite everything and also about dramatic improvements in Jack's physiological condition. It appears to be told by the therapist in response to two competing interpretations of Jack's current situation. Jack says "that he doesn't have anything to look forward to." The therapist counters with this story which reminds him how sick he had been in ICU. She also reminds him how brave he was, and how much his family seemed to want him to live. Jack gets quite sad listening to her; his change in stance is quite dramatic on the tape. He listens intently as tears start down his face. The therapist wipes his eyes and keeps on talking. Jack then follows the therapist's storytelling

lead, adding interpretations of his own. The therapist said in interview that: "He was talking about how determined he was to survive, and about how determined they (his family) were to have him survive." The therapist uses this recounting of those early terrible days to try and persuade him to believe in his future. "So we were talking about his will to survive, and then I got into what he has to look forward to."

The therapist felt Jack needed to try to remember what he was like, how he felt, when he was in the ICU because in doing so, he could see that he is travelling in a story of progress. She remarks, "at a time when he is feeling really frustrated like he is going nowhere and [so it is important] that he knows that he has come a long way." Jack cannot actually remember that initial period because he was too sick. The therapist is teaching him this story. She feels part of her therapeutic job is to remind him of this long way that he has come. So she says, "I am glad I was there for that time because it is nice for me to compare him to what he looked like and was like then."

The fourth story, told by Jack who resists dwelling any longer on the story the therapist has told, is about having no friends. They begin by talking about sports and soon a story begins about a benefit the Bruins had for one of the spinal cord patients. The moral of the story is that this patient had a fundraiser put on for him and "over 600 people came...They had to turn people away at the door." Jan

speculated after the session that this attention to the injured hockey players "is a little hard for him too" because it triggers a belief or worry that "he has no friends."

The session ends soon afterward. The point counterpoint structure of their conversation also fits the therapist's diagnosis of Jack's emotional and physical state.

The structure of the conversation follows the same roller coaster ride as the structure of the therapeutic process overall. In this sense, if Jan is treated as shaping the session into a story, she has shaped a story to fit her diagnosis and, given that the diagnosis of the illness experience is a roller coaster with the patient on the downward slide, she has found a way for a brief moment, to remind him, not only of his first days and how bad he was, but of the brave story he is struggling to live out in hanging onto his will to survive. That she follows a roller coaster of hills and valleys in her own guiding of the session is indicated in the curious way she lets the first hopeful story, one he initiates, about carrying out this moral action, slide into his second despairing story without trying to build on the first. She in fact initiates the second by asking about visitors knowing full well that his sister was supposed to visit and had not, so she could anticipate this question would bring on an angry response.

While the therapist mostly listens and only tells one of these stories she plays a key role in shaping which

stories the patient tells her by the questions she asks. The shaping of this session, what happens and the form it takes, is much more mutually guided by both therapist and patient than the pervious case, however. While there may be some sense here that the therapist is in charge, patient and therapist know each other well and have been working together for several months. There is a sense of teamwork here, of patient and therapist being part of the "same story" which is still unfolding.

Narratively speaking, the therapist does something else which gives a drama and a storyness to this session. She describes her goal as wanting to 'touch base" with Jack and "touching base," like any complex action, requires a certain cumulativity of single actions. The session itself builds in intensity, in "touching Jack" and peaks with the therapist's storytelling to which the patient responds so emotionally.

Perhaps she also wants to introduce another narrative plot which carries a different moral, one which runs counter to Jack's current illness experience rather than imitating it, for story she tells to Jack in the session is about having courage. The story she tells goes back to beginnings. She is tracing a path by reminding him of the very beginning when he first woke up. Once she has reminded him of beginnings, of immense courage at that hardest time, then she initiates her "Can you think of the future?" intervention. Here she locates his current situation with a

story of beginnings and a pointing toward the future. Present is sandwiched between past and future, and in being so wedged, is emplotted in her story as a courageous movement forward.

CHAPTER NINE

STRUGGLING FOR THE STORY WHEN THE STORY GOES WRONG

Clinical work often involves a collision between a prospective story which the therapist brings to the clinical encounter and the actual experience of treating the patient. In practice it is difficult for occupational therapists to completely avoid dealing with patients as idiosyncratic individuals who experience their illness in unique ways and who can throw up obstacles that can undermine any intervention the therapist wants to make. Since each patient has a historically particular life, the meaning of their illness or disease is necessarily unique, and this is expressed clinically in each patient's singular responses to disability.

The therapists I studied were quite aware of this. Many felt it that if they had to single out the key ingredient to a successful therapist, it was the therapist's capacity to respond flexably enough to deal with different types of patients and that this was even more essential than having a firm basis of theoretical knowledge. As one experienced clinician, whose practice was quite theoretically oriented, said:

If I have to choose between the student therapists, the one who is flexible and able to deal with different kinds of patients and be responsive to them, versus the one who is grounded in theory and has a solid knowledge base, I'd

rather have the first. I figure that any therapist who is able to work well on an interactional level with patients can pick up the knowledge base and can function while still learning that. But I don't think it works so well the other way around.

Even when patients are not practicing outright resistance, clinical situations can entail puzzles and frustrations that push the therapist to increasingly individualize her work with a patient. They require the creation of an individualized role for herself as therapist, a theme that occurs again and again in stories therapists tell about difficult cases. Responding effectively to a patient often takes therapists outside of preconceived role boundaries. "Widening horizons" through a difficult case with a patient often means widening professional boundaries, as is evident in the cases described below. When therapists recount these cases, the recurrent moral is that they learned to step outside the confines of their preconceptions about the required treatment.

Sometimes this collision between therapist expectations and patient realities is so minor, or the therapist and patient so resourceful, that it can be resolved through narrative improvisations which do not challenge the boundaries of a therapist's' understanding of his or her role. In other cases the two are at such odds that the confrontation provokes an "experience" in the strong sense, the production of a new way of seeing in the therapist.

"Story" here does not refer to a discourse of remembrance but to a guiding narrative therapists draw on

and try to live out in their work with patients. But in considering the way stories guide actions, I do not mean to invoke the cognitive science notion of script in the sense of a storyline which guides action in a rule-governed way. I mean "story" to refer to a richly particular narrative created from past experiences with patients whom therapist perceives as "like" the patient whose treatment is being prospectively envisaged through the it. Past experiences, remembered in the form of stories or snatches of stories and story-like images, are "matched" to new situations to which they seem appropriate.

These bits of past stories which are brought to bear in making sense of new experiences provide therapists with an armament of strategies for how treatment might be pursued in a present case. They suggest patterns of treatment which the therapist might follow. In their most integrated forms, they amount to a vision of the therapy which can help therapists to emplot the course of intervention. They allow therapists to project possible endings for novel situations with new patients, therefore providing them plausible and possible beginnings.

This narrative guide, this "prospective story" is a complex preunderstanding which therapists devise in an attempt to both make sense of ("to read") what is already going on, and to create new senses -- to guide in bringing about something clinically valuable in their work with a new patient. But such stories are only preunderstandings, and

as such, are always to some extent misunderstandings. For the new patient in the new situation is not simply a replica of other patients in other situations. Sometimes, though not always, this presents problems. The patient simply will not do his part to make the therapist's story come true. The patient has a prospective story of his own. Trouble arises. The therapist gets stuck.

Sometimes the surprises and frustrations which the patient throws up, the misfits between what the therapist wants to see happen and what actually does occur, provoke a rereading and reframing of that prospective story. Even in those cases which are "the best" from the therapist's point of view, there is a constant tinkering with and modifying of the prospective story. At the least, there is the kind of "improvising" practiced by Albert Lord's (1978) storytellers who kept to the essential structure but made modifications to suit the situations of telling.

At the other end of the spectrum are the more intractable contradictions between the prospective story and the lived experience of working with a patient. In such cases the therapist is thrown into a state of confusion, and frequently of anger as she tries to sort things out.

The confrontation is between prospective story as a 'preunderstanding' which the therapist brings to the clinical situation and the actual clinical encounter with the patient. The therapist's experience includes frustration at misfitting events and surprise at unsuspected

possibilities, both of which can lead to the revision of her prospective story to accomodate the unfolding of actual experience.

In this chapter I examine a set of stories therapists told to me or to members of my research team about times when they "got stuck" in their work with a patient. All except the first case are transcriptions from orally told stories.

