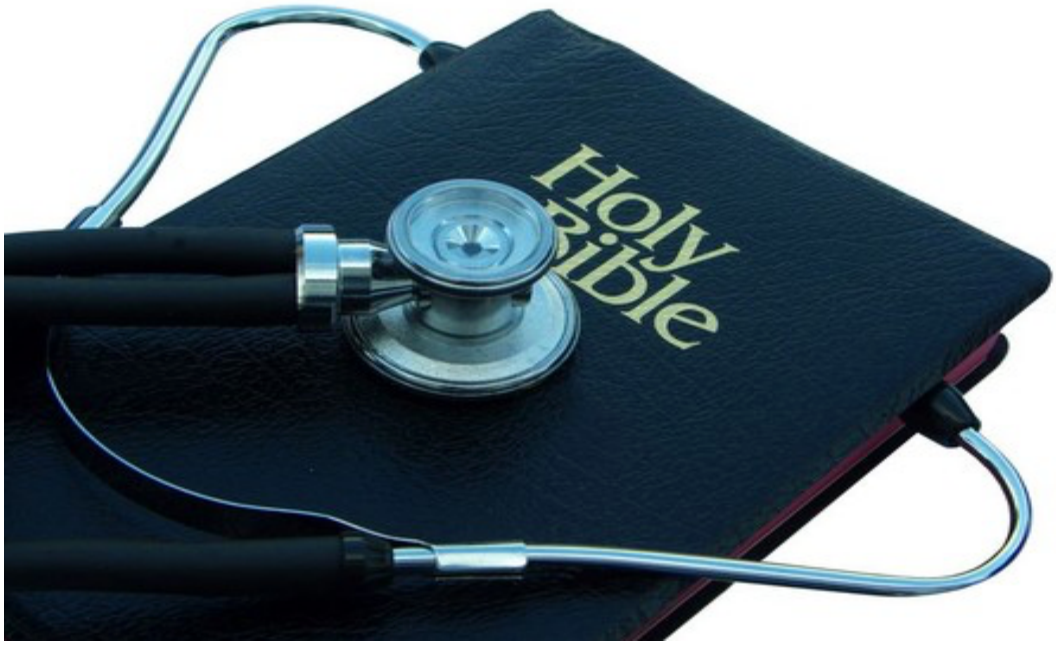
John Donne and Timothy Rogers: Exploring the Parallels Between Early Modern English Illness Narratives and Contemporary Illness Narrative Paradigms



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Introduction

Outside the parameters of mainstream media, interesting developments in the fields of medicine and the arts have been occurring. These developments have been under way for a while; the pivotal point going back as far as 1993, with a publication by the General Medical Council named *Tomorrow's doctors* (Kirklin, Richardson 1). In this publication, its authors put forth a call for change in the curricula of medical schools in the UK and suggested the implementation of "arts-based courses" (1) such as Literature (1). The objectives underlying collaboration between both fields are twofold: firstly, to "enable reflective practice" (2) and secondly, to garner a sense of understanding among future medical practitioners regarding the "experiences, perspectives and needs of their patients" (2). With the collaboration between scholars from the world of medicine and the humanities, a fairly recent inter-disciplinary field has been born: the medical humanities.

While the concept of such an inter-disciplinary collaboration is nothing modern, since philosophy was considered an imperative part of medicine in ancient times, the emergence of biomedicine and its dominant presence seems to have brought about an increasing demand among lay people and scholars for a more personal and humanistic approach to illness and the experience of suffering (1). When David Weatherall, a Professor of Medicine at the University of Oxford, had an editorial published in the British Medical Journal in which he challenged the modus operandi of the modern health care system and the "uncaring attitudes and lack of sensitivity" (Weatherall vii) of its doctors, many of his colleagues did not take to his critical view very well (vii).

Weatherall believes that the "bad press" the medical world frequently face, caused by the fact that "the horror stories continue, and a day rarely goes by without

some grizzly tale about the inadequacies of medical care" (viii), can only be solved by restructuring the national education system in which students are not required to specialise in a certain field of science so early on and thus acquire a "wider appreciation of the humanities" (ix). Weatherall asserts introducing the humanities into medical curricula can counter "the deficiencies of our national education system" (xi). If anything, a less clinical view on human nature "might help to generate a level of humility which is often lacking" (x) in medical practitioners.

The President of the Royal College of Physicians wholeheartedly acknowledges the value of an inter-disciplinary collaboration between fields of the humanities and medicine, as doctors who lack "sensitivity and imagination" (Alberti xiii) can never be "good clinicians" (xiii). Thus, this thesis is founded on the belief that without a rounded understanding of aspects of the humanities such as creative writing and philosophy, health care professionals cannot develop a sense of imagination, empathy and sensitivity needed to reflect not only on their own actions and behaviour, but also to "help them to empathise and deal sensitively with patients and their families" (xiv) as the story of their illness is being written.

Scholars such as Arthur Kleinman and Arthur Frank both recognise how the fairly recent shift in the world of medicine to a mechanistically biomedical model, is problematic when dealing with something so life-altering and personal as illness. Therefore, it would be of great value for doctors to develop a more humanistic approach to their practices and interaction with patients in order to come to a better understanding of the story of illness framing their patients' lives. Narratives define how people view themselves and the world around them, and the world around them defines how narratives are formed. In this thesis, one particular type of narrative shall be explored: the illness narrative. Illness narratives are stories relating all aspects of

what it means to be ill, from the first symptoms, to encounters with health care professionals and the process of treatment (Hinckley 91). However, these stories are anything but clinical, as "an important part of an illness narrative is the individual's emotional reactions, intentions, motivations, and inner experiences during diagnosis and treatment" (91). The latter part of this description largely contributes to what makes illness narratives interesting from a historical and socio-cultural perspective, since "illness narratives reveal our culture's view of living with illness or disability" and "are socially constructed" (90).

At the beginning of his book *The Illness Narratives*, Kleinman draws attention to what the term illness evokes. As opposed to the term disease, which is just one aspect of an illness (one that can be clinically analysed), the term illness signifies the "innately human experience of symptoms and suffering" (3). Moreover, the way in which people experience illness is "always culturally shaped" (5). However, in this technologically advanced era of biomedicine, where Kleinman argues interpreting illness narratives indeed still is "a core task in the world of doctoring" (xiii), the values of such narratives have been diminished by modernity.

Through a close reading of two early modern English illness narratives, more specifically John Donne's *Devotions upon emergent occasions, and several steps in my sickness* and Timothy Rogers's *Practical discourses on sickness & recovery, in several sermons, as they were lately preached in a congregation in London*, this thesis shall explore how illness, pain and human suffering were interpreted and given meaning in Early Modern England, thus attempting to gain a better understanding of contemporary views of illness, pain and suffering, while further exploring how this particular time in history can contribute to the construction of a socio-culturally relevant history of pain. This endeavour will be based on the belief that "human life is

fundamentally historical in character and that our understanding and knowledge are themselves utterly historical" (O'Connor 266); a premise proposed by Hans-Georg Gadamer, based on his view that traditional philosophy opposes historicity and universality and thus "neglects the historical conditions of human action" (266).

Although many explanations have been offered for the abundance of illness narratives today, the majority of these do not offer a framework for understanding culturally shaped views on the subject of illness. If critics of these collective views are to better understand not only each other, but also to develop a well-rounded awareness of the historical and socio-cultural connotations that accompany narratives of illness, then perhaps an acknowledgement of the value of illness narratives can be gained and the gap between patients and doctors might be reduced. In the least, this thesis might serve as a reminder that "philosophy (the love of wisdom) underpins all scientific endeavour" (Kirklin, Richardson 1) and that literature can serve as a (historical) reminder of our shared humanity.

Before the two aforementioned illness narratives can be considered in the light of contemporary views, the appropriate framework through which to do so must be established. In the first section of chapter 1, the early modern English perception of illness and suffering shall briefly be discussed and will be paralleled to modern day views on the subject. Subsequently, some of the work done in the field of medical humanities pertaining to illness narratives will briefly be touched upon. The second chapter will offer a specification of the different types of illness narratives as put forth by Arthur W. Frank, namely the restitution narrative, the chaos narrative and the quest narrative. These narrative types will function as a paradigm for analysing the early modern English illness narratives. Chapters 3 and 4 shall consist of close readings of John Donne's and Timothy Rogers' narratives on illness. The fifth and final chapter

will conclude by reflecting on the continuities and discontinuities between early modern English and contemporary views regarding the experience of illness, bearing in mind the historical and socio-cultural perspectives offered by early modern English narratives of illness.

1. Illness and Suffering in Early Modern Europe

Any discussion about illness and suffering cannot be complete without addressing the concept of pain. Since the concept of pain plays a significant part in "early modern reflections on the mind-body question" (van Dijkhuizen, Enenkel 4), highlighting this particular aspect within the illness spectrum, bearing in mind the time during which the illness narratives to be discussed in chapters 3 and 4 were written, will contribute to understanding not only the context of these narratives, but in addition, will also function as a framework to establish and evaluate connotations attached to illness and suffering in the early modern period and in modern-day Western society.

The majority of pain's meanings in Early Modern England were bound up with the physicality of pain, even turning emotions such as grief into a somatic affair, but this does not imply a separation between the body and the soul (5). If anything, the bodily materialisation of emotions like grief imply an inextricable link between the mental and physical realm. Furthermore, the idea of physical suffering was intertwined with morality, as the Galenic theory of the four humours coexisted with "the legacy of fifteen hundred years of Christianity" (Thomas 16) and thus the causal relationship between sin and illness was a culturally accepted doctrine (16). This belief is illustrated in a sermon by the "royalist clergyman" (473) John Reading, in which "the four humors, those familiar keystones of Galenic medicine, were understood not simply as corollary, but as a result of sin" (Smith 494). Certain bodily symptoms were associated with the Seven Deadly Sins; fever could indicate envy and palsy could be interpreted as a symptom of sloth (Thomas 17).

