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ANTHROPOLOGY OF CONSCIOUSNESS

ORIGINAL ARTICLE

Embraced: On hands and nerves

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Abstract

In 2001, I experienced severe radial neuropathy, leading to permanent dysfunctions in the fingers of my left hand. In this personal account of nerve damage, medical and surgical treatment, and adaptation, I first describe the sequence of neuropathies, then turn to how through serendipity, the brace enabled other connections—nervelines—with individuals and places. The brace is a metonym of a severed nerve with its associated loss of movement and capacity; it is also both a functional orthotic and an affordance. It carries me forward, activating other nervelines and networks to make things happen. I write of literal and metaphoric nerves, evolving connectivities, and fiber lines, thought lines and collaborations. I then extend the idea of nervelines and networks to global connnections; I emphasize how the organization of labor, the distribution of goods and services, and the expectations of workers shape body histories and life outcomes.

KEYWORDS

affordances, diagnostic uncertainty, functional loss, globalization, orthotics

> ***Nerve***. One or more bundles of fibers forming part of a system that conveys impulses of sensation, motion, etc., between the brain or spinal cord and other parts of the body (OED).
>
> Functions are revealed only when they fail.
>
> (Canguilhem, 1991 [1943], p. 209)

Over the past half a century, there have been major shifts in economic life, globally. These include the globalization of labor via the increased sophistication of communication systems, enabling the outsourcing of services as well as the production of goods. The second

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is neoliberalism and the concomitant retreat of the state from the provision of care, including in states that previously supported strongly social democratic agendas. These trends in economic and political ideologies and practices impact local communities, people, and individual bodies. This includes my own, as I illustrate below.

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Nerves are information lines, fibers that transmit messages between core and periphery. The control center—the brain and spine—maintains the system, receiving and managing information, sending out orders, and relaying responses. The fiber systems—nerveways—enable communication, pulsing and responding to the to-and-fro of information and instructions. Nerves pick up changes in the environment, ensure function, and transmit warnings. Nerves sense, respond, execute, and control. They sustain bodily functions and processes of the physical body, the polity, and the social body. Yet they are also mute: we don't hear nerves do the work they do. Much of their work is autonomic; the bodily processes that sustain life—blood flow, digestion, breathing, oxygenation—all happen without consciousness and intentionality. Working nerves are an absent presence (Leder, 1990).

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In this essay, I provide an account of the chronicity of functional loss (Manderson & Smith-Morris, 2010). My own indisposition of pain and medical response was relatively short-lasting, and the early drama and uncertainties have slipped into the background. The usual story, the one I still tell over two decades later, is a simple account of why my fingers fail to work and of my brace, with its particular provenance, pathways, and functions, as orthotic, curiosity, and artwork. My focus here is partly on the history of the brace but also on its social affordances and possibilities. It is a brace that enables as much as it contains. Rather than brace 'myself' to steady my flaccid fingers, the brace holds my hand firm and so enables my fingers to flex, grasp, flicker, and point. But the brace also serendipitously enables other connections—nervelines—with people and places. The brace carries me forward to make things happen. This essay is about literal and metaphoric nerves, evolving connectivities, fiber lines, thought lines, and collaborations. But in interrogating choice and its limits, diagnosis and cause, and the continued social disadvantages and advantages of disability, I also reflect on globalization, neoliberalism, and the organization of labor.

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I like the materiality of my brace.

I slide into the brace, resting my forearm in the aluminum nest. Rigid and counterweight, it holds its place and me in it. The lining is leather, slightly padded to limit friction. It is stitched in place to the edges of the frame, an ironic, barely perceived detail—how can aluminum be stitched? I slip my fingers into the leather slings suspended from rope swings of steel. The corkscrewed wire from the support brace to the dynamic splint swings provides strength and elasticity—I wriggle my fingers, curl, flex, and straighten them out. The brain and brace work together here, restoring to my hand the extensor functions of my radial nerve. I embrace the brace and its edgy, arty look (Figure 1).