The first case was important in my own thinking about prospective stories. It was written by a therapist for a seminar I conducted on trouble in therapy very early in my research with occupational therapists (December 1986). The therapist decided to tell about a time when she had tried to treat a patient in a way that had worked well with a previous patient whom she had initially seen as very similar. After writing her account, she came to me because she was worried that she had done the assignment incorrectly. She thought that perhaps she should have told two stories, one about each patient, in order to show how she had run into trouble with one of them. As she talked to me about the case, my thoughts about the role of storytelling in professional practice underwent an important reformulation.

From my observations of storytelling among project team members at the World Bank and among occupational therapists at the hospital, I had come to appreciate how critical it was for these professionals to create storylines which made

sense of the situations in which they were intervening. I had seen both development officers and occupational therapists talking with their colleagues, attempting to use what data they had to develop prospective stories about where they should be heading with their clients. This had lead me to become quite focused on the ways in which these stories were created in the midst of action.

This therapist's case story was a revelation because I suddenly saw that therapists not only created stories as they went along, which is how I had originally thought of it, but brought stories with them from the start. Then I remembered that this had been true of the project officers at the World Bank as well. The project officer in charge of the Calcutta project while I was there had told me that he had borrowed his idea for an urban land redevelopment project from some innovative land redevelopment projects in Kenya, his home country. His plan for Calcutta was an expansion and modification of projects he had successfully implemented in the past. Then I remembered that the previous officer in charge of the Calcutta urban development projects had spoken of the land problems in Calcutta in very nearly the same language he had used to describe the problems in Manila, where he had organized a land reclamation project which he had been very pleased about just prior to his assumption of responsabiity for the Calcutta projects. This suggested that the storymaking I had witnessed among project officers and occupational

therapists in the midst of their work was not the creation of original stories, but the revision of prior stories which each person brought to the situation from their past experience.

Matching A Current Situation To A Past Success Story

This matching of past and present stories is quite evident in the story the therapist wrote.

(A) Two Oncology Patients

The following case story is presented as it was written for me:

"When I try to think about a situation with a patient that "didn't work," the first patient that comes to mind was a guy named "Bob." He was a 23 year old male from South Boston, married with two children. He drove an ambulance. Bob had a wart on his finger that he bit off. That day he played softball. He noted much pain in the finger. The next day, he woke up with more pain throughout the entire arm. He also noticed a red streak moving up from his finger toward his shoulder. He took himself to the UH emergency room -- assuming he had an infection. This was also the assumption of the physician that treated him -- until his blood tests came back. The elevated white blood count of several hundred thousand made it rather clear that he had more than just an infection. As it turned out, he was admitted to the hospital that day and within 24 hours was diagnosed with leukemia. His hospitalization lasted over two and a half months.

Part of my role with patients on the oncology floor was to deal with stress management;

instructing patients in various coping strategies including relaxation techniques, visualization, guided imagery, etc. I had worked with several other patients in the same mode, including a 26 year old leukemic male who had many readmissions for leukemic exacerbations, chemotherapy, etc. This 26 year old openly expressed his difficulty coping with these multiple hospitalizations -- voicing feelings of "going stir crazy" or "being unable to relax." Paul (the 26 year old who was also married with children) was very receptive to any techniques I could provide him with which would decrease his anxiety or increase his ability to effectively manage being in the hospital and away from his family. As it turned out, in addition to the more concrete instruction I provided, Paul and I also developed a psychotherapeutic relationship that enabled Paul to begin to discuss his feelings related to his illness -- including the fear of death, the perceived loss of his role as a spouse, father and bread winner, etc.

Now, as I received the consultation request for Bob, I had preconceived notions about how our relationship would progress -- and I was very wrong. Unlike Paul, Bob was not eager to incorporate the techniques I gently introduced. Instead, I let Bob know that I would be available if he changed his mind. I also asked him if it was alright if I stopped by occasionally to see how things were going. He pleasantly and willing agreed. My hope was that by providing consistent, non-invasive contact, perhaps a relationship would develop that would allow Bob to trust and seek me out if needed.

I proceeded to "stop by" every few days. We would "chat" superficially. After several weeks, I again asked Bob (who was obviously having difficulty, i.e. -- unable to sleep at night, pacing) if he had thought any more about trying some of the things I had mentioned. And once again, he graciously declined. He expressed concern about hurting my feelings and I reassured him that that wasn't the case. I again explained that my role was to be there if he needed me, that my treatment was not "mandatory" by any means, and that I certainly appreciated his honesty.

Bob never took me up on my offer. I continued to stop by occasionally, to "chat" and to let him know, in a subtle way, that I valued his decision and would not abandon him.

Here the therapist uses a set of easily observable cues to match Bob's and Paul's cases as similar. She then tries to carry out with Bob a therapeutic story similar to that which she had experienced with Paul. Her written narrative includes no evidence that she ever was able to develop a new prospective story for her work with Bob. Her account does not focus on revision but simply on the initial experience of realizing that her prospective story was not going to fit the situation at hand when Bob turns out to be unlike Paul in his reponse to her interventions.

Generally therapists were not this explicit about their attempts to reprise a success story taken from their work with a previous patient in their encounter with a new patient. Such attempts to derive an expectation of the

course of a new case by matching it with a previous one on the basis of similarities was often revealed more indirectly, as in the story told by the hand therapist in Chapter Six. In her struggle to understand why she was having so much trouble with a particular patient, she reverted several times to telling a story about a patient whom she had just finished treating who had recovered from her injury and has been able to "go on" with her life. In the case of "The Girl Just Like Me" the therapist was also unable to create a revised prospective story for her work with the Hispanic patient. She was only able to see how her experience with him did not fit her expectations of a successful therapeutic process. While she never made the mistake of the oncology therapist in presuming the Hispanic patient's treatment would proceed according to the story of the young Jewish girl's treatment, she did imply that the Hispanic patient should comply with some identifiable version of that good clinical story.

Sometimes therapists were confronted by a mismatch between prospective stories cast in biomedical terms, generally due to the therapist's need to present her work to other hospital staff as the treatment of a medical condition, and the responses of the patient to the illness experience itself. These clashes between biomedically and phenomenologically framed prospective stories, place therapist and patient in different types of worlds. For instance, one therapist told about an experience working on

a burn unit with a patient who had been terribly disfigured.

The therapist described his burns:

Somewhere around sixty percent of his total body surface area with third degree burns. The burns included almost his total face. His ears were burned off. His eyes were quite heavily burned. His hands were both totally burned, uhh, circumferential burns on both hands, chest, legs. Just about every part of his body was burned.

The therapist was concerned that the patient needed to do active range of motion with his hands in order to keep as much motion in his hands as possible. There was an urgency in the therapist's concern to get the patient working to range his hand right after the accident because "the longer they [patients] wait, the harder it is to move." Soon after the skin grafting there is still some flexibility and scar tissue has not yet firmly formed. The therapist was anxious to try to preserve some movement for the patient, but it required the patient's immediate cooperation. The therapist's story focused on a physiological process which he felt responsible, as a therapist, to try to direct in the best possible way. The therapist's story of his own actions was framed within the biomechanical problems the disability was creating.

Well actually, after the skin takes, which is only five days after the graft, you can do active range of motion. But as the new skin matures, the collagen formation becomes thicker and the skin actually becomes thickened and scar tissue forms

and you have a decrease in range of motion in the skin which then limits the joints, if the new graft is over a joint.

While some decrease in motion is inevitable, there is some chance to prevent the development of severe contractures and complete stiffening of the hands, which renders them useless. The therapist knew this and for him the issue was getting that patient moving. The patient was in a completely different story. He was a young man in his early twenties who had just been horribly burned and who became extremely depressed and withdrawn, by the therapist's account. The patient wanted to hide and to be angry. The therapist said of him,

He was in the category of 'leave, like leave me alone, I'll do it when I feel better.' So he had to be... motivation was always a problem with him. And initially that was one of the most difficult things to work with was his... just anger, the anger, the self-pity. The idea that, well, he's in pain and, you know, 'leave me alone' kind of thing.