In addition to the belief that human suffering was a punitive act of God, another common meaning assigned to suffering was that it was a trial of faith (17). If, according to Christian doctrine, illness was a punishment by God, it served as a

"punishment for neglecting the rules of health" (20) according to a "strong explicit morality of self-care" as applied to Galenic theory. Either way, human suffering was a question of morality.

The link between pain and religious discourse was ubiquitous in the early modern era and in his sermons "Reading insisted upon the conflation of bodily and spiritual health already registered in the biblical alignment of healing" (Smith 487). Thus, bodily and spiritual health were inextricably intertwined and "corporeal suffering offered an opportunity for the good Christian to meditate upon his or her spiritual health" (473). The state of one's body reflected the state of one's soul, and the abundant variety of medically related metaphors, as noted by literary scholars and those studying the history of medicine, have especially noticed the blending of "vocabulary of health with the language of divine will and judgment" (474). The terms cure and conversion were almost considered to be interchangeable and in a time of religious turmoil brought on by the Reformation, the threat of the rapidly growing Ottoman Empire, and explorative quests chancing upon unknown peoples, "religious conversion haunted the early modern English imagination" (476).

This link between pain and suffering on the one hand, and religious discourse concerning matters such as conversion on the other, is of significance here, because early modern English works pertaining to this subject matter can reveal the "sociocultural implications" (476) of illness. Furthermore, the "narrative techniques" (476) and metaphors utilised in the early modern English narratives of illness to be discussed lend credence to the "possibility that metaphors might reveal affective and embodied forms of religious sensation" (476), while also encouraging and demonstrating "the visceral experience of divine inspiration" (476). While Smith mainly focuses on the subject of cure and conversion in the sixteenth and seventeenth

centuries, her mention of the diverse use of metaphors and their significance is striking, especially in light of a prevailing contemporary debate pertaining to the use of metaphors within illness narratives. This debate revolves around what some scholars consider to be the problematic use of metaphors when expressing pain, a point instigated by Elaine Scarry, who inspired many scholars to maintain that pain cannot be expressed in language; rather, "pain destroys language" (Jurecic 50). However, this matter will be revisited further on in this chapter, where the world of the medical humanities is discussed.

When considering the use of medical metaphors, Smith surmises that their value lies not in what they express, but rather in what they represent:

> Rather than explaining away the pangs of illness or making plain divine mysteries, medical metaphor establishes early modern spiritual experience as something that was felt as much as thought, blurring the distinction not only between ratiocination and sensation, but between bodily and imaginative feeling. (477)

This link between pain and its rhetorical merits is also expressed in *The Sense of Suffering, Constructions of Physical Pain in Early Modern Culture*, when Van Dijkhuizen and Enenkel state that "early moderns employed the idea of physical suffering as a *rhetorical tool* in debates over other issues, for example the nature of religious experience" (6).

In a sense, the matter of religion became a marketing tool for promoting good health: "illness and considerations of death were generally seen as powerful persuasive factors impelling people to consider whether they belonged to the true Church" (qtd. in Smith 479). Catholics utilised miraculous cures to demonstrate the merits of divinity, while Protestants viewed illness and cure as "markers of divine

grace" (479). Similar to the power of social media today, news outlets, pamphlets and other means through which accounts of cures were able to reach a wider public, effected "a decisive rhetorical and dramatic charge" (481). Comparable to the tasks of a physician, who first and foremost endeavours to make a diagnosis, advocates of a certain religion, like John Gerard who Smith labels "the Jesuit conversion machine" (481), made a craft out of "diagnosing occasions for conversion" (481).

While the intertwining of illness and religion was undoubtedly a useful development for some, it also came with questionable socio-cultural implications. This holy matrimony between religion and illness meant "many medical practitioners recognized the operations of God as a crucial tool in their pharmacopoeia" (482). Thus, there were concerns that the authority of doctors might lead them to abuse the vulnerability of their patients, in order to exert "improper influence" (482). John Gee, a vehemently anti-Catholic convert, expressed this concern in a way that reiterates the common early modern belief that mind and body are two sides of the same coin:

> Somewhat of my owne knowledge, concerning the insinuations & incroachments vsed by those of that stamp, who prefesse physic; Who, whatsoeuer they doe vnto the bodies, infuse into the mindes of many the Kings Subiects, bitter distempers; whereby those patients tongues distaste the wholesome food of our Church, and their hearts are stricken with *antipathy* against our present State. (qtd. in Smith 482)

Implying that a vulnerable body implies a weakened soul, this statement clearly reveals how bodily and mental health were considered to be intertwined (483).

It could be argued that the early modern history of pain was founded on "biblical history" (486), which "offered the reader numerous instances of physical cure prompting conversion to a saving belief in Christ's divinity" (486). The magical

potion of cure and conversion seemed a potent one, ubiquitously present due to the socio-cultural need of early modern people who were "attuned to scrutinizing themselves for the signs of sin" (486).

Smith asserts that the pervasive presence of medical metaphors reveals not only the early modern belief for the necessity of nurturing both physical and spiritual health, but that it also acts as a "transformative" (483) vehicle. In this way, the cure is not simply conversion, or vice versa: it also signifies a transformation and places the ultimate restorative power in God's hands. In a treatise from 1617, entitled *Davids learning*, Thomas Taylor literally likens God to a physician and employs surgical terms to convey the transformative process of conversion:

> The conuerting of a sinner, is the curing of a sick and wounded soule, and the Physician is God himself, who, that his cure may bee sound, first searcheth and lanceth, and stirreth in the wound, which puts the patient to much paine, before he power oyle into it, and binde it vp. (qtd. in Smith 488)

Contemporary views on the use of metaphorical thinking in early modern England are, however, paradoxical; one theory by Margaret Healy holds that '"in the absence of medical knowledge, metaphorical understanding"' (qtd. in Smith 489) aids people to cope with the problem at hand. Thus, "the terms of religious discourse…offer a mechanism through which the mysteries of pain and bodily experience can be reckoned with and rendered at once more concrete and less terrible" (489). Other scholars argue the opposite, claiming that "it was medical language that rendered divine mysteries accessible rather than vice versa" (489). These assertions, however, are strictly explanatory; they create a framework for "decoupling of language from the body" (490), rather than contributing to an appropriate history of pain in which, as will become apparent, there is a connection

between the collective socio-cultural conscience and physicality, which are inherent to "lived experience" (490). Thus, illness as an embodiment is not merely biological in nature; it also reveals dominant socio-cultural beliefs.

1.2 The Modern Myth of the Duality of Pain

If history is to teach us anything about the meanings which cultures have attached to pain, then the way early modern English literature depicts pain can be of great interest indeed. If one is to abandon the contemporary notion upholding the "absolute dualism of mental and physical pain" (Morris 27), the Early Modern English stance on pain might offer an enlightening insight. Not only may literature offer insights conducive to the dialogue with critics of narratives of illness, but as Morris suggests, an "effective dialogue between medicine and literature" might also be the answer to breaking down the myth of two pains (27).

When considering the concept of pain, people seem automatically inclined to link two separate connotations to this term: it is either mental or physical pain (Morris 9). This is a reaction in contemporary society David Morris refers to as the "Myth of Two Pains" (9). A myth, he claims, which is so persistent because of the "serviceable truth it brings into a murky world" (9). When challenging the post-modern perception of the duality of pain, Morris does not imply there is a fundamental difference between bodily and mental pain. He merely aims to create awareness that "different sources do not necessarily imply different pains" (9). Creating awareness of what pain truly entails and the social and cultural implications for those in pain, by shedding light on the erroneous chasm by which pain is perceived, might be more important than one can fathom, as Morris asserts that the "rigid split between mental and

physical pain is beginning to look like a gigantic cultural mistake" (12), a mistake that "puts our own health at risk" (12).

The notion of differentiating physical from mental pain was an influential notion put forward by John Calvin during the Reformation (Van Dijkhuizen 193). The intertwining of physical and mental pain, as discussed in the preceding section, "disturbed Calvin" (Van Dijkhuizen 153). It is, however, René Descartes who supposedly initiated a "pronounced dissociation" between the self (one's soul or mental state) and one's physicality, a chasm "from which we are still trying to recover" (Schoenfeldt 11). The subjective nature of pain seems to make it almost impossible to define; Aristotle regarded pain as "an emotion, like joy, whereas Descartes saw it as a sensation, like heat or cold" (Morris 15).

In most cultures, pain is considered an unwelcome and negative part of life. Kleinman even suggest that Western culture's "ideology of personal freedom and the pursuit of wealth" (23) seem for many to denote a "guaranteed freedom from the suffering of pain" (23). This contemporary view on pain is in stark contrast with early Christian perceptions on pain and suffering, during which time, suffering was believed to "serve as a form of empowerment, analogous to the way in which Christ's pain had led to a triumph over death" (191). In addition, similar to traditional practices among exotic tribes across the world, pain served as an "initiation into adult manhood" (van Dijkhuizen & Enenkel, 11) in the early modern era, and Morris points out how pain can indeed be viewed as useful in that it acts as a warning system to induce people to make "continual minor adjustments" (Morris 14) in their posture in order to prevent "inflammations and infections" (14).

To recount, Calvin's attempt to conceive of the Christian concept of pain as being either physical or mental, reverberates in the contemporary dualist notions of

pain as challenged by Morris. If these contemporary dualist notions are Calvin's contribution to modern-day's history of pain, then one must be aware of how they were intended. As Van Dijkhuizen points out: "Calvin's interest in the meaning of pain is primarily doctrinal, not experiential or phenomenological" (215). Perhaps current views on pain can begin to be reconsidered from a more phenomenological and experiential point of view. Understanding the impetus behind these views might lead to a reassessment of our historical and socio-cultural heritage of pain and suffering, and could influence the process of (secular) moralization in contemporary views on health in a positive way.