In the following, I write of a series of bodily indispositions leading to the need for and the making of the brace. I then turn to make the film *Nerve* and how the themes in the film pursue other kinds of nerves and connections. In this essay, I explore fragments of a life, and these fragments direct and shape the text. The result is an edited account, as any and all writings are; as anthropologists and as authors, we curate, direct, edit, and cut. But I also tie individual bodily dysfunctions and incapabilities to the organization of social and economic life, and so conclude by reflecting on the production of inequality and its effects on bodies.

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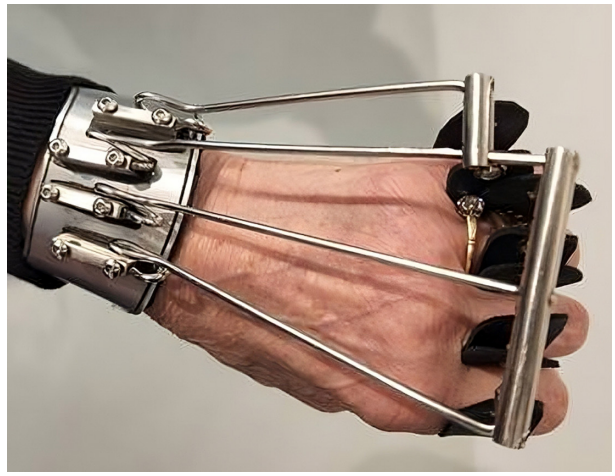

FIGURE 1 Author's brace. © Jason Patterson 2002–4. (Photo by Ilana Friedman, 2021).

NERVE ATTACKS

> ***Nerve***. A sinew or tendon; Courage or control under pressure; Fortitude; Stamina.

In 1998, while living in Brisbane (Queensland, Australia), I began to work on chronic conditions and disability, undertaking observations and conducting interviews that formed the core of *Surface Tensions* (Manderson, 2011). That first year, I went to interview Will (his chosen pseudonym). I invited him to recount his illness and surgery—cancer, bladder removal, and a urostomy—and to describe the impact of this on everyday personal care, intimate relationships, and identity. As we often assure our interlocutors, I emphasized that this was his story. I invited him to "tell me about" living with the condition. "Where do you want me to start?" he asked. "Well," I suggested, "why not begin with the first signs of illness, before you had surgery?" "The surgery was in 1966," he said gruffly. "I thought you said I could tell it my way." And so he did, beginning in 1941 when he joined the army, 25 years before he was diagnosed with bladder cancer. Many of his recollections were of World War Two, and they told a story of normative masculinity of a particular time and circumstances. His identity endured despite extensive surgery and its permanent reminders—the urostomy, the collection of urine in a bag, the everyday impositions on bodily function. "I just get on with it," he explained, "except when I forget it, and stand before a urinal rather than enter a stall." It is a perfect example of habitus.

It is almost a truism that studies of reproduction prefigure personal experience—people become pregnant in the course of their research. In contrast, scholarly interest in illness and disability is largely preceded and shaped by their experiences (as familiarly captured in Frank, 1991; Jain, 2013; Lorde, 1980; Sontag, 1978). In my case, however, I anticipated—or confused into being—various bodily experiences. My research for *Surface Tensions* rehearsed and then shadowed my transition to cyborg citizen. Were I to push this transformation, I could now include multiple bodily assaults and their mechanical resolutions: myopia, astigmatism, cataract surgery, the implantation of intraocular lenses and laser surgery; tooth decay, bone loss, grafts, and dental implants; a broken wrist and a metal plate; breast cancer, lumpectomies, mastectomy, and reconstruction. I could write of how pharmaceuticals have made me and us all: drugs keep our cholesterol down, our blood pressure steady, our moods stable, our thinning bones strong. As other anthropologists, social scientists, and

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cultural critics have written, diagnostic uncertainties, medical interventions, their tolls on the body, and technologies in response all intervene and interfere with aging and disablement, transmuting us in the process (see Dumit, 2012; Greene, 2007; Nissen & Bech Risør, 2018; Smith-Morris, 2015).

The events that anticipated my need for the brace provided me with a touchstone to test out my emerging ideas of body-self. The film which I describe below—*Nerve* (Woodson, 2008)—likewise preceded the completion of the book, and gave me further ways to articulate the tensions of functional loss and its imaginative resolution. Filming and writing gave me insight into my interlocutors' experiences and rationalizations and new ways to think about the relationships between bodies and sociality. As Kathleen Stewart (2007, p. 20) writes, a "charged particularity" in objects, images, and events helps make "implicit things matter."