In this story there is nothing very removed about the therapist's biomedical account. The therapist's experience of trying to catch and ameliorate the disastrous consequences of the burning, his absolute dependence on mobilizing the patient's commitment if he is to achieve this goal, and his helplessness and impotence at not knowing how to do more for the patient, all come through just underneath

the surface of his description of a worsening biomechanical condition:

Then he developed contractures in the elbows, this, heterotopic ossification, where the elbows, or many joints, primarily the elbows in the case of burns, begin to develop calcifications right in the muscles, right around the elbows, and uh there's nothing you can do about that. You can try to attempt range of motion to prevent that but once it starts going, then it's a process that will just continue, until, until it stops and then at that point they have to have surgery on it to release it. But because of that, we lost the elbow motions and any hope of him doing self-care kinds of things. Because the hands just went.

The involvement of the therapist, his sense of personal failure and failure of the patient show in those last sentences, which say "we lost" the physiological battle. The therapist's sense of what this loss of movement and loss of ability to do self-care would mean to the patient is utterly graphic.

When we has to go to the bathroom he can't even toilet himself. He was able to pull his pants down and everything, but if he had to have a bowel movement he couldn't even wipe his ass. And he would have to rely on nurses, on therapists to do those kinds of things.

The three examples noted above are all cases of mismatch between the therapists' sense of what ought to happen in treatment, particularly what they expected from

the patient, and the patient's despair or hiddenness. Each of the patients in these stories is a bitter or too-silent partner who remains mysterious to the therapist, out of reach. The disability, meanwhile, grows worse without the patient's involvement. In the first example, the therapist abandons her prospective story when she recognizes that the new patient will not work with her, that he was not another Paul after all. In the second and third examples, the therapists do not appear to initially perceive these difficult patients as repetitions of other particular patients they have treated but as examples of general types of difficult patients which both therapists contrast with patients who they have felt more successful treating. The hand therapist implicitly compares the Hispanic patient to another with whom she had great success. The therapist working on the burn unit also makes oblique reference to other patients who do not withdraw in the same way. He describes this particular patient as belonging to "that category of... 'leave me alone'" which implies that there are other categories of patients who do not give this message. He also has suggests comparisons with other patients he has treated when he says, "They, different people cope in different ways. Some of them, the best comes out. You know, you see some real amazing kinds of things. You know, other times it's the worst comes out."

In the following case a psychiatric therapist faces a recalcitrant patient who remains passive in the face of her

attempts to get him actively involved, to take responsibility for his rehabilitation. She comes to the clinical encounter with a story which she wants the patient to realize with her and grows increasingly frustrated at his unwillingness to play his part. This account more clearly involves reframing of the initial storyline than the previous examples. It is a case of collision between her expectations and her experience which provokes an experience in the "emphatic sense," one which involves a revision of her own assessment of herself as a therapist.

The therapist introduced her story by saying, "I'll begin by giving an example of one patient who has clearly changed my way of thinking." This patient, a man in his mid-forties, had a diagnosis of depression. He was readmitted to the acute care hospital where she worked about every six months. Upon discharge he would appear to the staff to have improved somewhat during the course of his hospitalization, and yet he would be back to his previous condition upon his next readmission. "When this guy left, always I think in the back of our heads we thought, 'Well, in a few months he will return,' but we always tried to do the best we could."

Readmitted chronic cases, whether physically or mentally disabled, often frustrate therapists who feel a sense of failure at not have been able to effect significant improvement. They often feel angry at the patients, especially in cases where it appears that if the patient

cooperated properly during the course of the therapy, readmission would not be necessary later, or at least there would be a noticeable improvement in their condition even if further hospitalization was necessary. Patients are also often angry to find themselves back in the hospital, caught in a cycle they cannot get out of and frustrated with medical professionals for not being more helpful.

The last time the therapist saw this patient the chronic stalemate between them shifted, for a moment at least, in a way which she felt changed her practice. This experience threw into doubt her assumptions about patients taking responsibility for working on their own rehabilitation. She outlined these beliefs at the beginning of her story.

This gentleman came back one time, the last time I had worked with him before I left, and, you know, as usual, in the groups we would really encourage people to take a look at themselves, to help them to identify their strengths, and how to use those strengths to overcome certain problems... look at different ways to cope. We really focused on taking responsibility for yourself. And, you know, 'You're responsible for your actions, for your own decisions, etc. And knowing that, what can you do about it? Let's make a plan.' So along with stressing certain points, we're very concrete, saying, 'You have this knowledge. Now what can you do with it?'

The patient's response was an unusually direct resistance to these messages about the possibilities of

individual responsibility and efficacy for one's own destiny. The therapist described an instance of direct confrontation between herself and the patient which made her anxious.

He said, 'It's not up to me, Mary.' He'd say, 'It's up to God.' He had these delusions of religiosity. Not real articulated, not real verbalized, but it would definitely come out when he was confronted with what responsibilities he could take for his life. But this guy was adamant about just resisting the whole idea of taking responsibility, of doing anything to change in his life. He felt like a victim. A helpless, innocent victim that, what happened, was a result of fate, or a result of God. And he just refused any idea. And at that point in time I had always been real firm on taking responsibility for your own actions, for your own beliefs, for your own thoughts, for your own feelings. And when this guy resisted so much, inside I would, I would get like this turmoil and as a result I confronted him with it.

The therapist described the escalation of increasingly direct and hostile confrontation between herself and the patient in which the patient would leave the room and the therapist would find herself getting angrier and angrier.

He had been in the system, he had heard all of this before, and I felt perfectly safe confronting him about it. So I would do so and frequently during this hospitalization he couldn't handle it. He'd get up and he'd walk out of the room saying, "There's nothing I can do about it." And it would

infuriate me. Because I thought, Mister, you know, you've been through this, you know, not that I want you to repeat what I'm telling you, but to help him ... really believe deep down, that he had a responsibility.

This escalation came to a head in a way which recalls Gadamer's and Heidegger's descriptions of what it means to confront the other in such a way that your own preconceptions are revealed as inadequate to encompass them. Finally she recognized him as foreign to her understanding, finally actually experienced him. She had an experience of confronting someone strange, someone whom she could not judge and understand in familiar terms. This is the way she described that experience.

Anyway, one particular day, you know, I was becoming somewhat confused as to what to do about this at this point. I made a comment to him one session in which he couldn't handle it and he left the room. And I thought, this can't go on. I don't want this guy to think that I'm threatening him. I mean, if anything, I want to be supportive and I want to help him to realize that he has potential, just, how to actualize it. So I went to talk with him...So anyway, I went into the room to talk to him and ... then he, talking with him definitely gave me a better understanding of him, and of, and of what I was projecting upon him. I honestly felt that this guy was sincere in that he did not think that there was anything that he could do. Prior to that, I felt that he was denying any type of responsibility, just plain denial. But I actually felt that he was sincere.

The reasoning being, he had been in several times before and all of this information he had learned before. Somehow or another he couldn't follow through or it didn't work, and it resulted in the same thing, him coming back. He went into God -- that's the only thing that he had -- to hang onto, and his family. And he went on. I don't remember the specifics of the story but I remembered at that point I stopped and I said, 'Mary, who the hell are you to say, 'Hey, these are my values, these are my beliefs, and you should follow them.' And it just, it just changed my whole treatment, my everyday treatment from that point on. And at the end I told him, I said, 'Listen, I want to thank you. You've really shown me a new perspective and I've learned a lot from you.' At that point I left. It's amazing because (sigh) it's so easy as a therapist to impose, you know, like I said, your values and your beliefs on others. And it's not always the case. I think that a lot of people have a potential and they may not see that potential. And I think by reflecting some of your values and beliefs may help them to see alternatives. But I think there's also cases like his where it doesn't matter. You know, that they have a different set of standards. And I think that recognizing that makes all the difference, all the difference in effective treatment.

This is an account of the revision of a story about her therapeutic work with this client. Her earlier story, which is abandoned in her final confrontation with this patient, embodied frustration at his irresponsibility, his unwillingness to take on his proper role in the work of

therapy, which could have led to improvement and, ideally, his ability to function in his job and with his family, and an end to the repeated hospitalizations. The earlier story affixes blame firmly on the patient: Therapy is not working and it is the patient's fault. Her confrontation with the patient reaches a climax in which she comes to question the simplicity of her earlier story. Therapy is not working with this patient but perhaps she is wrong in the story she has told about who this patient is and why she and the rest of the staff have been so ineffective. In her revision of the therapeutic story, she comes to see the patient as holding a set of beliefs which she certainly does not share and which she finds unfortunate but which nonetheless are real beliefs, not mere excuses for irresponsibility. Her revised story is that she and the other staff, who believe that patients should tackle their problems, were coming into conflict with an equally strong, and equally respectable set of beliefs the patient held.