Although linking morality to illness can have stigmatising effects, "disconnecting disease from its historical associations with sin, moral turpitude, and idleness" (Brandt 56) will not help towards a better understanding of the culturally shaped construction of meanings ascribed to pain, illness and human suffering, because "the problem of suffering" (Kleinman 28) cannot be explored from a purely "medical or scientific perspective" (28). Not only could this be advantageous to addressing the multi-faceted nature of pain and suffering, it might also facilitate a more "affectively rich criticism" (Jurecic 114), but perhaps most importantly, it might serve as a reminder of how the experience of illness is

> intimately interconnected with local moral ideas of what constitutes life and death, personhood, and how doctors and society should relate to these moral categories as they become manifest in medical treatment. (Zigon 109)

Zigon illustrates this assertion with a tangible example of secular morality when considered in the light of "cross-cultural responses to irreversible loss of consciousness, or brain death, by doctors in Japan, Canada and the United States" (109). While doctors from all three countries arrive at this particular diagnosis with

access to the same tools, medical knowledge and means of deduction, the conclusions they arrive at based on this diagnosis differ significantly: whereas doctors from Canada and the US commonly deem such patients "no longer alive" (110), Japanese doctors will feel far less inclined to adopt a similar attitude (110). These morally divergent views will, in turn, result in varying medical conduct concerning how these "doctors treat these persons in terms of the procurement of organs from them" (109).

The difficulty scholars have pertaining to the subject of pain, is that it "poses the philosophical problem of subjective reality" (Jurecic 44); one cannot understand what one has not experienced. This view has been reiterated by Elaine Scarry's influential publication *The Body in Pain*, in which she argues that pain is ineffable (44). Scarry even goes so far as to claim that pain destroys language. Yet the diversity of medical metaphors referred to earlier, arguably suggests that the experience of pain and suffering can in fact lead to an enrichment of language. Moreover, Riessman has pointed to "the importance of subjective reality in adaptation to chronic illness" as it offers great insight into how "disease is perceived, enacted and responded to by the "self" and others" (qtd. in Sparkes 191). Furthermore, narratives of illness exemplify how "personal and cultural realities are constructed through narrative and storytelling" (191).

Allowing the subject of pain to remain so elusive will never lead to a better understanding of pain and all its physical, psychological, social and cultural ramifications. Furthermore, as Steenbergh remarks "other human experiences can come to be expressed in terms of pain when they, too, are characterized by this lack of an object" (181). The question of whether or not pain can be put into words should not be the prime focus of attention, rather, the main concern should be what stories of pain reflect and what their value is.

1.3 Illness Narratives in the World of Medical Humanities

In his book *The Illness Narratives (Suffering, Healing, and the Human Condition)*, Arthur Kleinman recalls an encounter with a patient that serves as a telling example of how body and mind are indeed linked when it comes to pain. Perhaps more importantly still, the patient's pain reveals a great deal about the true cause of his acute condition. The case referred to, demonstrates how psychological pain materialises physically, and perhaps not entirely coincidentally, is known in the medical world as "conversion" (Kleinman 40). He explains:

> I once evaluated a patient with acute paralysis of the legs (paraplegia), which his neurologist suspected was conversion because the neurological examination revealed no clear-cut pathology; the patient had previously been in good physical health. (41)

During the interview between Kleinman and this patient, the latter appeared in serious psychological distress, which Kleinman deduced to have been caused by a conflict between the patient and his father regarding his involvement in the family business (41). The revelation of the patient's true anguish lifted his temporary paralysis, and "over the course of half an hour it was entirely gone, leaving no physical consequences" (41).

In this embodiment of mental anguish and pain, the "paralysis of muscle covertly expresses the patient's paralysis of will" (41). Not only does this example demonstrate how mental and physical pain are not two separate things; it also illustrates how important it is to focus attention more on what is communicated by pain, rather than being blinded from its meaning by an erroneous understanding of pain as purely physical. The importance of studying illness narratives lies not in finding the perfect physiological description of pain, but in understanding the

experience of pain, an experience influenced by a shared historical and socio-cultural heritage. The IASP (International Association for the Study of Pain) defines pain as an experience rather than a sensation (Morris 16). Stories about pain call upon one's imaginative ability; "reading about pain can bring one to sympathy, but not to complete knowledge" (Jurecic 58).

Jurecic asserts that the problem critics have with illness narratives, or any literature or art concerning suffering and pain for that matter, reflects an "empathy gap" between creators of such works and "disinterested critics" (13). Affect theorists are suspicious of "emotional rhetoric or sentimental literature" (14), as they believe such works facilitate certain ideologies in society (14). The apparent need for illness narratives (as can be deduced by their abundance), born out of the need for a certain form of empathy or sympathy lacking in the medical world, seems to have resulted in something Jurecic coins "compassion fatigue" (14). However, to dismiss testimonies of suffering because they are emotionally engaging "does not serve literary and cultural criticism well as a tool for understanding life's precariousness" (14). If pain, as the IASP states, is indeed an experience, then these experiences deserve attention, for "people's ability to have experiences depends on shared cultural resources that provide words, meanings" (Frank 14) and structure people's lives.

Across disciplines, there is a divide in the manner in which illness narratives are approached. Scholars in the field of medical humanities focus "primarily on the pedagogical and therapeutic value of writing about illness narratives" (Jurecic 12), while other critics prefer to eschew such "works that tug on the emotions" (12), because they have become suspicious of works that evoke any type of emotion, something Jurecic refers to as the "hermeneutics of suspicion" (94), asserting that "critics tend to prefer indeterminacy [of meaning] to emotional engagement and

imposed ethical obligations" (11). Although there may not be a consensus on how to evaluate something as diverse and personal as illness narratives, their prominent presence and abundance do reflect important aspects of how illness is perceived in modern Western culture.

In the 1980's, when AIDS was stigmatised as a "gay plague" and "openly discussed as a divine punishment" (Jurecic 8), activists "used writing as a weapon in a cultural battle against homophobia, the disdain of the medical establishment, and the indifference of the government" (9). The flood of illness narratives about AIDS paved the way for illness narratives pertaining to all kinds of conditions. As Jurecic asserts, the abundance of this genre

> Reflects the profound need people have to tell these stories in an era when religious and folk explanations no longer give a satisfying and complete meaning to their experiences, and when biomedicine largely excludes the personal story. (9)

The lack of "conceptual, therapeutic, and existential" (9) components in physicalist medicine has created a niche for "explanatory stories about illness and healing" (9). Furthermore, according to historian Anne Harington, contemporary narratives of illness "function as amplifiers of a range of very distinctive moral and social concerns about the costs of modernity" (qtd. In Jurecic 9) and reflect the need for society to cope with "cultural and spiritual dislocations" (qtd. In Jurecic 9).

In the world of medical humanities, several approaches to interpreting illness narratives have been proposed. Arthur Kleinman has drawn attention to the existing cross-cultural difference between patients' descriptions of illness, proposing certain guidelines for physicians in order to aid them with their understanding of patient experiences (11). Psychologist James E. Pennebaker has studied illness narratives in

order to ascertain their authorial therapeutic value, illustrating how their composition can help organise and contribute to an understanding of life and the self (11). Rita Charon's medical programmes help medical practitioners to "develop an active textual and cultural knowledge of narrative" (11), thus improving '"the effectiveness of care by developing the capacity for attention, reflection, representation, and affiliation with patients and colleagues"' (11). The work of Arthur W. Frank on the subject of illness narratives, and the different types of patterns most commonly found within the genre, shall be the subject of the following chapter.

2. Interpreting Illness Narratives: Restitution, Chaos and Quest Stories

In his book *The Wounded Storyteller*, Arthur. W. Frank emphasises the need for stories about suffering, as he asserts that "to tell one's own story, a person needs others' stories" (12). People value these stories, because they are relatable at times when those who are battling illness feel most alone, and serve as a reminder that "anyone who has suffered and lived to tell the tale" (12) is a "wounded storyteller" (12). Although the experience of illness is a very personal one, "we don't make up these experiences by ourselves" (14). The very fact that Frank was able to extract three distinctive genres of illness narratives depends on the existence of "shared ways of narrating illness" (14), which demonstrates how views and beliefs on how to handle something so personal as illness are based on a shared socio-cultural understanding of illness experiences. As the core chapters of this thesis shall demonstrate, these beliefs are bound up with the historicity of illness and suffering.

As indicated earlier on in this thesis, Frank has outlined three types of illness narratives in his book: the restitution narrative, the chaos narrative and the quest narrative. By proposing these three types of narratives, Frank aims to create a paradigm for the interpretation of narratives of illness, a tool for "listening to the ill" (102). Because illness narratives can often contain all three types, which makes them difficult to interpret, his aim with the three proposed genres is to make the different stages within an illness narrative more discernable. In the following section, all three types will be discussed, more specifically those elements pertaining to plot, aspects of embodiment, how the narrative reflects the story of the self and lastly their socio-cultural values and limitations (103). Although every one of these narratives "reflects strong cultural and personal preferences" (103) which might act as barriers between

those who are recounting their illness narratives and those listening, these "barriers provide possibilities for insight" (104).

2.1 The Restitution Narrative

Although the restitution narrative is most prevailing "within Anglo-Western cultures" (Wong & King 579), this narrative is motivated by the goal of achieving a full recovery of health, which clashes with the realities of an enormous group of people belonging to a society Frank has coined "the remission society" (36). This society is a result of biomedical healthcare, in which people with life-threatening or chronic diseases are granted a second chance of life, or a longer life in the case of the chronically ill, by the grace of biomedicine (35). In line with the dualistic contemporary notion of being either in physical pain or mental pain, "in modernist thought people are well *or* sick" (36). Within the concept of the remission society, people alternately reside in what Susan Sontag refers to as "the kingdom of the well and the kingdom of the sick" (3).