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Like Will, I take my memory back, now over 50 years ago, and to my recollections, of which I had first written over 20 years ago (Manderson, 2002); I am struck by the consistency of my recollections of injury and nerve pain, in content, structure, language, and flow. But for coherence and completeness, I revisit these events here, elaborating on them while proving (if only to myself) the ways some narratives firm up.

October 1970, Canberra, Australia. I looked in the mirror early one morning and saw my scapula rising over my right shoulder. This was obviously wrong. I saw a general practitioner and was referred to a neurologist. I had a myelogram, and then, with a dreadful headache, retreated to bed. The descriptive diagnosis was a paralyzed serratus anterior, the muscle that stabilizes the scapula and connects it to the ribs. Its cause, the neurologist suggested, was a wild poliovirus. Although most cases of such infection are harmless, he explained, the displaced scapula suggested damage to the thoracic nerve, and he referred me to a Sydney-based specialist. Ever practical, even then, I took advantage of my break in undergraduate classes over Christmas to marry and then travel to see the specialist. One week after that wedding, I sat in bed, the hospital gown serving as a modesty drape and my back bare, and I slid into self-pity as specialists, residents, and medical students mulled over the anomaly and its likely etiology. I discharged myself as soon as I could. My scapula continued to wing, hindering rotation and protraction. I gave up swimming: over-arm movement was impossible. Slowly, though, the nerve healed; five years on, I realized that muscle function had fully recovered.

Eight years later, November 1978, Kuala Lumpur, Malaysia. I had finished my doctorate and was molding it into a book (Manderson, 1980). My right hand hurt continuously. I soaked it in hot and cold water until it turned tepid from either extreme, and my fingertips shriveled to prunes. I saw a general practitioner; again, I was referred to a neurologist.

My then-new partner flew to Kuala Lumpur to join me and acted as my amanuensis as I got the book to press. Once done, I pursued a diagnosis. The pain, tingling, and numbness, the neurologist proposed, was psychosomatic—a case of bad nerves/nervousness—"You must be missing your family," he prompted. I responded with hostile denial. He suggested, then, that I had carpal tunnel syndrome and proposed surgery to release pressure on the nerve.

Carpal tunnel syndrome is a common condition causing pain, numbness, and tingling in the hand and arm when a major nerve to the hand—the median nerve—is compressed as it travels through the wrist. I had paresthesia/tingling when I moved my hand, my thumb was numb, I endured throbbing pain. At the time, conditions like carpal tunnel syndrome, ganglion, bursitis and tendonitis, and other conditions defying diagnosis, were grouped as repetitive strain injuries (RSI). The pain of such injuries was commonly considered to be exaggerated—instances of women's hysterical action in the face of the repetitive demands of office work (Bammer & Martin, 1988; Reid & Reynolds, 1990). RSI was a diagnosis to resist: it suggested hysteria, excessive feminine weakness, malingering,

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poor posture, poor work environment, and inadequate self-care. If it was an RSI, it was my fault.

The day before carpal tunnel surgery was scheduled, however, the neurologist changed tack; the demyelination of my peripheral nerves was likely a symptom of multiple sclerosis. There was no internet to check my symptoms nor to follow the logic of the neurologist's diagnosis. At that point, therefore, anxious and confused, I flew back to Australia and reconnected with my first neurologist.

Multiple sclerosis (MS) involves damage to the myelin coating of nerve fibers in the central nervous system, affecting the bundles of nerves that transmit to the peripheral nervous system. With this conjecture, I went from the contested diagnosis of repetitive strain injury to a possible serious, degenerative disease with a limited toolbox for its management. But because this was speculation, I was to have a daily injection of synthetic cortisone (ACTH—adrenocorticotropic hormone) to establish a differential diagnosis. A decline in symptoms might confirm MS; no change in symptoms, no MS. And so around noon daily for five days, a community nurse came to give me a painful injection in my buttocks. Within a few days, I had a moon face in reaction to the drug; I could barely recognize myself in the mirror. Of this, I had been forewarned. But neither my partner nor I were alert to possible signs of psychosis. I spent the days in tears, frustrated when the simple task of making a cup of tea eluded me. At night, I swung from depression to mania, cleaning the oven and scrubbing floors at 3 a.m. And worse, my arm kept hurting. I did not have MS.