In this example, the therapist relinquishes the right to blame the patient for not getting well. The reframing of most consequence in this last case is not the therapist's recognition that the patient could be seen as holding a set of beliefs rather than as stigmatized by his irresponsible personality, but, rather, her recognition that certain preconceptions of her own as to the therapeutic participation which characterized sincere patients were her own beliefs, not a universally relevant set of truths. This

discovery is one which anthropologists love to recount: That when you confront the other, you may come to see that what you previously had known uncritically as the truth, as simple facts, change their ontological status and suddenly appear as beliefs. What was natural is suddenly visible as cultural.

Searching For a Story And Getting Lost

Some accounts of trouble in therapy were not about mismatches between expectations based on previous therapies and the realities of a present attempt. Instead they were stories about the difficulties of attempting to understand a new patient through a story about an "ideal type" of patient. Such matches offered the therapist a familiar starting point. In addition to past experiences with other individuals, therapists relied on a repertoire of patient types, and they often turned to the diagnostic categories of biomedicine for this kind of help in organizing the treatment possibilities.

When the diagnostic categorization proved uncertain or when new evidence arose that suggested another category might be more appropriate, the therapist would often find herself lost, between clinical stories. Such diagnostic confusion was rarely the sole problem, though it was often the one therapists initially cited. Even when therapists who were interviewed initially identified their primary confusion as a diagnostic one, further discussion of their

problems nearly always revealed a set of issues which connected their difficulties not only to an uncertain diagnosis but also to confusions or conflicts with the patient's interpretation of the meaning of the disability. Confusion over the appropriate diagnosis of the disease tended to be confounded by conflicts and confusion over the meaning of the illness experience.

This is evident in both of the following cases. In each, the initial impetus for the therapist's dissatisfaction is a realization that there are symptoms present which do not fit the treatment approach she has adopted. In some cases this confusion is exacerbated by the therapists' uncertainty as to the biomedical significance of the symptoms.

A pediatric therapist initially diagnosed a three year old child as having sensory integration dysfunction and began working with the child with that in mind. She later became increasingly unsure about the child's problems, wondering if she was not seeing a head injured patient instead. When she was interviewed, she at first discussed her confusion in terms of the difficulty of making an accurate biomedical diagnosis.

My impression at the time that I first saw him was that he might have sensory integration dysfunction. He was so opposed to any kind of movement and tactilely defensive that I was looking at him and kind of that that was why he is so clumsy. But the other issue was the head

injury. They really made... the family was making light of that. So physically, I guess it is his diagnostics that are not clear. He now looks more like a head injured child than anything and even at the time he did to me. He also had a lot of things that shouldn't... that sensory integration dysfunction doesn't have. So I was trying to decide: Should I treat him more like a physically disabled child or try to integrate the information from the environment?

As she continued to recount her problems working with this child and his family, other aspects of the situation were presented as candidates for the "real problem." She admitted that she usually does not have a clear biomedical diagnosis when working with young children, which is typical for pediatric occupational therapy in general. Patients are often referred by pediatricians simply as "developmentally delayed" which "doesn't tell me anything," she said.

If I get a referral and it says 'developmental delay' I really don't have any information when the child comes in. I can get information from the medical record, but when they send me the consult often what it says is 'developmental delay.' I don't really know how they will look when they come in.

Even though lack of clear biomedical diagnoses was common, she felt especially lost with this child. When pressed by the interviewer, her language shifted and she described the patient as having gotten lost.

Therapist: I just want to be more clear.

Interviewer: Do you think that most cases are clear?

Therapist: I don't think that most cases are clear.

Interviewer: So why was this case so much more frustrating than others?

Therapist: I don't know. I think it's because it became kind of lost. I hate it when people get lost.

She never really understood any of the actors involved in this child's illness. It is as though she walked on stage where a play was going on and she didn't know the script. This therapist was new at the hospital and was not yet familiar with how things were done. Her patient's family was Spanish and she didn't speak Spanish. She could talk with the mother through an interpreter when one could come, but she couldn't always get one. The family was not regular in their visits to the clinic so she would go for weeks without seeing him and then when she saw him again, things would look different.

The thing I feel most frustrated with is he is three years and eight months old and the family is not so good about bringing him in and I see him so infrequently that it is almost like I can't get a handle on him. Every once in a while I'll change my view point but then it is a couple of weeks before I see him again. And just when I think I am getting a handle on him I don't see him for a while.

The mother explained to her, through an interpreter, that the child had been dropped on the head by an uncle but

the mother didn't seem especially upset about this or appear to take it very seriously, which further confused the therapist. The child had been treated in the hospital for the head injury and yet no one at the hospital had followed him up. The therapist described herself as bewildered at this. "That sort of surprised me that even after he had been to the hospital and the fact that he had been delayed he hadn't gotten any follow-up except by his pediatrician. This is kind of surprising because to look at the child, he looks very clumsy... very awkward movements."

At the end of the interview she repeated her surprise at the hospital staff's lack of response. "I am really surprised with him after being in the hospital for four hours with the head injury at that age, why he never got any follow up. He definitely doesn't look like a normal child. I mean even if you just saw him you would know it." The importance of the hospital's neglect initially was that it simply added to her confusion about what she was seeing. Neither family nor medical staff had seemed to take the head injury seriously and the child's behavior was ambiguous, so perhaps it wasn't a head injury related problem after all. But then she saw increasing signs that this was indeed the problem. But if this was the problem, and the injury happened two years prior to her treatment of the child, then a very different scenario should have occurred. The child should have been followed right at the time of the injury and this did not happen. This led her to a whole different

kind of conclusion, to a different kind of story, one in which her patient had "gotten lost.". "People get lost in the system all the time. That is a very big frustration of mine." She also believed that she had contributed to the child getting lost for the months she had treated him. The child was not coming in frequently because the family was poor and she was treating him in a private pay clinic. The child really needed to be in a school program which would not charge the family but she, being new herself, did not know how to go about getting the child into a school program. The therapist summed up her sense of how she had never "found" this child or gotten him to a therapist who could "find" him:

I started to see him in May and I felt the reason he got lost is the private pay. It is so expensive to the family that I tried to get him into a program real fast. Now I feel kind of bad that it is going to take so long he is just now into the school system. Part of the problem is that it [seeing this patient] was six months after I got here and I didn't know the system well enough. When I first saw him I should have gotten him right into the school system...He really needed more therapy and that is what I feel bad about. They are private pay. They don't want to come in a lot to see me. So they are pretty good about bringing him in but it feels... and I can't get a handle on him. I can't get a good feeling of what he can or can't do. I mean, I know I have an OK idea. It is probably pretty good, but with

some cases you feel like you know the child, but with him I don't.

The therapist never finds a place in which can become effective in this story. The patient is lost. He shows symptoms of this, symptoms of that. The family is lost. They are paying for something they cannot afford and they speak Spanish so no one is helping them locate good resources for their child. The therapist is lost. As often happens when therapists describe troublesome cases, she narrates a short scenario which conveys her understanding of her proper place in a therapeutic process. Unlike the cases reviewed above, she does not refer to a previous case in constructing her understanding. Instead, she sketches a generic story which sums up a particular aspect of many previous cases.

Changing Stories In Mid-Stream

In the two cases discussed in the preceeding section, mismatches occurred when therapists tried to prospectively emplot their work with a particular patient by using a story derived from previous work with another patient. Each of these therapists had serious difficulty in coming to a way of responding to certain aspects of their new patients' behavior. It is as though they could not invent a revision of their initial story which would make their work with these particular patients "go somewhere" in terms of therapeutic productivity. They could not emplot a course of

therapy for these particular patients which led to a rehabilitative ending.