The reason why the restitution narrative features predominantly in narratives of illness, Franks asserts, is because "contemporary culture treats health as the normal condition that people ought to have restored" (104). Thus, the ill person's wish to have their health restored is amplified and conditioned by the cultural and social demand for stories of restitution (104). In the basic plot of these stories, the ill person relays how they were healthy in the past, ill in the present, and will be healthy once again in the future (104). Narratives of restitution can be recognised by their employment of metaphors such as "as good as new" (104), serving as a reminder of what is at their core: health (104).

Frank discerns three modes of telling a restitution story of illness: "prospectively, retrospectively, and institutionally" (104). Prospectively framed narratives serve as opportunities for the ill person to consider an array of outcomes, a proactive attitude towards the prospect and outcome of, for instance, surgery (105). Retrospective narratives mainly consist of a description of the particular illness, a timeframe, and most commonly end with a proclamation of restored health, reflecting the need of restitution narratives (105). Restitution stories thrive on the "natural desire to get well and stay well" (105). In addition, they are proliferated institutionally, as demonstrated by Frank's example of a glossy hospital brochure featuring three cancer patients and their restitution stories, and the manner in which people are bombarded with television adverts promoting over the counter drugs by introducing a sick person, followed by the remedy for that illness, and ending the advert with a healthy person (106-107).

These examples illustrate how society is not only conditioned to have certain "expectations for how sickness progresses; they also provide a model for how stories about sickness are told" (107). Stories of restitution are powerful and have proven to be resilient, as the restitution plot can be found in the story of Job who "after all his suffering, has his wealth and family restored" (107), but extending this plotline into contemporary society and applying it to stories of illness and suffering has resulted in "the modernist expectation that for every suffering there is a remedy" (107). In this technologically advanced era of biomedicine many aspects of illness and its symptoms have turned from a mystery to a puzzle to be solved; the solution leads to restitution, but if the mystery remains it is a "scandal to modernity" (107).

The obsessive pursuit of contemporary biomedicine for a cure, the final piece of the restitution puzzle, has resulted in a complete disregard for the question of

mortality, a process Zygmunt Bauman refers to as "deconstructing mortality" (qtd. In Frank 111). The terminally ill are being put through an array of aggressive treatments, leaving no room to reframe their life and allowing the ill person to cling on to a misguided fragment of hope, when they should be guided to find closure and come to terms with what Frank refers to as their "own version of a good death" (111). In order to face the inevitable question of mortality, the restitution plot shall not suffice.

2.2 Restitution: Embodiment and the Self

Each of the three types of illness narrative reflects "a *stage of the embodiment process* of illness" (111). This embodiment can be linked to aspects of "control, body-relatedness, other-relatedness, and desire" (111). When faced with an illness, one is effectively forced to relinquish control over certain parts or abilities of the body. The ill person employing a restitution narrative seeks to regain their body's "predictability" (111). Any illness is a reminder of mortality, and framing an illness within a restitution story "forestalls" (111) the "intimation of mortality" (111). Contemporary thought views the body as "an autonomous entity" (112) and the (ill) body in a restitution narrative is "fundamentally *monadic* in its relation to other bodies" (112). Opposed to this is what Frank refers to as the "dyadic body" (62), in which illness and suffering are not only personal, but also a shared experience during which the ill person can relate to others in similar predicaments, is reassured by acknowledgement of their affliction by others, and experiences empathy, the monadic body is its exact opposite (62-63).

The monadic body of the restitution narrative views "itself as existentially separate and alone" (63). When confronted with disease, the ill body becomes "it" and "the self is *dissociated* from the body" (112). Modernist restitution stories reflect a

disconnect between body and soul and promote the chasm between physical and mental pain by maintaining that the body is ill, but the self remains untouched (112). In this way, the question of mortality is reduced to physicality; the individual as a being remains untouched (113). Thus, contributing further to the deconstruction of mortality.

The desire to be cured is a driving force in modern society, and restitution is "commodified" (113). The adverts alluded to earlier promoting cures for everything act as a "powerful master narrative" (113) within the desire for restitution, a cure has become something one simply purchases packaged, and it buys the individual yet another day to avoid the question of mortality (113). Although biomedicine's technological advances have unquestionably improved and saved countless lives, these same technologies contribute to the deconstruction of mortality by implying that "mortality itself is an avoidable contingency" (113-114). Thus the dominance of the restitution story seems to have led to a restitution society, leaving little, if no room, for other narratives.

The body as presented in the restitution narrative is described by Frank as being in between the "*disciplined body* and the *mirroring body*" (114). The body must be disciplined in order to surrender itself to a certain medical scheme designed to cure that ill body, but this same body also mirrors itself to "an image derived either from its own history before illness or from elsewhere" (114), as in, for instance, the glossy hospital brochure. The mirrored body creates a self that is comprised out of exterior impressions; all of these impressions combined form the self (114). This preferred self is a self that consumes remedies in order to have a healthy body, and that desires to model itself on the socially imperative figure of the "functioning worker" (115). Frank reiterates that the mirroring body and the disciplined body are imperative to an

individual's "mode of being" (115), only when one becomes obsessively preoccupied with either one does this "imaginary" (115) mode become problematic.

Contemporary society has turned illness into a "mechanistic" (115) matter; the body is viewed as a machine that simply needs fixing. The answer to solving the puzzle of a certain ailment is sought in the future and the "question of origin is subsumed in the puzzle" (115) of restitution. This focus on fixture and restoration of the former healthy self, and the lack of concern for the origin of illness in restitution narratives, becomes problematic when the events leading up to the illness are crucial and the possibility of restitution does not apply (115-116). Seeking the answer to solving the puzzle of illness in the future affects how illness is perceived as a life experience; in the narrative of restitution illness is merely an interruption (116). Reducing illness to a mechanistic matter of physicality, viewing it as a mere interruption that can be jumped like a hurdle never to look back on, means to neglect the "innately human experience of symptoms and suffering" (Kleinman 3), rather than acknowledging "how the sick person and the members of the family or wider social network perceive, live with, and respond to symptoms and disability" (3).

The restitution narrative contains a much-desired message for both individuals and society; it tells the ill person that all illnesses can be cured and restitution to the self before the illness is possible. On a cultural level, "this narrative affirms that breakdowns can be fixed" (Frank 116). On a social level, this narrative leaves little consideration to other-relatedness, as "the responsibility is limited to taking one's medicine and getting well" (118). In other narratives, the question of responsibility is extended beyond the self. Such narratives express the understanding that life after illness has changed and "responsibility is based on an ongoing sense of solidarity with the ill, this solidarity transcending the present health or illness of one's

own body" (118). Within this perspective, illness is not viewed as an interruption of life, but as a life experience. Returning to the same self and the same life before the illness is "impossible as a moral choice" (118). This view is also echoed in Kleinman's account of a physician by the name of Hiram Bender, who believes that "medicine must be at heart a moral enterprise" (215):

> Healing is rooted in an archaic human endeavor whose ancient lineaments—shamanism and priestly functions and poetic insights into the darker side of man's soul—are more a part of religion, philosophy, and art than of science (214).

Kleinman surmises that the "experiential core of doctoring is a moral domain" (222) that cannot be reduced to the prevalent "technical and economic metaphors" (222) employed within the medical world today. Frank concludes that restitution narratives do not present the story of the self; rather they present a story of a self dependent upon the expertise of biomedicine (119).

2.3 Restitution Narratives: Their Value and Limitations

Frank attributes the fact that restitution narratives have become so culturally powerful, to a contemporary love for "heroism of applied science as self-overcoming" (119). Doctors, firemen, police officers, when they successfully carry out their job, they did not simply "do a good job": they are heroes. The restitution narrative "treats sickness as banal" (120), something the patient must simply live through and thus "ill people who tell restitution stories practice their own banality of heroism" (120). The ill person is presented as a passive hero, while the physician plays the part of the active hero, thereby assimilating the ill person to a "moral order that subordinates him as an individual" (120).

The hero in a restitution narrative beliefs in a greater cause, a cause that warrants risking the "comfort and often the safety" (121) of its leading characters, causes which might ensure "'the continuation or promotion or triumph of an idea'" (qtd. in Frank 121). This description, articulated by Zussman, seems appropriately applicable to the earlier reference regarding the terminally ill who are exposed to horrendous and poisonous concoctions of chemotherapy, all in name of a greater cause: deconstructing mortality. Appropriately, Bauman offers an alternative for this destructive hero: the "'moral person"' (121). This moral person "takes as his cause "the life or wellbeing or dignity of another human being"' (121).

The deconstruction of mortality is the first, and perhaps the most critical, limitation of the restitution narrative (121). The restitution story does not suffice when there is no possibility of restoring one's health; for the terminally or chronically ill, even for those who have been cured yet consider their lives to be changed, rather than restored, cannot set their soul at ease within the restitution framework. Sherwin Nuland, a "senior physician who has attended many deaths" (121) has fiercely criticised colleagues who he accuses of falling for '"the seduction of The Riddle'" (121), and in doing so deprive their patients of what Nuland refers to as the '"final sharing'" (121). This final sharing is part of the "good death" alluded to earlier, the restitution narrative "leaves no place for stories that will disencumber the dying person" (121) and will result in the dying taking certain baggage to the grave, thus possibly affecting those who are left behind (121).