Three months later, although the numb patches of tissue and the paresthesia continued, the pain had abated. I returned to Malaysia to continue my postdoctoral research.

MY LEFT ARM

Nerve. Firmness or courage; an assignment requiring nerve.

In late March 2001, I was in Mérida, the capital of the eastern peninsular state of Yucatán, Mexico, for the annual meeting of the Society for Applied Anthropology. I had organized a panel; I gave a paper; I met with friends and colleagues; I attended the awards ceremonies. Being at that meeting was an annual pilgrimage designed to connect me to those who shared my scholarly interests and to overcome my sense of isolation and bruised nerves of depression. The meeting ended on March 31. On April 1, I caught a bus to Cancún, then flew to Mexico City and, via Los Angeles, to Melbourne. There, I would touch home base, swap suitcases and their contents, then fly to Canberra to speak at a conference on women's leadership.

On the morning of my departure in Mérida, I woke with extraordinary pain in my left forearm. The bus and plane trips, with their multiple stopovers, were a trial of determination and pain management—primarily paracetamol, but with ice packs as I traveled from Los Angeles to Melbourne. I went from the airport to home, as planned, but then immediately to my general practitioner. She referred me to a neurologist, who diagnosed Saturday Night Palsy—numbness and tingling from radial nerve compression, which occurs stereotypically after sleeping heavily on an arm after a drunken night, which would resolve in a month or so. I was adamant that I had not squashed my arm in a stupor, either from drinking or from sleeping on the plane. I flew to Canberra.

By lunchtime on the second day, I had lost all sensation in my hand and the ability to move my fingers. I had wrist drop, I could not extend my fingers or grasp. Alarmed by both the numbness and the searing pain, I went back to the neurologist immediately upon return to Melbourne.

The nervous system is a complex system of information pathways. The brachial plexus is a bundle of nerves—ulna, radial, and median—that run down from the spinal cord in the

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neck into the arms, governing muscle function, mobility, and sensation in shoulders, elbows, wrists, and hands. My pain, paresthesia, numbness, and loss of movement all pointed to nerve damage, but the neurologist reassured me that these nerves usually recover. The immediate task was to manage the pain, and so I was referred to a physiotherapist. I left the clinic with a TENS machine to deliver small electrical pulses to my arm to ease the pain and a splint to immobilize my hand. The pain continued. I persisted with the TENS machine, and I took a mix of paracetamol and ibuprofen rather more often than recommended until—two weeks or so later—my urine turned cyan blue. I changed tack and found an acupuncturist. Acupuncture and moxibustion worked to ease the pain, it seemed, although in retrospect, the nerve had possibly completely ruptured by then, and for this reason, there was no further pain. But at the same time, my hand was still flaccid. I continued along a train of ultrasounds and X-rays, anti-inflammatory medication, physiotherapeutic massage, electronic stimulation, and an exercise ball to restore forearm strength, extension, and grip.

Two or more months later, my dean queried my continued paralysis and my failure to draw on the expertise of my medical colleagues. I had not even considered this to be an option; I had never used the resources directly around me. I had no idea it was a right or an entitlement, and rather, regarded this privileged access as playing the system. But now I was desperate.

Once under the care of colleagues, I moved into an even more medicalized setting of MRIs, nerve conduction studies, and, in September 2001, exploratory surgery. Captured in photographs taken by a surgical registrar in the theater and later emailed to me, the radial nerve above the spiral groove appeared distended, translucent, oedematous, and twisted (Manderson, 2002, p. 354). I awoke from surgery to learn that the radial nerve in my upper arm was completely severed, hence the loss of extensor function in my wrist and fingers. I took this in as I stood at the nurses' station late at night, as we watched reportage of the collapse of the Twin Towers and the world as we knew it.