The confrontation between story and experience does not always happen in this way. It can also be triggered by changes in the patient. These can be complex, meaning-centered changes as the patient comes to see herself and her illness differently, or they can be changes in the illness experience which are created by new physiological complications. In the following example, the therapist had been working successfully along one treatment path until some unexpected and puzzling physiological symptoms occurred. This violation of her prospective plotment led to an involved exploration and a change in the clinical story:

I've known this client for at least ten years. He was a student in the school where I was working and he grew up into the adult program. He was verbal and he had some of the problems that are inherent in being severely retarded, you know, poor ADLs ["activities of daily living"] and things like that. About six years ago he developed retinal detachment and he became blind. And I didn't know too much about training blind children, whatever. We got over that hump and he, once again, attained independence for his daily living tasks and vocational tasks, whatever. And then about a year ago, I was still working for the adult program, Joe became very wobbly, poor balance, started to fall. Not tripping over things as if his blindness was getting in the way but like his muscles were losing control. And I

was calling the head nurse in the residential facility where he lived and I was telling her these things that I was observing...Well, within two months later, Joe would fall and not be able to get up. There was no muscle control. Pretty soon he couldn't feel anything. And I was very upset at this point. We ended up, I pushed, got him into a rehab center here -- at least for an outpatient evaluation. They found out that he was a T9 paraplegic at that point. And because, what we didn't know, that the neurologist had not even touched him during his assessments these first four months after the symptoms were noted. It had gone too far and operations could not help at this point. There was too much nerve involvement at that point. So I had to, so this young man is now paraplegic in addition to being severely retarded and blind. So that really made me have to rethink -- now what do I do?...So I think that's the scenario for how I had to rethink things and really struggle to get him back on his feet, so to speak.

In a narrow sense, what was reframed here was the diagnosis as the patient's new symptoms were finally understood and named. The therapist saw her role as helping the patient perform his ADLs but as new problems arose, this required her to change her approach. The deeper story here, however, the one which she elaborated later in the interview, concerned her sense of uncertainty and impotence not only about what was happening to Joe but about what her role should be in trying to get help for him. She was very close to this patient and felt responsible for him. She was

the one, according to her story, who was most aggressive in noting symptoms and trying to find out what was going wrong. What she found out in the end was that if he had been diagnosed four months earlier, he never would have had to be a paraplegic. This hit her very hard.

There were two vivid narrative moments in this interview. One was where she remembered how Joe talked to her about what had happened to him.

There was a point, it was about four or five months after the first symptoms happened, where he was saying that his legs were 'gone away.' 'No more legs.' 'All broken.' 'All gone.' And he was sad. He was very depressed. He didn't care. He wasn't eating. You know, he just shut down." He loved music and she had spent time listening to music with him. When he could no longer use his legs he would tell her "I want to walk. I want to dance.

The other striking moment was when she described what it was like to try to do something for the patient and not be able to find her way through bureaucratic channels, all the while knowing that something was going more and more wrong.

Therapist: I saw something happening and I was scared. I didn't know what was going on. And especially as it seemed to get in his everyday, in the way of his everyday life, I was afraid. As I tried to take steps to get this situation changed, I, boy, I felt frustrated and angry. Real angry.

Interviewer: At whom?

Therapist: Most. well, I don't know if it's an "at whom" or at the whole situation. But it

seemed like every new person we went to talk to, to consult, therapy, was like running into a brick wall. I felt frustration with the system, quote unquote, working with DD [developmentally delayed] adults to begin with. There's a lot of medical people who don't automatically know how to handle a DD adult in their office. You know, because the person can't talk fluently or can't express the symptoms verbally. It's real hard to diagnose or to treat. And I think I was very frustrated with that situation. And the frustration grew into anger as the problem was not identified."

While this therapist began the interview with a story in mind which centered primarily on how she had had to change her treatment approach as this new complication occurred, particularly how she had had to call upon her rusty capacities as a physical disabilities therapist (her primary training is in psychiatric occupational therapy), her narrative shifted to focus on her own frustration and fear at not knowing how to get help for the patient, and her feelings at seeing her patient become paraplegic.

The heart of her revision is not the shift in her patient's diagnosis but the vicissitudes of her own role as therapist. At the beginning of the interview she stressed her role as one who worked on ADLs. But as the interview progressed, she went over and over her fear and frustration at not being able to get the patient diagnosed. She ends the interview, by describing her revised sense of what it meant to be a therapist to these kinds of clients. Her change which she ultimately emphasizes is not the tragic change in this particular client's mobility, it is the change wrought by the entire episode in the kind of therapeutic story she wants to realize with her retarded

patients, particularly in her intensified concern with talking for them to medical professionals who are not used to listening to such people.

This is a much broader story, one which includes more characters, even the entire medical bureaucracy in which she works. And it is less "strictly OT" in its dimensions because it emphasizes her need to listen to patients and then to try to communicate what she sees and hears to others whose help is essential in addressing problems which these patients can not adequately describe on their own. Her widened conception of the problems involved in treatment is evident in the "moral" she attaches to her case story at the end of the interview.

I think I feel a little bit more sure of myself in making, yeah, in making decisions for people, for clients that I work with. And I do work with... you know, the majority of my people are severely, profoundly handicapped. I feel much more sure of the recommendations I make. The recommendations I have made, I find myself qualifying why I'm making the recommendation and how, if such and such is done or carried out, how this is going to impact that person's life on a daily basis. I think I'm more careful now in putting in more details so then more people can understand the whole situation when I'm making recommendations for clients. I think it's changed the way that I think about things like advocacy and confidentiality, and even follow through for somebody who can't talk for themselves, you know,

who can't express the feeling or whatever. So it's made me listen with a third ear in a sense.

Re-emplotments were often provoked by ambiguities or difficulties in a patient's diagnosis. Accounts of these changes in narrative expectation often took the form of a drama in which shifts in the patient's diagnosis directly provoke shifts in the therapist's view of her role. The following account has many of the qualities of a detective story in which the therapist is trying to discover the correct diagnosis of a patient. It illustrates particularly well the integration of the two forms of clinical reasoning differentiated in earlier chapters: narrative reasoning, which deals with motive and with developing a coherent story of the illness experience; and propositional reasoning associated with a biomedical approach, which concerns the diagnosis of a disease (and associated dysfunctions) from symptoms and signs.

This therapist's story concerned his treatment of a girl with cerebral palsy (CP) who had been tentatively diagnosed as psychotic. When he heard that she would be arriving on his ward, his first reaction was nervousness about his own ability to deal with someone with a severe physical disability.

I remember feeling apprehensive about it, about going to see her and taking on this case because I felt, 'Oh my God, I don't know anything to do. What am I going to do with this person?' So I went and met her and she was very nice. It kind

of allayed some of my fears because at least we had a good rapport from the beginning and that was good.

The medical diagnosis provides therapists with an initial picture of the patient and therapists can have quite strong reactions to that picture even before they meet the patient. Because the patient was in an unfamiliar diagnostic category, the therapist experienced being at a loss for those particular skills and competencies which physical disabilities occupational therapists accustomed to handling CP patients would have. He was also at a loss for ways to 'make sense' of the patient. "What am I going to do with this patient?" he asks himself. He did not have a repertoire of stories about working with such patients. He then turns to puzzling about what is really wrong with her, because he mistrusts the tentative diagnosis of psychosis which has brought her into the hospital.

Her school was sending her to the hospital. They were afraid that she was psychotic, that she was hearing voices and that she was hallucinating more, and things like that. My immediate thought, even before I met her I guess, was that, 'Well, is this psychosis or is this just a retarded person's consciousness talking to them and it's being construed as auditory hallucinations, which sometimes happens?' An MR [mentally retarded] person will get labeled psychotic when that's just the way the (unclear) can express themselves and, when they express it to someone who's not also MR,

they start to (unclear). But it's not so weird.
It's normal."

His initial response to meeting her, as he narrates it, is relief because "she was very nice." This is an interesting statement, implying that in that first meeting she began to emerge as a person for him, someone more than a member of an unfamiliar medical category. In his story he discovers more and more about her life history and about the particular pressures and stresses that plagued her up until her entrance on his psychiatric ward. This portrays his progression from a biomedical way of seeing to an increasingly phenomenological one. The therapist himself refers to this theme in conclusion to the account. William Labov has described oral narratives as tending to conclude with a final "evaluation" segment where the storyteller informs the audience about how the story should be interpreted. In this story the narrator gives an extensive final evaluation which returns him to the opening theme of the story, his initial concern with treating a "CP" and his relief to discover that he could see her "as a person."