Another limitation of the restitution narrative can be closely linked to the one just discussed: the restitution story might apply to some, and due to the commodification of cures discussed previously, "restitution is increasingly a commodity that some can purchase and others cannot" (121). This development could

be argued to make the restitution narrative even more morally deficient. Not only will the restitution narrative not apply to those who cannot be cured for medical reasons but it might also not be applicable to those who could medically be cured, but who cannot afford a cure. Thus the rapid technological advancement within the world of medicine has a paradoxical result: on the one hand it enables the spread of restitution stories, but on the other it "can be predicted to become increasingly restricted in its availability" (122). Moreover, even if the restitution narrative can be said to apply, it still lacks the morality concerning other-relatedness, to mention merely one aspect, and ignores what Frank observes to be an increasing shift from physicians who "seem less interested in being heroes…and more interested in being moral persons" (122).

Just how deeply rooted the restitution narrative is, and the extent to which it affects the decision-making processes of patients becomes apparent in *The Cultural Construction of Risk Understandings through Illness Narratives* by Nancy Wong and Tracey King. Their research pertains to women who have been diagnosed with breast cancer, and shows how a majority of these women "undertake a far more severe form of treatment when a lesser one would suffice" (580). From interviews with these women and the choices they made regarding treatment, their findings suggest that these women were culturally influenced "by the predilection toward restitution narratives in Anglo-Western societies" (580), which is "reinforced by the long-established biomedical model through its emphasis on personal agency, control, and survival" (580). Thus, this extends beyond the mere embodiment of illness in narratives; life-and-death decisions regarding illness become the "embodiment of culturally reinforced illness narratives and metaphors that are distributed throughout society" (580). The near obsessive focus on determining and minimising risks is a big part of contemporary Western culture, and is reinforced by the "belief that we can

exert control over each and every experience, including death itself" (580). Thus further contributing to the deconstruction of mortality.

Perhaps the only value to be found in the restitution narrative lies in its inspirational merits. For those with prospects of a restored health, this narrative might provide solace and comfort. However, even for those who find themselves within the kingdom of the well again, the question of mortality cannot be evaded indefinitely. On a sociological level, the restitution narrative does not offer anything "beyond the language of survival" (122). If there is no place for language signifying anything but survival within the dominant restitution trope, then anyone not fitting the restitution profile will be silenced and will "have lost any language in which they can remain available to themselves" (123). The real "tragedy is not death, but having the self-story end before the life is over" (123). Preceding the discussion of a better alternative for the restitution narrative, offering a trope that affirms "life beyond restitution" (123), will be the delineation of Frank's second type of narrative: the chaos narrative.

2.4 The Chaos Narrative

The chaos narrative is the exact opposite of the restitution narrative; this narrative type paints a grim story of a life never improving. Chaos stories lack any form of narrative order or coherency; they represent a life in disarray, as events unfold (Frank 124). Chaos narratives abandon precisely those elements which restitution narratives refuse to relinquish: control, hope, the prospect of a cure. Considering the dominance of restitution narratives in contemporary Western culture, it is not surprising that Wong & King point out their rarity (581). Frank asserts that due to the chaotic trope of these stories, the difficulty of discerning any coherence or causality, causes these stories to be "anxiety provoking" (124) and hard to listen to. The chaos narrative

represents all that contemporary medicine "seeks to surpass" (124) and if translated to the story of Job, it would be the equivalent of "Job taking his wife's advice, cursing God and dying" (124).

Apart from the fact that chaos narratives are hard to hear because of their lack of narrative cohesion, they are also "too threatening" because of their anxiety-provoking characteristics (124). Despite the rather negative feelings these stories emit, Frank surmises that these stories can be useful: it was not until taking in similar chaos stories, albeit not pertaining to illness directly, that he could begin to acknowledge his own "chaotic side of illness experience" (124). Another reason for the acknowledgement in hindsight of this type of narrative, is what Frank asserts to be one's inability to structure a narrative while "living the chaos" (125). Thus, the only way to tell a chaos narrative is retrospectively, for "lived chaos makes reflection, and consequently storytelling, impossible" (125). This assertion somewhat echoes Elaine Scarry's claim that illness narratives cannot express pain, because pain is inexpressible.

Ultimately, Frank asserts that chaos narratives "cannot literally be told but can only be lived" (125). Therefore, when Frank refers to chaos stories, he actually refers to stories that have been "reconstructed" (125) based on the stage in life when the chaos was actually experienced, hence their retrospective nature. Although this might strike one as rather paradoxical, what Frank denotes when speaking of a chaos narrative, is a narrative reconstructed based on the "voice of chaos" (125). Despite the chaos narrative being constructed in hindsight, the voice narrating it still captures the sense of frustration and despair experienced during this chaotic life experience, as one of Frank's exemplary excerpts concerning a woman dealing with a chronic illness as

well as caring for her Alzheimer-stricken mother, contains "only an incessant present with no memorable past and no future worth anticipating" (126):

> And if I'm trying to get dinner ready and I'm already feeling bad, she's in front of the refrigerator. Then she goes to put her hand on the stove and I got the fire on. And then she's in front of the microwave and then she's in front of the silverware drawer. And—and if I send her out she gets mad at me. (126)

This is the first feature of a chaos narrative: its lack of "narrative sequence" (126).

Another characteristic of this narrative type is what Frank refers to as a sense of "overdetermination" (126). This overdetermination could be explained as seeing the world through dark and gloomy glasses, a world where "troubles go all the way down to bottomless depths" (126). Apart from the narrative incoherency and evocation of overdetermination, there is a linguistic feature that clearly signals the listener or reader of a chaos narrative: the syntactic arrangement of "and then and then and then" (126). This particular feature can also be discerned in one of the excerpts of an interview with an Asian American woman who recounts her experience with reconstructive breast surgery:

> *Ivy:* They cut it and they reshape it. When they cut it, they lift it a little, and there is this piece of flesh hanging from the side. And then I told him, you did a lousy job on my tummy. What's this thing hanging? And he said, oh no, this is going to be wonderful. I said, what? So then he used the flesh to reconstruct a nipple, and then after that, I am supposed to go back and get it tattooed, you know, on my nipple, which I have never done. (Wong & King 589)

This particular fragment is especially interesting, because not only does its syntactic structure represent the voice of chaos and uncertainty, it also reveals a rejection of "the restitution story's corporeal model" (589). By refusing to fully restore her breast to what it most closely resembled preceding the illness, she recognised "that complete restitution is really an illusion" (589). Wong & King assert that this refusal to conform to the culturally indoctrinated narrative of restitution within the Western world, can be explained by the woman's heritage: "national statistics" show "that Asian American women are significantly less likely to receive breast reconstruction as compared with Caucasian women, despite having similar access to medical care" (589).

2.5 Chaos: Embodiment and the Self

Chaos narratives reflect the loss of control during illness experience, and often "accuse medicine of seeking to maintain its pretense of control" (Frank 127), as it does in the restitution narrative. Demonstrating the dominance of the restitution narrative, in which entrusting that control to the hands of the caregiver is "close enough" (127), Ivy's doctor presupposes and claims this control by his reassurance that the result "is going to be wonderful" (Wong & King 589). The doctor's attempt at transforming Ivy's narrative of chaos into a story of restitution illustrates how challenging it can be to voice the chaotic side of illness; no one seems to want to listen.

Lawrence Langer, who has studied "recordings of oral histories of the Holocaust" (128), has also noted this unwillingness of people to listen to chaos narratives. During his research, he noticed how time and again the interviewers steered the survivors toward a narrative fitting the restitution trope, one that displayed

‘“the resiliency of the human spirit”’ (qtd. in Frank 128). Frank surmises that “the chaos narrative is probably the most embodied form of story” (129). Therefore, to ignore another person’s chaos narrative is to ignore their suffering. Although Frank reiterates Scarry’s claim of suffering being beyond language, he does recognise that any expression of suffering deserves to be heard. The challenge is not “to steer the storyteller away” (128) from the feelings being expressed: “the challenge is to *hear*” (128). Perhaps language does fail in approximating pain and suffering, but can one really expect “for language to be so precise that it provides a form of cognitive control over pain, giving the person in pain authority over the embodied experience”? (Jurecic 53). The key is to understand *what* is being expressed, although the shape the message assumes can be helpful toward a better understanding of the message, it should not be the main focus. Ultimately, it is not the language that fails, it is the listener (54).

The “and then” sequence referred to above and frequently present in chaos narratives might seem cumbersome to listen too, on a social level it may even strike some as childish, but the message to hear is not in these words: it is in what they represent. Illness is embodied in the chaos of the narrative, “in the most hurried “and then” telling, chaos is the ultimate muteness that forces speech to go faster and faster, trying to catch the suffering in words” (Frank 129).

Like the restitution narrative, the chaos narrative reflects “a *stage of the embodiment process* of illness” (111), pertaining to aspects of “control, body-relatedness, other-relatedness, and desire” (111). Whereas the ill body of the restitution narrative seeks to regain control over the body, the body of the chaos narrative “defines itself as being swept along, without control, by life’s fundamental contingency” (129). Attempts may have been made to seize control, but their failure

has led to an acceptance of the inevitable (129). One of the first attempts at rejection of the chaos narrative, on behalf of the listener indoctrinated by narratives of restitution, will entail an account of how the listener would "find some way out" (129). This response is a reflection of how the anxiety-provoking circumstances are projected onto the listener, who, "on the outside of some chaos" (129) needs "assurances" of the possibilities for a way out (129).

This inability of the listener to accept the chaos side of illness as a reality leads to a chasm between other-relatedness and the chaotic body. Like the ill body in the restitution story, the chaotic body is monadic, therefore adding "to the inability to find recognition or support for the body's pain and suffering" (129). The problematic communication between narrator and listener is bilateral; the chaos narrative acts as a barrier and the "and then" recurrence is an attempt to "breach that wall" (129).