My surgeon's solution to my enervated hand, not world security, was a tendon transfer. I rejected this trade-off between one function and another in favor of a splint. I visited a rehabilitation center to be fitted with a dynamic thermoplastic splint with velcro slings and rubber bands. A brittle technology, given the work that hands do, I went back several times for repairs and replacement splints. At the same time, I met another specialist, one with experience in rare peripheral neuropathies, who had flown interstate and confirmed this final diagnosis. By this time, six months after Mérida, I was over the pain, over the fuss, and frustrated that the pursuit of etiology and the possibility of correction had diverted me from work. With the splint, perfected some months later by a hand therapist and without pain, I installed voice-to-text software on my computer and got on with my life.

BRACING UP

While the drama of my damaged nerve and floppy wrist played out, I was working on *Surface Tensions*, attending health consumer meetings, and interviewing people with dramatic, sometimes catastrophic, injuries and diseases that required life-saving surgery. These were people who had to adapt to major physical disfigurement or loss, often with resentment, broken lives, and fractured family relationships.

In the process of this research, in addition to field research, I read memoirs and biographies, examined art practices around disability and bodily differences, and talked to artists. Coincidentally, others interested in sexuality, gender, and the body had begun to extend their inquiries beyond the terrain of social science, and through these connections, I came upon the work of performance artists pushing the boundaries of human bodies.

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Stelarc is an Australian-born international performance artist who became known first for his naked suspensions between high-rise buildings in Yokohama and New York. From 1976 to 1988, he performed some 26 suspensions, with industrial fish hooks threaded through the flesh of his back; he continues variations of this to the present, although he is probably now better known for his later work, including an ear implanted on his arm (Byerley & Chong, 2015; Filas, 2013; Zylinska, 2010). He is a prodigious artist, working with digital technology, electronics, body sculptures and augmentation, cell cultivation, and more. His exoskeletal work, including the third hand and the extended arm, his exploration of prosthetics, and other work on robotics, insertions, and attachments—"alternate anatomical architectures," in his words—in manually and digitally mediated worlds, make him arguably the most prolific performance artist of the self today (Abrahamsson & Abrahamsson, 2007; Clarke & Stelarc, 2005; Farnell, 2001; Gere, 2012).

My own interest in body surfaces and their disruptions—physical appearances and limits, stomas, limb amputations, mastectomies, dialysis, transplants—for the work that would become *Surface Tensions* inevitably led me to him. Stelarc: dressed all in black, with a dapper hat and loud outbursts of laughter. Enigmatic, always on the edge. He is not a gallery poster boy, but he entices other artists and cultural theorists.

Nervousness and nerves played a role in our first meeting. I was reluctant to ring him cold; even had I the courage, I could not locate his phone number. But he was to appear at an art gallery, and I figured that if I simply stood at the back of the room on the evening, the dynamic splint made for me by a hand therapist would be a beacon. It was—Stelarc was lured by the splint. And he was adamant that I needed something better than a somewhat grubby flesh-colored thermoplastic splint with colored rubber bands. I should see the jeweler who had made his endoscopy camera and other technologies for his projects on the spatial and physical parameters of the body (Stelarc, 2024).

Jason Patterson is Stelarc's opposite—slight, unassuming, reserved. He has a background in kinetics, and while he repaired and made fine jewelry, he had worked with dancers too, bringing these disparate interests to the task. At our first consultation, he sat with a heavy volume on hand physiology and sketches of Stelarc's exoskeletons and arm augmentations (the third arm, the extended arm). Drawing on this work and the trapeze made by my hand therapist, Jason produced a counterweight brace, too large to be used, of brilliant red anodized aluminum. We opted in the end for the industrial minimalism of unembellished metal, a decision that gave me the option to retreat into the background; a red brace would never have allowed this.

The brace was trial and error: I wore it, it broke; Jason modified the design. The original brace had three arms, one on either side of my little finger and one running to the outside of my forefinger. Too slight, the arms of the brace snapped as I bore weight, so Jason added a fourth arm running up my middle finger. Then, the point of connection of the arms of the brace to the armrest proved to be the weak point, liable to snap off: this was resolved by corkscrewing them at the point of their attachment to the base (see Figure 1). The other improvement, almost a decade later, was to replace the foam lining—incorporated to prevent chafing—with leather padding, stitched into the aluminum frame. Nearly indestructible now—in contrast with the temporary fix of the orthotics—the brace still keeps my fingers in motion for most everyday purposes.