So at the end it felt much better because I wasn't seeing her as CP [cerebral palsey] anymore. I was seeing her as another person who came in with a psychiatric problem...What's weird now is since her, I've had two other CPs on the unit. It's kind of neat because now I don't feel so...I don't feel like such a (unclear) that I've never had this complication. In fact, we're getting more

medically, or dual diagnosed, patients. It's just another patient with a psychiatric problem too.

This patient emerges as an individual person only as her therapist is able to recategorize her from an unfamiliar to a familiar medical category. The narrator never leaves his professional categories behind, and his journey of becoming able to see the patient follows a rather different path than hermeneuticists have described. He confronts a patient who is initially foreign to him, not because of some unassimilable uniqueness but because she represents a member of a medically unfamiliar classification. The story is one where the therapist is gradually able to make her more familiar to himself. This familiarity goes hand in hand with the therapist's growing understanding of the patient's particular life history. She is most stereotyped when she is the strangest to him. As he can assimilate her to familiar ways of seeing and familiar ways of treating, as he is able to see her as "just another patient with a psychiatric problem," he is paradoxically making it possible to see her as a particular individual. Familiar categories are not at war with the ability to experience someone as having a personal identity which comes from a particular life history and illness experience. They serve to help the therapist see the patient in less stereotypical ways.

The drama of this story is the therapist's work to try to make sense of this patient, diagnostically speaking and narratively speaking. He begins his diagnostic search with

the question of whether the patient is really psychotic or whether she might be retarded (an MR patient). That was quickly settled: "It turned out that her intelligence was OK. So that wasn't a problem." Having ruled out that possibility, he examines other options, unwilling to settle for psychosis and confronted by another complicating factor which might explain her unusual behavior.

I remember thinking that (unclear) or I wasn't going to believe that she was psychotic unless I had good reasons to believe. I remember another thing that I didn't like about this case. One of the reasons she was coming in was because she had gotten more autonomy away from the school where she was staying and could leave the school and come back. On one of these trips she had met this fellow from a church group and he was kind of, very, oh, I guess the best way to say this is he was kind of a cult, church follower. He started putting into her, she started having more and more problems after this relationship because a lot of her hallucinations, or such things, had to do with religiosity. So there was a lot of concern by everyone, all her school teachers and the dorm manager where she was staying, and things like that. So I guess the first way I started approaching her was that, was to find out whether or not she really was psychotic. After I had heard all of these other stories about the religious cult and, I guess I felt less and less confident that she was schizophrenic and just our interactions were also pretty logical.

His attempt to understand her was organized as an attempt to appropriately categorize her, as is evident in his description of his interactions with her as clues favoring various possible diagnoses. His interactions with her gave conflicting evidence about her mental status. At this point, he was trying to decide between two possible categories, psychotic or "just a behavior" probably induced by her association with the cult church leader. While for the most part her interactions with himr "were pretty logical" there was some conflicting evidence.

We were setting goals in a group one time and she said her goal was to not live in an imaginary world. And I go, 'Oh my God, she is psychotic!' And, but then she wrote some of her days (unclear) down and some of her steps that she was going to take, which didn't sound so psychotic. But what was weird was that later on that day she came up to me and told me that she shouldn't have told me about living in an imaginary world, that was a mistake and I should just forget it. Then I said, 'Oh (unclear)' [audience laughing, covers storyteller's words on tape] So then I thought that she was trying to be manipulative with me and wanted to talk about certain things but not other things.

The turning point in the story came when the therapist had a talk with the school social worker who offered some background information on her. This changed his whole picture of her, because crucial facts about her situation emerged. The girl was graduating from her school in three

months and was going to have to find a place where she could live on her own for the first time in her life. This led him to become confident that the diagnosis which he had suspected -- behavioral rather than psychotic -- was the correct one, but it also required changes in the story which he had constructed about why these symptoms had emerged. Rather than believing that her association with the church cult has caused them, he decided that it is her impending departure from the school to live by herself for the first time -- an impending loss and a difficult test of self reliance -- which has created the stress that led both to her wish to join another home (hence the church group) and to her fantasies and hallucinations.

Then when I talked to her social worker at school there was a whole different picture of her altogether. I started... I think I started reframing it right then. The problem was that she was going to graduate in like three months and she didn't have a place to live and she was going to have to find a place to live. The school was going to help her but that was something that she was going to have to deal with. She had been living at the school for like three years or so and she really didn't have a family to speak of. They weren't supportive. They didn't see her that often. I started seeing this attempt to go find this church group as an attempt to find a family. The...[thing I] was starting to see that ...she was really worried about this change in her role. She was going to have to be on her own, yet she didn't know how to do that. So her response was

to forget how to do everything else. She forgot how to get to school on time. She forgot how to clean up her room. She got kicked out of everything that she had been doing before.

The reframing the therapist describes allows him to choose between the two competing diagnostic categories he had been debating and to assemble a convincing narrative of the patient's history in which the cause of the patient's symptoms is interpreted as a common psychosocial stress. A biomedical model of clinical reasoning and a narrative model of clinical reasoning go hand in hand here, one reinforcing the other. "Getting a handle on the case" simultaneously means coming to understand the patient's illness experience better, suddenly understanding the stressful and frightening situation she was facing -- a young girl with cerebral palsy and little or no family support about to be let loose on the world -- and feeling confident about his diagnosis. The therapist goes on to describe how this sudden emplotment of the patient's life entailed a significant revision of the story of the onset of her current symptoms which he had developed earlier, which had also diagnosed her problem as behavioral but which attributed the cause to the church group.

And it was funny because I started, I think, going on a path that it was all a result of meeting this guy and getting into this religious cult. And that certainly was one, I am assuming, one of the major precipitators to her coming to the hospital.

But I was going on this path thinking that that's why her other roles got disrupted. She started this church role, and her school and homemaker roles were disrupted as a result. But I think that was just kind of a (unclear) because, eventually, I started thinking that the case was that she was having difficulty with the idea that she was losing her family, losing the school.

When the therapist is able to identify the patient as belonging to a familiar category of problems, he is able to draw on his own competencies and therapeutic narratives to emplot her treatment. He is able to act. He is able to create a prospective story which leads to a rehabilitative ending. This prospective story is informed by: (a) diagnostically relevant concepts from biomedicine and psychiatry; (b) an illness narrative constructed from information gleaned from the social worker and other sources; and (c) theories within occupational therapy, notably role theories from the Model of Human Occupation. All of these he utilizes in constructing a practical story about how treatment would go with this patient. The "behavioral" category in which her current problems are ultimately classed is given solidity and concreteness by the illness narrative the therapist constructs which explains the onset of her symptoms. Simultaneously, her illness as diagnosed leads him, via his knowledge of the principles of treating psychiatric disorders of this type, to a repertoire

of narrative fragments which he then sees as appropriate to draw on in prospectively emplotting a course of treatment.

So I guess I ended up feeling real good about the case because what I ended up doing was to focus with her on roles and reorganizing her life around activities that support certain roles and how she was going to make plans for the next three months between the time she went back to school until the time that she graduated. Although, during the acute hospitalization she wasn't able to set...to be realistic with that three month period. I think that she did learn some skills in terms of realizing that, I mean, she had a plan for at least the first week when she went back to school, things that she was not going to do and strategies that she was going to use with the team. Her team came in from school, and we had a talk both as a team and I had a talk with her [the social worker] as a leisurely (unclear) and felt like we were able to come up with things that were realistic for them [the team] to do in terms of giving her more structure.

This case shares some important features with others in this chapter. The accounts of re-plotting therapeutic expectations given by the pediatric therapist and the psychiatric therapist who worked with MR patients concern difficulties in getting a fix on the patient, both diagnostically and narratively. This lack of a clear diagnostic category appears to leave therapists at a loss for resources out of which to fashion a convincing prospective story, which is what they need to identify their

role and plan their interventions. The case of the psychiatric therapist with the CP patient concerns the therapist's search for a diagnosis. The closer he gets to a good diagnosis, the closer he gets to the patient's illness experience. His deepening understanding of both diagnosis and illness experience enable him to orient himself with increasing confidence to a particular set of therapeutic plots drawn from his own past experience and training. His initial prospective story is hardly a story at all, giving him no confident ground for action, so he searches for a different story, and chooses to conduct this search via the search for the correct psychiatric diagnosis. He explores different versions of the etiology of her symptoms. When he identifies causes and symptoms which he feels confident about applying to this patient, this allows him to construct a better prospective story, one crafted for this individual patient but informed by general professional theories.