The chaos narrative reflects a "lack of desire" to even attempt to find a way out of the misery that has become life (129), which is reinforced by the lack of other-relatedness; no comfort or solace seems to be found. The chaotic body finds itself in a downward spiral; attempts to regain control have failed, attempts to find comfort and understanding in others have failed, and "in a world so permeated by contingencies that turn out badly, desire is not only pointless but dangerous, just as relationships with others have become dangerous" (129).

Because the chaotic body, like the body in the restitution narrative, is monadic, the sense of self is dissociated with the body (129). The chaotic body does not simply live: it survives, and this survival "depends on the self's dissociation from the body, even while the body's suffering determines whatever life the person can lead" (129) in the face of a debased "overdetermination of disease and social mistreatment" (129). In the chaos narrative, the body assumes the role of the

antagonist; "it" is "hurting me" (130). The chaotic body has "lost any agency" (130) and is diminished to "an occasion of obstruction" (130).

The employment of the "and then" structure in a narrative of chaos is an attempt to interrupt this same chaos. The challenge of responding to such a narrative is not to challenge the wounded teller's perspective, but to "elicit an evocation" (130) of the experienced chaos, and thus closing the other-relatedness gap by acknowledging what is being conveyed. The self in the chaos narrative is "unmade" (203) in the face of fears provoked by illness: a loss of control, a sense of disconnect with the world, a pessimistic view on contingencies. The chaos story is part of a process Elaine Scarry refers to as "unmaking the world" (130). The listener, or reader for that matter, is not expected to take what is being conveyed as "complete knowledge" (Jurecic 58). Rather, being open to a narrative of chaos effectively entails being willing to offer sympathy, being willing to "honor and value" (58) the "account of suffering" (58) and to bear witness to the chaotic body's "remaking of his world" (58).

The chaotic body cannot relate to the dominating body, the mirroring body or the disciplined body found in narratives of restitution (130). The chaotic body is battered by the force of the dominating body, is a "scandal to mirroring bodies" (130) because it confronts them with life's transcendence, and to the disciplined body it "represents weakness and inability to resist" (130-131). The fourth, and final type of body constructed by Frank is the communicative body. It must be noted that these types of embodiment should be considered for what they are: "theoretical constructions designed to describe some empirical tendency" (56). To use yet another biblical analogy: the chaotic body is to the communicative body, what "the traveller"

is to the "Good Samaritan" who discovered him "robbed and beaten by the roadside" (131).

2.6 Chaos Narratives: Their Value and Limitations

Partly due to socio-cultural tendencies, and partly due to the fact that the chaotic body is its own antagonist, the sense of self is lost in the narrative of chaos. While illness interrupts the stages of life, the chaos narrative interrupts the narrative trying to make sense of this interruption. Translating "those interruptions into a coherent story…neutralizes the chaos immanent in them" (132). This does not imply that chaos narratives are not to be told, or received, most ideally unprejudiced, for they are part of the embodiment of illness. Just as the "ideal types" (56) of bodies designed by Frank to assist in the evaluation of illness narratives, the chaos narrative is a narrative type to aid the assimilation of real life events and experiences. If these events and experiences can arguably be said to be anything but ideal, then perhaps an imperfect and somewhat paradoxical exemplar like the chaos narrative seems appropriate indeed.

Despite all their limitations, Frank requests narratives of chaos to be honoured, for both "moral and clinical" (136) reasons. To deny chaos narratives, is to deny "the world in all its possibilities" (136). Denying the story is denying "the person telling this story, and people who are being denied cannot be cared for" (136). In order for people to become constructive participants in the story, they must first be prepared to "become witnesses to the story" (137). Echoing the "you can't change what you don't acknowledge" catchphrase of a certain celebrity psychologist: the chaos must be accepted before the narrative can progress, because "that chaos always remains the story's background and will continually fade into the foreground" (137).

There is a tendency in the medical world to label narratives of chaos as expressions of "depression" (137), due to the "anxiety that the chaos story provokes" (137). This inclination underscores the dominance of the restitution narrative, since it seeks to convert the chaos into "a treatable condition" (137), thus transforming the chaos narrative into a narrative of restitution. Frank calls for an "enhanced tolerance for chaos as part of a life story" (137) in both clinical and "interpersonal relations" (137). Perhaps what society perceives to be most troubling regarding the chaos narrative, is that it foregoes any sense of purpose to suffering, for when it comes to stories of chaos "no sense of sequence redeems suffering as orderly, and no self finds purpose in suffering" (131).

2.7 The Quest Narrative

Because restitution narratives consider illness "transitory" (142), and are primarily focused on restoring the self to the extend that one might pretend the illness never occurred, it effectively denies any suffering that accompanied the illness. Similarly, suffering conveyed in the chaos narrative is denied by attempts to steer the chaotic voice towards the restitution paradigm because accepting it would amount to accepting "that life sometimes *is* horrible" (139), and despite what the restitution narrative might have one believe, not everything is fixable. Quest narratives, by contrast, offer a way of dealing with suffering: they "meet suffering head on; they accept illness and seek to *use* it" (142). In quest narratives, suffering is not considered something to be denied, something to escape and erase from one's life canvas; "illness is the occasion of a journey that becomes a quest" (142). Within the quest trope, illness and suffering are not rejected or denied; they are embraced.

The quest narrative allows for the real voice of the sufferer to be heard. In narratives of restitution, the ill person is a passive agent and its voice is hijacked by the cure or the curer (142). Although the voice of the chaos narrative is that of the sufferer, its voice becomes lost in the chaos (142). Illness experience allows for all three narratives to be employed intermittently, the use of one type does not imply that the others are forever excluded. While "the quest narrative speaks from the ill person's perspective and holds chaos at bay" (142), chaos and restitution will still linger in the shadows of illness experience (152).

Frank appoints Friedrich Nietzsche as the precursor of the "contemporary quest story" (143). Nietzsche suffered from several chronic that remained undiagnosed, yet he named his illness "dog" (143). Unlike the restitution body that seeks to label the illness in order for it to be cured, Nietzsche, much like people naming a pet, names his illness because he accepts it as part of him. In doing so, he seeks to create "a new relationship to illness" (143). Furthermore, by naming his pain he "has in effect taken charge of his pain" (Morris 284), thus he resolves to "be the master rather than the slave" (284) of his pain. The self of the quest narrative searches "for alternative ways of being ill" (Frank 143) and in this remaking of the illness experience, suffering becomes part of the journey toward making it purposeful (143).

While Frank recognises that to refer to anything as a journey risks the connotation of "a New Age spice sprinkled indiscriminately to season almost any experience" (144), he still surmises that the sense of a journey "represents a form of reflexive monitoring" (144). When describing the framework of the quest trope, Frank draws from the work of Joseph Campbell's *The Hero With a Thousand Faces* (144). Joseph Campbell is a "moral philosopher who…has profoundly affected the narrative presuppositions that inform illness stories" (144).

In Campbell's view, the protagonist's journey as told through the quest story can roughly be divided into three stages: the departure, the initiation and the return (144-145). The departure coincides with the detection of symptoms, often times this emergence of symptoms is ignored "because the hero, who has not yet become a hero, knows how much suffering will be involved" (144). At the inevitable moment when the symptoms can no longer be ignored and the illness becomes a reality through diagnosis, "the first threshold" (144) is taken by means of treatment such as "hospitalization and surgery" (144).

Once this first threshold is crossed, the second stage is entered: initiation (145). This "metaphor of initiation" is used "implicitly and explicitly" (145) and the initiation is not experienced as such until the end of the process. The initiation can be "indentified in any illness story as the various sufferings that illness involves, not only physical but also emotional and social" (145). Unlike the self in restitution narratives, the self in the quest narrative takes responsibility of the illness "transformation" (145); one does not transform into one's former self, but transforms into a self with new insights (145). To be clear, the moral person of the illness quest narrative does not take responsibility for the disease, but for the transformation of the self; a transformation initiated by the illness experience. This type of morality is formed by one's own experience of pain and suffering and is "based on an ongoing sense of solidarity with the ill, this solidarity transcending the present health or illness of one's own body" (118). The moral person of Frank's quest narrative effectively attempts to dodge the philosopher's stone slung by the hubris of biomedicine's restitution narrative.

The return ushers in the final stage of the illness quest: "The teller returns as one who is no longer ill but remains marked by illness" (145). Unlike Sontag's

analogy of dual citizenship, which implies one alternately resides in the kingdom of the well and the kingdom of the sick, the "marked person" of the quest narrative can be considered '"master of the two worlds'" (qtd. in Frank 146). This hero is not to be confused with Hercules (146). Rather, "mythic heroism" (146) is redefined "not by force of arms but by *perseverance*" (146). This "moral insight" (147) is gained through the initiation process of "agony to atonement" (146). Thus, as alluded to before, it is a sense of morality based on experience. Although the return presents the moral self with a chance "to share her enlightenment with others" (146), the fact that this concerns a personal enlightenment to critics presents the problem of a lack of empiricism.

This is a problem because illness narratives incite and perhaps even require "affective and intimate engagement, responses that have little currency in academic discussions of the arts and literature, they disrupt critical expectations and typical standards of judgement" (10). However, if the early modern illness narratives to be discussed in the following chapters prove to be a successful testing ground for contemporary notions regarding illness, pain, and suffering, and can contribute toward a reconstruction of a history of pain, then perhaps the importance of studying illness narratives can be acknowledged.

2.8 Quest Narratives: Memoirs, Manifestos and Automythologies

Frank distinguishes at least three different types of quest narrative: "memoir, manifesto, and automythology" (146). The memoir can also be classified as "an interrupted autobiography" (146), whose author is typically someone with a status that warrants "formal autobiography writing" (146), but whose illness has obscured that possibility. This particular narrative does not unfold chronologically and often

consists of fragments that alternate between "past events" and the illness experience (146). The quest story memoir is what Frank refers to as "the gentlest style of quest story" (147); the suffering is conveyed, but resignedly (147). There is a sense of humbling, which perhaps is why no "special insight" (147) is offered; the only insight is the acceptance of the illness "into the writer's life" (147).