FILMING *NERVE*

Nerves convey information about sensation and motion to and from the brain or spinal cord and other parts of the body. So, too, fiber optics function as the nervous systems of contemporary communication networks, working across space and avoiding the interference that

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troubles wire transmission. Industrial fiber optics have the durability that human nerves lack. While the bundle of nerves that governed my hand was flawed, the bundles that link our worlds worked to my advantage.

Wendy Woodson and I built our long-term collaboration before fiber optics were commonplace. The nerves of our early friendship centered on my nerves—the bundles that made up the brachial plexus, the severed radial nerve. But our collaboration and friendship began with our own nervousness—our excitability and boldness in stepping outside of our familiar distinct fields of creative and knowledge production.

We made a video of my hand and the brace following our first meeting at the Bellagio Center in Italy in 2003. Wendy was intrigued by my brace. I was captivated by her focus on hands and hand movement in her short films, which she showed at the Center one night. We began to talk, to share stories, to chat over an aperitif and at meals. It was the kind of interdisciplinary friendship nurtured at Bellagio, the kind that is possible in such settings of exclusion, common values and interests, and curiosity about others' work.

We began to work together, me as author, subject, and object, Wendy as a videographer, editor, and director. The internet sustained this nascent friendship, but together, at times reticent, we used the work of film-making as a vector for communication. My nerves, the demise of my radial nerve, my brace, and the eye of Wendy's video camera created a network of pathways of communication with each other. On the back of a visit to New Zealand, Wendy came to Melbourne and began to film me; we continued in New York, then in Amherst, MA. For 14 months, when we met up, Wendy followed me with her heavy hand-held camera, asking me endless and repetitive questions, trailing behind me into trains and trams, shops, clinics and classrooms, coffee shops and restaurants. In the end, we had 30 hours of film and months of conversation with no start or end points; she then spliced, cut, and crafted this footage into a 30-minute video.

The video, *Nerve*, is an account of my demise and the brace; it tracks my visits to neurologists and physiotherapists, nerves and connections, including across continents, settings, disciplines, and practices. It is also, for me, a reflection of my nerve to be on film, so as to expose myself. I saw that later, when I watched the film at first cut and realized how much I had revealed of myself, self-conscious, sometimes sad. The video is still—many years later—true. It touches a nerve.

The nervelines are reflected in the systems of communication in the film. Some are visible: the trams and trains and cars that carried Wendy, her camera, and me across Melbourne, Manhattan, and western Massachusetts; the cell phone on which I talked; the technologies that imaged my internal nerve ways. Other nervelines are invisible, yet essential to the task and outcome: other transports, including the planes that moved us between hemispheres; reflections in windows of trams and trains capturing other travelers and passing landscapes; the recursive images in the monitors in Wendy's editing suite. The brace was a stimulus for the new connections that occurred as we worked with each other and as I interacted with her friends.

When I first saw the video, I was struck by the techniques of anonymization—the discontinuities in editing and the unsettling of conventions of time, space, and affiliation that enabled privacy and confidentiality. Scenes are sutured into a single story, without linearity—my brace changed over the time the film was made, but this is irrelevant in the film—Wendy's narrative depends not on the chronology of material, the storytelling, or fragments of read text, but on the integrity of the account. The film, to an extent, is a fiction of space as well as temporality. The video cuts from one building, often one continent, to another. We drive across a bridge in Melbourne and arrive at Ground Zero in New York. I walk towards the door of a department store in Melbourne and purchase goods inside one in Northampton. One front door shot is the only glimpse of my Melbourne life; the interior shots are of houses and apartments that are mostly neither hers nor mine. My family is not present; neither are

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my students: I speak of embodiment to Wendy's dance students, not my own. The anonymities so affected provide privacy; they mirror the techniques of confidentialization, which we assure our interlocutors in ethnographic research.