And, when I reframed it, I could use the whole idea of roles, from the Model [a theory of practice in occupational therapy called the Model of Human Occupation] but also psychodynamically, the issue of family and having a place to live and how the disruption was a symptom of this psychodynamic issue that she was facing. And she was able to have some insight about it too. She realized what she was looking for, at some level. It was an interesting case.

CHAPTER TEN

THE DIALOGUE BETWEEN STORY AND EXPERIENCE

This thesis is about thinking with stories. It is about narrative as a powerful organizing framework for making sense of experience, a framework which also serves as a practical guide for doing things, for altering experience. Among the occupational therapists in this study, narrative was one of two dominant sense-making modes and therapists called upon it variably, according to how they interpreted the clinical problem they were treating. They treated clinical problems in two broad classes, as a biomedical matter or as a matter of illness experience. They shifted, often quite fluidly, from one perception of disability to the other in a single session. They also sometimes worked in such a way that the same activity carried meanings in both domains simultaneously.

Therapists sometimes reasoned in a mode which was a recognizable version of the medical model and of the medical framing of clinical reasoning as an applied science. This mode of reasoning deals in the application of general and abstract principles -- clinical reasoning as applied physical science concerned with the diagnosis (and treatment) of disease. This is a mode therapists rely on particularly when they address the biomechanical body. Although therapists are not diagnosticians per se, they do a certain analogous work in the identification of

dysfunctional status of the patient. From tests and structured elicitation of information from the patient (called "assessment tools" or "assessment instruments") they work from the manifest symptoms and signs to an assessment of the patient's functional deficits and possibilities.

Narrative thinking especially guided them when they treated the phenomenological body and wanted to make sense of a patient's disability as an experience. I have examined two kinds of relationships between story and experience in occupational therapy. One is narrative as a discourse for reflection on experience. The other is narrative as a vehicle for actively configuring experience. Both these uses of story were particularly addressed to the body as a "seat of experience."

Narrative As Reflection on Experience

Clinical stories, as discourse, are about clinical experiences. When therapists describe their personal experience of working with patients they tell stories. And when therapists describe their clinical work as the treatment of illness experience, they also tell stories. These two experiential accounts generally go together in the same story. That is, when therapists describe their own clinical work as a personal experience, they nearly always also describe the clinical problem of the patient in phenomenological ways, as an illness experience. And conversely, when they focus on the patient's illness

experience, they also describe their own experience as interventionists.

Narratives offer a mimetic discourse which allows therapists to reflect on their experiences by "imitating them" through the telling of a story. Narratives provide an imitatively organized reflection on experience, a reflection which explores why something happened and the significance of its happening by showing how it happened. The imitation of action in a story -- showing-how -- provides implicit explanations and evaluations.

Because narratives are imitatively structured reflections of actions, they provide a particular vantage point for viewing the nature of experience. The stories therapists told portrayed disability from an actor-centered point of view. They were personal, even individualistic, built on the structure of actors acting. Their stories explained the meaning of disability intentionally. Disability itself shifted from a physiological event to a personally meaningful one, to an illness experience. General physiological conditions were shadowed as background context. What was brought to center stage were the ways that particular actors, with their own motivations and commitments, had done things for which they could be praised or blamed. As Alisdair MacIntyre says, "To identify an occurrence as an action is in the paradigmatic instances to identify it under a type of description which enables us to see that occurrence as flowing intelligibly from a human

agent's intentions, motives, passions and purposes. It is therefore to understand an action as something for which someone is accountable...(1981:195)"

The therapists' narratives worked at two levels, a "landscape of action" and a "landscape of consciousness (Bruner, 1987:14)." Their narratives, focused on therapeutic experiences and illness experiences, had an 'outside' and an 'inside.' They rendered a visible world of actions and conflicts and a simultaneous inner world of thoughts and feelings which revealed something about how these events felt for the actors themselves. This double rendering allowed an especially experiential and individualized interpretation of clinical activity; these narratives often gave a strong message that the clinical encounter was a singular event, familiar in some ways but still the quite particular experience of individuals located at a specific time and place. The portrayal of an inner landscape often gave the patients described in the story a consciousness, a suffering of their own, which "spilled over" a conventionalized reading of them as diagnostic or cultural types.

The social scene created by these therapeutic narratives was not an unpeopled world of social rules or cultural beliefs but a multiplicity of individual actors, with their own personal points of view, struggling to bring about the ends they desired and thwart those they did not. The sense of clinical practice as an intersection of

multiple actors, each with their own ways of perceiving what is needed and what is to be done and with their own particular desires and commitments, was particularly highlighted in the therapeutic tales because they so often concerned clashes among actors with different ways of seeing the same situation. The fact that this individualistic and multiple rendering of a social world could also simultaneously reveal so much about socially shared conventions and commitments, uncovering deep beliefs of the professional culture of occupational therapists and commonly shared aspects of illness experience, is one of the most interesting and paradoxical features of narrative.

Most of the stories therapists told were organized around a conflict between anticipation and desire, on the one hand, and actual events, on the other. Therapists told stories about times when they or their patients had expectations which clashed with the clinical events that transpired. Therapists chose situations of conflict and reframing of expectations as those which produced experiences significant and dramatic enough to provide good material for a story. The more closely the experience reflected a hermeneutic structure of collision between expectation and clinical events -- either for the patient or for the therapist -- the more easily it made for a story. Perhaps it is theoretically possible to tell a story about almost any experience but some kinds of experiences, namely dramatic, confrontational ones where something significant

is at stake for the actors, provide the most natural material for a story.

There were three main types of confrontations therapists recounted in their stories. One type was where it was the therapist rather than the patient who was confronted. These were the topic of stories recounted in Chapter Nine, stories in which therapists had powerful and memorable clinical experiences triggered by the limitations of their own approach to a patient. These confrontations were not ones which the therapist guided, ones in which the patient was the recipient, but ones the therapist suffered through because the initial prospective story crumbled. These therapeutic troubles precipitated a gradual sense that the therapy was running into trouble and the trouble was significant.

Therapists also told stories about their patients' illness experiences. The drama of these stories centered on the trauma of patients and their families facing the disability. These were stories about patients confronting their own injured bodies. Sometimes these were stories of courage, heroic tales of patients and caretakers (and therapists) finding some successful path through the tremendous obstacles the disability posed. More often they were stories of pathos, sympathetic accounts of the difficulties patients and families faced or stories about how tragedies could have been averted or lessened, how patients should have gotten better help -- especially from

doctors -- than they did. Such stories were typically told at the end of staff meetings and at lunch, as were the following short vignettes.

Therapist: There's another patient, Kong.
[Patient on the spinal cord unit.] That's what we call him. He is a Laotian. He was in a car accident and he was in the backseat. The people in the front of the car walked away. Evidently everyone had been drinking. So they carried him to the hospital. The doctor thought he was drunk. He told him, 'You are drunk. Take aspirin and go to bed.' So they took him home. He couldn't sleep all night. Then they carried him in the next day and he saw another doctor and he found out he had a spinal cord injury.

Second Therapist: There was this poor athlete from South Africa. He was black. He and another white guy wer injured. They came and picked up the white guy and left him there by the side of the road. They left him there for 48 hours, then came by in a taxi and took him to the hospital.

Finally, therapists told stories of successful therapy.

Those success stories were never about a smooth path of progress. I did not collect one story that was structured in that way though many of the biomedical accounts were so organized, moving linearly through a list of identified problems, to a set of goals and the outline of a treatment plan, to a description of a treatment process in terms of those identified problems and goals, and finally to a description of the treatment outcome. When stories were told, even success stories, they too were structured around a confrontation of some kind. Generally, this was a confrontation between therapist and patient or, more complexly, between patient and the disability which was initiated by the therapist. Therapists would remember the

times that they had pushed the patient to try to eat a bagel or make a phone call or negotiate their way around the hospital gift shop, dramatic milestones in a process where the therapist structured situations in which the patient was forced to confront and try to overcome the limitations of their body. The following story is a typical example of the therapist telling a success story about orchestrating such a confrontation. It is about taking a spinal cord patient in a wheelchair to the hospital pharmacy, the first time he had maneuvered his wheelchair outside the spinal cord unit floor.