Frank described the manifesto is the least gentle quest story (147). The insights gained through this type of quest narrative are so profound that they often contain a call for "social action" (147). These manifestos display a great sense of responsibility that accompanies "even provisional return from illness" (147) and its authors are inclined to believe they must profess "a truth about suffering" (147) which is stifled by society (147). They reject the illusory view, sustained by the restitution story, of returning to one's former self before illness, and are inspired to use the experience of suffering "to move others forward with them" (147). The dominance of the restitution story becomes clear once again through the quest narrative of Audre Lorde, who, after having had a mastectomy, recalls the reaction of a nurse when Audre visits the doctor's office without wearing her prosthetic breasts, as Frank quotes:

> "Usually supportive and understanding, the nurse now looked at me urgently and disapprovingly" The nurse's bottom line is, "We really like you to wear something, at least when you come in. Otherwise it's bad for the morale of the office." Lorde describes this incident as "only the first assault on my right to define and to claim my own body." (qtd. in Frank 148)

Lorde, through her quest narrative, not only reclaims the body colonised by a predominant restitution society; she also attempts to affirm "visual recognition of

other women who bear her mark of pain" (148). Thus, she takes the wellbeing and dignity of fellow sufferers as her cause.

In effect, the quest narrative rejects the deconstruction of mortality mirrored in restitution narratives and endeavours to reconstruct not only a new perspective on suffering, but also to reconstruct mortality, since to consciously and visibly bear one's mark of pain is to present "a human being facing mortality" (147). Denying one's sense of mortality can never lead to the acceptance of mortality as an undeniable part of life, to accept it might contribute to making mortality more of an accessible topic. Mortality is perhaps the only thing universally shared, and "only by displaying our common mortality can humans accept this mortality as common and cease to fear it" (148).

The third, and final type of quest narrative to be discussed, is what Frank refers to as the automythology. Typically, this narrative symbolises the metaphor of "the Phoenix, reinventing itself from the ashes of the fire of its own body" (149). In this type of quest narrative, the self can be said to have experienced the illness as somewhat of a Renaissance; the self is "reborn" (150). In the face of illness and suffering, life is reconstructed "to help define a new existence" (150). Comparable to the manifesto, the automythology is a call for change, but the latter focuses more on personal rather than social change (150). Although the self is reborn, the former self is not denied. Rather, the newfound self comes to acknowledge the "ordinary" (151) things in life the former self did not appreciate (151).

Like the name suggests, automythologies often exhibit language of certain grandeur. Typically, words such as "momentous, decisively, universe, and destiny" (151) are employed. Part of what makes this type of quest narrative mythological, is that the illness and suffering force the person into pushing, and crossing, limits they

never envisioned crossing before (152). Thus, the automythology is a testament to the resilience and power of the human mind, a refutation of the "self-imposed limits" (152) holding back the self. In the grander scheme of things, the illness becomes a "paradigm of universal conflicts and concerns" (152) in which there is a place for "human potential" to reconstruct a better world.

2.9 The Quest Narrative: Embodiment and the Self

As alluded to before, the protagonist of the quest story materialises in the form of the communicative body. Unlike the body of the chaos narrative, who fears contingency, the communicative body "accepts contingency because the paradox learned on the quest is that surrendering the superficial control of health yields control of a higher order" (153). Unable to find any peace amid the chaos, the chaotic body fears the only thing that is certain: contingency. For the communicative body, embracing contingency "even with its suffering" (153) is the first step in the journey toward "change and growth" (153). Unlike the restitution and chaotic body, the communicative body is dyadic; its desire is "productive" (153) in relation to itself and other-relatedness.

This dyadic quality is reflected in the motivation for writing the quest narrative in the first place: communicative bodies "had every other option of entertainment or companionship open to them, but they chose to write" (154). This quality is what makes the communicative body the most ideal embodiment from a moral and social perspective, there is a profound desire to reach out and "to touch others and perhaps to make a difference in the unfolding of their stories" (154). It must be reiterated that moral in this context does not imply a certain autonomous pretense leading to a judgement of what is right or wrong, but rather the most basic

humanity of caring for others which may amount to something as simple as listening which Frank surmises is a "fundamental moral act" (52). The moral person of the illness narrative, and context is crucial when engaging with the question of morality, is motivated by empathy and compassion because as a fellow sufferer who has endured pain and suffering these fundamental human affective responses can be healing in themselves: it is "not just treatment which cures you, but all that encompasses the human touch" (Petrone) 32).

The dyadic body does not seek to be a hero and save others from suffering the way restitution heroes impose their "heroism" by suppressing the restitution body. Communicative bodies do not seek to change whatever contingency is waiting; they simply seek "to affect how the other understands her embodied contingency" (154) and to share the insights obtained through their return from the journey of illness (154).

In quest narratives, the illness that disrupts one's life experience is viewed as a "challenge" (155), as something from which to rise above like the aforementioned Phoenix. This does not imply that illness is viewed as a positive interval, but the changes it sets in motion are considered to ameliorate life. In this way, the illness and accompanied suffering are like a sacrifice one was not necessarily willing to make but willing to accept (155).

To the self of the quest narrative, character is key: "character merges both persona, the character in the story, and quality, having a good character" (156). A successful quest narrative, successful in the sense that it benefits the self and others, does not only claim change, but also demonstrates this new and changed sense of self (156). While Frank asserts that "published illness stories" (156) are read for numerous reasons, "the moral purpose of reading is *to witness a change of character through*

suffering" (156). Such illness narratives can be inspirational as they not only offer the possibility of change as a positive influence on character, they also provide "a model" to draw from when a change in the self is required to turn the chaos narrative into a quest narrative (156).

When it comes to the quest narrative, perhaps it is more appropriate to speak of a new sense of the self, rather than a new self. Frequently, metaphors employed in quest narratives have a "retrospective" (156) quality; they unite the new sense of self with the dormant self that was always there. Such metaphors, Frank argues, are a testimony not only to "the credibility" (157), but also "the morality" (157) of a changed self. Thus, such metaphors can be argued to be the embodiment of a successful return from illness.

Since quest narratives are not only concerned with the self, but also recognise the importance of other-relatedness from a moral perspective, Frank distinguishes three dominant ethical modes of narrating within the quest narrative (158). Frank classifies these "ethics" as follows: "an ethic of recollection…an ethic of solidarity and commitment" (159) and "an ethic of inspiration" (160). All three ethics are concerned with matters of "voice, memory, and responsibility" (158). The voice of ethical recollection shares memories of the past. Certain actions in that past might be "disapproved, but they cannot be disowned" (159), because of the sense of responsibility (159). The ethic of recollection offers a reflective stance on past events and provides a "moral opportunity to set right what was done wrong or incompletely" (159).

The ethical voice of solidarity and commitment is concerned with its responsibility towards others. This particular ethic can often be found in people who find themselves in the position of being able to reach a wide audience, and, for

instance, use this opportunity to speak out against stigmas surrounding certain illnesses. This voice does not infer taking responsibility for others; rather it presents itself as a "fellow-sufferer" (159) who seeks to garner awareness for those who cannot be heard.

The moral voice of the quest narrative frequently applies the ethic of inspiration, and offers an exemplar of victory over seemingly "impossible situations" (160). The "agony" (160) and "woundedness" (160) are not obscured; indeed the fact that suffering plays a lead part in the narrative contributes toward the narrative's inspirational qualities. If restitution narratives endeavour to suppress the voice of the sufferer by rendering its voice passive, and chaos narratives leave little room for any voice, then the quest narrative returns this voice to the self who seems to have had to suffer to earn it. This voice "is found in the recollection of memories" (160) and takes responsibility for these memories, while seeking to provide others with a paradigm that might aid them in avoiding the same pitfalls and endure the same lonely afflictions.

Quest narratives, essentially, endeavour to appeal to the good side of human nature. These narratives are essential for re-establishing "the moral agency that other stories sacrifice" (161). Heroism is restored to the true protagonist, not the doctor, but the ill person is the hero of the quest narrative (161). The hero did not persevere because of bio-medical technology, but was an active agent in this perseverance by living through the suffering (161). At this point it must be noted that quest narratives must be balanced by chaos narratives, for regarding the quest narrative as the one and only ideal paradigm for framing illness narratives, risks the invitation of "hubris" (161). Chaos narratives are a necessary "antidote" (161) to the "pretense of invulnerability" (161) sometimes inferred by quest narratives. Moreover, quest

narratives “risk romanticizing illness” (161). The antidote for this romanticism can be found in restitution narratives, which despite all their limitations, express the undeniable desire of every person to be in good health and the role others might play in keeping their health sustainable (161).

3. Donne's *Devotions*: a Self-Conscious Quest Narrative

Although Donne's *Devotions Upon Emergent Occasions* has been "relatively neglected in Donne scholarship" (Guibbory 3), the illness narrative that unfolds holds the promise of great potential as a testing ground for more contemporary views on illness and suffering. In the *Devotions*, Donne's illness becomes an occasion to examine the "condition of Man" (Donne 1. 1-2) and shares a lot of common ground with the types of illness narratives, particularly the chaos and quest narrative, as put forth by Arthur Frank. As illustrated in chapter 1, the link between physical suffering and morality was ubiquitous in Donne's time and the manner in which the question of faith appears in Donne's quest of interpreting and attaching meaning to his illness experience will act as an important framework within the discussion of this illness narrative. Thus, this chapter shall reveal the important connection between collective socio-cultural conscience and physicality, through which illness as embodiment is not simply a physiological experience, but indeed a lived experience framed by dominant socio-cultural beliefs.