I had initially tried to steer Wendy to include my own ideas of esthetic imagery—the spokes of my brace and its resonances with the structure of a bridge, the spikes of the nerve conduction images, graphically displayed on a screen. I wanted her to capture the lines of my nerves, as I invited her into neurology consultations, and to push the nerves as objects. Wendy resisted: she was finding images, freely, ethnographically, where they scratched at the truth of the story, one I was only partly telling through speech but revealing in my silences. I recognize my self-consciousness. The nerve of *Nerve* is partly the subject of disability and the brace, partly my willingness to be exposed. The discontinuities and anonymities, at the same time, allowed for generalizability.

I like *Nerve* because of its narrative ruptures. I can tell a triumphalist story in my own way, but the brace has a life of its own that keeps on developing. If I told a story as text or on film, of sexual harassment and school bullying, or depression (these are connected, of course), or breast cancer, I could slide into the genre (just another breast cancer survival story). And none of these seem possible to write about, because I lack the nerve to do so; they are too personal. I can step back because of the materiality of the brace, its history with Stelarc and Jason, and then later with museums, in engaging with strangers, as a caveat in a will.

I thought *Nerve* was a story of a (radial) nerve, a left hand, and a brace, and not me (even if this seems an odd disconnect). But there are many ways to think this through: my nerves on a neurologist's screen; my nervous talk in unfamiliar settings; the nerves that propelled our work, alone and in dialog; the nerve that I had in teaching Wendy's dance class well beyond my own domain. The nervousness of exposure and the nerve of embracing it. My nerve is in talking about the nerve, and to be seen to do. Sadness sneaks through the bravura, and so there is the nerve of exposing points of vulnerability, as true now as during filming. The gestures, postures, cadenza of speech, a style of text exactly as you would hear me now, a shift in tone, a pause.

There is one last story of my brace as a salve and social lubricant. It precedes me; it gives me the nerve to interact; it makes introductions. I was at a conference at the National Library of Medicine in Washington, DC, with authors presenting images and the archive, as the first steps towards a book on health and the visual (Serlin, 2010). Attending a conference reception, I scanned for anyone I might know well enough to approach. And so I came to be chatting with a curator from the Smithsonian Institution, who was well familiar with the institution's own stores of orthotics and prosthetics. She had been admiring my carapace, and I retold the brace's history; she expressed interest in its destiny. The conversation ended with an offer to me to gift it, and while I pointed out that I was using it, I left elated with the possibility that the brace—my brace—would outlive me in the museum. “I'm going to be in the Smithsonian,” I told myself, then and on return to Australia. I internalized coloniality: I had spent my life as an antipodean other to a US center, and my brace in a US museum was proof of its worth (however measured). And then I saw the folly of my assumptions and the question of provenance. The brace and I were not fungible. But also, if the Smithsonian (or a staff member) wanted the brace and even showed a passing interest, then it perhaps had more than face value and Australian value. So the brace came to be a composite artifact—a material object, but also part of my history with Stelarc, Jason, and later, Wendy. And—excluding the film as a product and Wendy herself—we were (and are) Australian. The result was a new puzzle around museums and their collections, of which museum would be interested in an artifact like the brace and how one might make such a gift.

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Nerve: a sore point; *the criticism touched a nerve*.

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Once I took time off work, depressed, unable to function. “Have you had a nervous breakdown?” a friend asked me by phone, and hearing my defensiveness, argued the utility of the term—nerves might fray, snap, shut down, cease to function. Reflecting back, that was how it felt. At the time, it seemed another fraudulence, the impression that I was backing out of work rather than dealing with the load I had taken on. I cried at the weather reports, not because of global warming—this was not yet a common concern—but because everything overwhelmed me. My nerves were raw.

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Nerves. Nervous agitation caused by fear, anxiety, or stress.

The brace—as a necessary accoutrement when I opted for an orthotic rather than surgery—means that the functional damage to my left hand is always present even though the brace itself was quickly absorbed into everyday habitus. As I have noted, “(d)onning the brace is as habitual as putting on shoes” (Manderson, 2011, p. 9). It is a curiosity, admired and coveted. My first braces—make-do splints crafted by an occupational therapist and then a hand therapist - aroused muted curiosity or were politely ignored. Now, an Uber driver/barista/hairdresser/student/stranger takes it as an invitation to engage: *Is it jewelry or medical? How's your hand*, *is it getting better? Does it hurt*, *does the brace help?* I relax with the familiar response. *I hope you don't mind me asking*, *but* … I don't mind.