He [the patient] had just learned how to use a sit-puff chair [a wheelchair which can be guided by puffing, for quadriplegics who have no use of arms or legs] and he got really competent on the floor [the spinal cord ward] but that was the time to get off the floor because we started talking about discharge. He needed not to be afraid to take risks even if it meant to go into a wall in a restaurant. So when we ran in [the pharmacy] he stopped about an inch short of this whole pantyhose rack and there were a lot of people there. And I turned to him and said, 'Well, you know, do you want the open toe or support hose?' There was a woman with a wonderful sense of humor who said, 'I think he should go for the knee-highs.' He didn't have prostheses on at that point. [His legs were amputated at the knee.] He just got hysterical, it was just a wild experience for him because he saw other people in the world that directed themselves toward him as a human being. I purposely made that comment to him even

though some people must have been aghast. When I said that to him in hopes that he would see I'm not afraid to treat him like any other person, like I would have treated him anyway, in front of other people. The fact that a stranger responded in such a comfortable way was perfect for him. Then we went through the revolving door, trying to get out. They are electric. They slow down when you press the button. So we got stuck cause the chair doesn't move so smooth. We got hysterical cause there was an old lady caught in the other way with her cane. We just got hysterical."

Narrative As A Configuration Of Experience

Stories do not merely reflect experience, they help us configure experience. Arendt (1958) describes the ancient Greeks held the view that one should live one's life in such a way that stories could be told about it. Taking this maxim that a life worth living is a life worth telling stories about and applying it to the occupational therapists, it would seem that therapists tried to live out clinical experiences in which there was a confrontation between expectation and experience (Koselleck, 1985). Certainly this was the kind of experience they considered most worthy of a story, judging by the stories they liked to tell the best. Realistically, it is hard to believe they tried to create difficult clinical situations in which their own expectations were frustrated. But they did particularly like to tell stories about their role in initiating a certain kind of confrontation between patients and their

bodies. Their favorite success stories concerned helping patients confront their sense of limitation and showing patients how much they could do, even as disabled people. This had to happen through the patient actually doing something he had not believed possible so that he had an experience of transcending what he had taken to be his limits.

I have argued that the experiences therapists tried to create were often guided by stories. These stories, derived from past particular experiences and stereotypical (collectivized) scenarios, were projected onto new clinical situations in order to help therapists make sense of what story they were in and where they might go with particular patients. Therapists then attempted to enact their projected stories in the new clinical situations, working improvisationally to narratively pull in and build on whatever happened in a clinical session so that it added to the story's plotline. Therapists "saw" a possible story which they recognized as clinically meaningful and they tried to make that story come true by taking the individual episodes of their clinical encounters and treating them as parts of a larger, narratively unfolding whole.

Experience As A Confrontation With Narrative

In this study of occupational therapists, I have begun to examine the way the practice influences the stories that are told and, in reverse direction, how stories influence

practice. In my exploration of how therapists try to create stories out of their clinical interactions, turning sequence into plot, I have worked to go beyond those theorists (i.e. MacIntyre, Carr, Olafson, Ricoeur) who have argued that actors structure experience narratively. My primary extension of this theoretical work has been a focus on confrontation, on how therapists develop prospective stories which provide them narrative expectations that run into trouble as their experience of working with a patient progresses. Perhaps it would be most accurate to say that their prospective story becomes confronted by the story they would tell about what was actually going on as the clinical encounter unfolds. When this confrontation becomes acute enough, and at those times a therapist allows herself to be open to it -- to "feel" the acuteness of the misfit -- the therapist may then have an experience in the hermeneutic sense Gadamer and Heidegger reserve for moments when our anticipations and prejudgements are thrown into radical doubt.

The clinical stories therapists projected onto new situations often run into trouble because the new situation was often resistant to being scripted by the old story. Clinical practice is idiosyncratic enough and illness experiences are contextually specific enough to render stories created from other times and other patients often fail short in providing ideal guides to new situations. While clinical stories are rarely ever applied wholesale --

the therapist is always tinkering, always improvising, to make the fit appropriate -- this constant improvisational work is often not enough to carry things along. When it is not, therapists experience the anxiety and frustration of falling out of the story, of losing their way. When the story no longer makes sense they lose faith in their strategies and plans for the patient because the outcomes are too far afield from ones they consider desirable.

The stories therapists told about their troubled times of getting lost portray extreme discomfort and their repeated attempts to "fix" the story or to find one which is more appropriate. If therapists were never able to find their way, never able to locate and enact a story they considered clinically meaningful, the stories they told retrospectively were often explorations or justifications for who is to blame. When troubles arose, therapists told stories which argued narratively for how things went awry because of the faulty actions of key actors. Because in narratives key causal factors which link events to outcomes are organized around the motivations of the actors, narratives are natural vehicles for explaining what happens by showing who was at fault. However, the stories therapists told were often experientially dense enough to reveal an unease with any simple allocation of blame away from themselves. Stories of getting lost with patients, even when patients or other medical personnel were firmly blamed, almost always echoed worry that perhaps the

therapist should have been different, should have acted in another way. The stories themselves sound unsettled, as though therapists were still anxiously trying to sort things out.

This study has been an experiment in considering the relation between story and experience and both concepts, story and experience, look different when studied in terms of their connection to one another. Generally those who study storytelling, even those interested in the role of stories in the life of a social group, consider the relation between story and experience through an exclusive treatment of stories as discourse, either stories as texts or as performances. On the whole, even folklorists and anthropologists who study story performance and focus on the cultural context in which stories are told do not also study the very specific practices which are being described in the stories. Conversely, those who study a group's practices, even when they have an interest in how the group narrativizes experiences from their practices, rarely examine the structure of the stories told and the structure of the practical experiences to which those stories refer.

I have tried to embed my study of story within an examination of the practice of occupational therapists and how they define and address those clinical problems they identify as theirs to solve. While this thesis is primarily about stories and their place in a professional practice, it

is also about the nature and shape of experience. There are many implications, in all this, for an interpretive anthropology which takes the problem of meaningful experience as a central question. Using narrative as a way to think about experience brings to light features of experience, and how we make sense of it, which have been neglected by anthropologists, even by interpretive anthropologists.

Interpretive anthropologists have concentrated on the problem of meaning and its social construction. But meaning has tended to be equated with systems of belief, with a kind of complex shared naming that allows actors to distinguish twitches from winks. Because every culture provides not only a system of names but attitudes toward the world it names, interpretive anthropologists have thought about meaning as something one just has as a member of a culture. Narrative, too, makes meaning of central concern. But narrative is concerned with the meaningful structuring of life through time. Narrative meaning is based on a metaphor of movement. In anthropology, meaning is more statically portrayed. Note, for instance, Clifford Geertz' famous image of cultural man as "an animal suspended in webs of significance he himself has spun (1973:5)." Here is a metaphor of containment, meaning held.

Meaning is made problematic in a narrative mode; it equals the ability to configure, to "grasp together" the heterogenous events that just happen to occur. Meaning is

something to be reached for. While anthropologists have described the problem of meaning in cross-cultural encounters where actors hold different beliefs which provide them different interpretations of what is going on, they have not taken the problem of meaninglessness as an ongoing possibility. The special cross-cultural situation of multiple, conflicting meanings is the everyday situation of narrative for commitments to an ending are rarely completely shared and almost always require the cooperation of others.

A narrative view makes meaninglessness a possibility. Meaningless is the horror of sheer succession, of one damn thing after another. Things may not add up. Therapists may then pronounce on a situation, "Nothing happened." "We didn't get anywhere." "He wouldn't budge." "It was a waste of time." "The whole session was senseless." The possibility of doing something and nothing happening, of moving through time and losing it because time moved while actors did not, of intending things but having a senseless experience, these are all ordinary expressions of everyday experiences of meaninglessness. While therapists may strive to emplot their clinical sessions for directly pragmatic reasons, to get something done, they may also struggle to do so for the less obviously practical reason that this is what makes their clinical work meaningful.

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