People who work with cognitive behavioral therapists find techniques to overcome nervousness. Acting gave me some techniques to disguise this, but the brace was better yet. The brace braces me. It resolves my nervousness. It gives me permission to offer a good enough introduction and a way of establishing—validating—myself, even if name-dropping. Stelarc, the genitor of the counterweight base; Jason, the jeweler; the Smithsonian interest—a story against myself. Self-deprecation opens up new ways of talking and reflecting on power and emplacement.

REVISITING THE STRUCTURE OF WORK

In this account, there are obvious touchstones of gender, class, race, and positionality; these resonate with our wider understanding of disability and its chronicity. Youth and gender shaped my early interactions with clinicians; being middle class in an industrialized, relatively wealthy country ensured my access to medical care. And my subjectivity and agency shifted as I moved from being a young undergraduate to a postdoctoral researcher to a senior professor at a medical school. Professors have unique access to other senior medical professors with new technologies and up-to-date knowledge of body function, disruption, demise, and repair. Encouraged to take advantage of these connections, I was able to break away from my own shame, pain, and dysfunction.

In recent years, with all three episodes of damaged nerves at a distance, I have pinpointed each episode to intense scholarly demands, using a typewriter in the first two cases and a computer in the last. It is now, I concede, probable that the pain and loss of function in all cases were linked to overuse, perhaps exacerbated by other kinds of distress and anxiety. I now also have mild Dupuytrens contracture and Raynaud's syndrome, possibly associated with or exacerbated by repetitive movement and overuse of my computer. They are occupational injuries, as are recurrent neck pain and shoulder pain.

In countries like Australia, attention to overuse injuries has declined, probably because many routine work tasks have been outsourced to poor people in poor countries. Clerical work and routine office procedures in call centers and publishing houses, like repetitive work in factory lines, have been offshored, where unstable employment reduces occupational

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safety and discourages union action. In informal work settings especially, there are few protective mechanisms, little paid sick leave, or unlikely compensation for injury. For those who are injured, a good brace, a prosthetic hand, or microsurgery are unimaginable interventions.

While perhaps repetitive strain injuries have decreased in countries like Australia, I still balked at a diagnosis of carpal tunnel syndrome. Then and earlier, as noted above, such injuries were contested. Researchers especially contested reports from women; they asserted that muscle fatigue, stiffness, cramps, and pain were being reported by office workers who were malingerers, suffering from compensation neurosis, a conversion disorder, or experiencing 'normal' fatigue (Bammer & Martin, 1988). The counter introduction of ergonomic design to reduce work injuries and optimize workplace productivity simply fed into ideas of the unreliability of reports of pain and the responsibility of workers to avoid the circumstances that might provoke it. At the same time, other conditions of unknown etiology or pathogenesis continue to be treated solely as socially and psychologically constructed, linked to excessive work stress, work dissatisfaction, poor interpersonal relationships, and poor communication (Phillips & Trundle, 2023). At least some of these factors could be treated as examples of (bad) nerves.

CONCLUSION

Repetitive strain injuries of various types, from office work and the use of contemporary technology as well as manual labor, are commonplace. Such injuries, while fading from public contestation, have likely increased in prevalence with the constant pressure on workers to be productive. Casualization feeds the reluctance of employees to report injury, and increasingly, avoiding injury is part of self-care. And even those of us in privileged positions often work far beyond a 'normal' working day—to write grants, write up field notes, and write articles for publication. And even if injured as a result, the sense of self-blame and the shame associated with this persists; it has taken me decades to contemplate whether my own work practices are implicated in my damaged arm.

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Nerves are like spaghettini, thin, even, and smooth. Nerves grow back, but not always and not completely. My nerves, in contrast—as exposed in surgery, photographed and shared − were lumpy and uneven. The radial nerve that ruptured recovered partially. I no longer have wrist drop, and the superficial sensations of my arm and hand are restored. But the muscle on my forearm remains enervated, and my fingers never recovered extensor function. The brace is essential to how I work and how I am in the world.

Hold on, I need to get my hand, I say, as I rush to grab the brace on my way out the door.

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