Although Donne's framing of his illness experience in relation to God is culturally specific, he also displays a humanistic approach which effectively demonstrates how the experience of one man can emit a sense of universality regarding the experience of illness that defies the problem critics have with the question of subjective reality framing any illness narrative. Donne is mystified by his illness and struggles with what Kleinman would refer to as "the question of bafflement" (28): why me? Donne's quest is also bound up with the question of responsibility, which correlates with the question of bafflement and the manner in which the self is changed by the illness experience. As opposed to the world of biomedicine, where suffering is viewed as "a problem of mechanical breakdown

requiring a technical fix" (28), Donne is able to embrace a "teleological perspective on illness that can address the components of suffering relating to the problems of bafflement, order, and evil, which appear to be intrinsic to the human condition" (28).

As has been argued in the preceding chapter, illness narratives are about creating order in the face of chaos while attempting to offer fellow-sufferers a method of coping with illness and the inspiration to remake their world during and after illness. Although Donne undeniably "asserts there is an actual, discoverable order created by God, he also seems very modern in flaunting the fact that, in metaphor-making, he is actually creating (not simply perceiving) order in experience" (Guibbory 5). Comparable to Nietzsche naming his illness 'dog' in order to regain a sense of control, Donne redefines the relationship between body and soul and his sense of self and God, thus remaking his illness experience and effectively rendering it purposeful.

Quibbory contends Donne's works reveal a man "embracing and promoting a liberal, universalist (anti-Calvinist) view of grace" (171-172). Furthermore, Donne seemed to reject religion's propensity towards absolutism, since he demonstrated an interest in "a broadly conceived and tolerant spirituality" (Shami 80) by approaching matters in a way that invited "inclusiveness" (80). Perhaps most importantly, Donne's ruminations in the *Devotions* allow an insight into the process of interpreting illness and display Donne's meta-awareness in the fact he is attaching meaning to his illness through the use of metaphors that serve as a testimony of a changed self; if he must forego control of his physical state and accept God's mysterious ways, he reasserts this control by taking control of what his illness and suffering signify.

Donne's *Devotions* are saturated with biblical references and concerns regarding his relationship to God, but they also display concerns characteristic of the

communicative body in the quest narrative: "how a person relates to other human beings" (172), i.e. other-relatedness. However, before addressing why Donne's illness narrative can be classified as a quest narrative, the segments that can be classified as a chaos narrative will be discussed, thus detailing his transformation from a chaotic body to the communicative body of the quest narrative. It should be noted there is no clear break in the text where chaos ends and Donne's true quest begins, after all, each mode of narration reflects the state of mind at that particular time and any illness narrative as a whole often is a combination of "a shifting foreground and background of types" (Frank 78).

Donne is mystified by his illness and he attempts to locate the cause of his affliction, but because he must first transform from a monadic to a dyadic body (i.e. communicative body), the question of responsibility is first sought outside of him. The monadic body is only responsible for following doctor's order and getting well, while the dyadic body is a "reflexive project" (Frank 40) who takes responsibility for the transformation initiated by the illness experience. Unlike biomedicine's propensity of seeking the answer to solving the puzzle of illness in the future, which affects how illness is recognised as a part of one's life experience, Donne ponders the origin of his illness: a perspective which is vital when ascertaining the cause of illness and when restitution is not an option (Frank 115-116).

As discussed in chapter 2, quest narratives generally consist of three stages: the departure, the initiation, and the return (Frank 144-145). The departure coincides with the stage wherein the first symptoms of illness appear and the protagonist has difficulty interpreting these symptoms. Once the materialisation of the illness can no longer be ignored, and the reality of being ill is accepted, the second stage within framing the illness experience is instigated: the initiation. The initiation spans the

majority of an illness quest, as it frames the experience of "the various sufferings that illness involves, not only physical but also emotional and social" (145).

The return marks the final stage of a quest narrative, and it is only at the start of this stage that the former stage, the initiation, is experienced as such. Perhaps it is this retrospective quality of the initiation stage which allows for the quest narrative to yield to fragments of chaos, since the chaos narrative can only be composed retrospectively (125). The return signifies a rebirth of the self, a self who has gained a "moral insight" (147) through the initiation process of "agony to atonement" (146) and is marked by the experience of illness.

Donne uses his illness experience, which presumably was either "typhus" (Raspa xiv) or "the seven-day or relapsing fever" (xiv), as an occasion to examine and contemplate what it means to be human, while considering "the vicissitudes of human health" (xiii). This assertion, combined with the fact that the *Devotions* are autobiographical, clearly echoes Frank's description of the quest narrative automythology, in which illness figures as a "paradigm of universal conflicts and concerns" (Frank 152). Inspired by concepts based on "humoral theory" (Kuchar 16), which through contributions of Michael C. Schoenfeldt has "been recognized as providing a complex network of diagnostic, regulatory, and anatomical modes of representing the body/soul relationship" (16), Donne seeks to shed light on the many mysteries and uncertainties that accompany his illness experience.

The *Devotions* are interesting from both a historical and a cultural perspective, because they show how Donne and his contemporaries were confronted by the clash between "Galenic and Paracelsian thought" (Kuchar 16) on the one hand, and "the anatomical adventure of early modern science" (15-16) on the other. The emergence of the latter field of mechanistic medical science resulted in a "metaphysical

incoherence" (15) rendering traditional views on the body incomprehensible (15-16). In an attempt to counter this mechanistic approach, Donne's *Devotions* operate within the Galenic trope; drawing from the "richness of the Galenic lexicon" (16), Donne attempts to mend the chasm between body and soul which was beginning to occur due to the emergence of a mechanistic view on medicine, a chasm that has proven difficult to suture up unto the present day.

Donne's *Devotions* contain three clear divisions: his Meditations, Expostulations, and Prayers. With the intention of offering an overview that authentically represents the work as a whole, fragments from all three divisions will be discussed. The Meditations are interesting in this endeavour, because they reveal Donne's thoughts from a more humanistic and universal perspective, as opposed to the other Devotions, which "interpret the present moment in terms of the Bible" (Guibbory 8). However, Donne's sacramental and devotional language and biblical references play an important part in Donne's quest of attributing meaning to his illness; amid opposing religious and corporeal views Donne employs a language of embodiment, not only in order to make sense of his illness, but also of his illness experience as it relates to his relationship to God (Kuchar 19).

3.1 Donne's Chaotic Departure

At the outset of the *Devotions*, Donne has not yet become the dyadic body of the quest narrative he will gradually transform into. He immediately touches upon the vicissitudes of life and implicitly expresses how illness can be a stark reminder of life's unpredictability: "Variable, and therefore miserable condition of Man; this minute I was well, and am ill, this minute" (1. 1-3). This concern over the sense of unpredictability that comes with illness is universal, as "disease itself is a loss of

predictability" (Frank 57). It is a contingency, i.e. a situation wherein the body is "subject to forces that cannot be controlled" (57). Donne expresses his surprise over the suddenness with which the illness struck him and his confusion over how he "can impute it to no cause" (1. 4-5). In addition, he conveys the sense of helplessness that comes with illness and observes that whatever sense of control one might attempt to exert over one's health seems ineffectual: "We study Health, and we deliberate upon our *meats*, and *drinke*…and so our Health is a long and regular work; But in a minute a Cannon batters all" (1. 5-10).

In consonance with the link between cure and conversion discussed in the opening chapter, Donne's road towards attributing meaning to his illness experience is paved with a combination of interconnected interpretations he assigns to that experience, all contributing towards making it purposeful. Those interpretations can be divided into the following four assertions which are based on a phenomenological approach to illness: firstly, Donne's illness experience is intertwined with "the experience of coming to know Christ in and through the linguistic and conceptual resources of the early modern body" (Kuchar 16), thus making his suffering meaningful though the concept of *imitatio Christi*.

Secondly, Donne's focus on physicality and his employment of corporeal language serve to emphasise the "symbolic function that the body performs in the constitution of identity" (Kuchar 34); thus illustrating the relationship between body and soul, as the corporeal metaphors employed are an attempt to make the emotional and psychological side-effects of illness more tangible.

Thirdly, apart from relating his suffering to the hardships of Christ, Donne develops a sense of other-relatedness through his suffering. This other-relatedness offers new perspectives when considering the hardships others must endure; it

inspires him to embrace his suffering and even accept death if it can be considered purposeful to others. In addition, and this makes up the fourth and final assertion, physicality, for Donne, represents the "symbolic order of God's Word" (Kuchar 34) in which the self becomes a "subject of the Word" (35). In Meditation I, Donne views illness as "unprevented for all our diligence…undeserved, if we consider only *disorder*" (1. 10-12). What Donne seems to imply here is that a literal focus on the physical, or disorderly body, will not safeguard one from illness. Opposite to this disorder is the order represented by God, who through the concept of "immanence" (17) was believed to "exist within each soul" (17).

Donne is suggesting that regardless of the efforts one physically puts into maintaining one's health, if one does not tend to spiritual health (or if one forsakes a sense of morality) all will be in vain. In accordance with the monadic body of the chaos narrative, Donne starts out very preoccupied with his own suffering. He laments the symptoms accompanying his illness, these "sodaine shakings…sodaine flashes…and darknings of his senses" (2.5-7). Furthermore, Donne asserts man's sinful nature has afflicted him with not only the torments of sickness, but also with "these jelousies and suspitions, and apprehensions of *sicknes*" (1. 22-23). Thus, he points out how sickness is not merely physical, but the very experience or even anticipations of becoming ill invoke psychological distress as we "wrap a hote fever in cold Melancholy (2. 15-16). This observation is strikingly similar to the view of Michele Angelo Petrone, who through her illness experience surmises that "the very nature of illness, of the human condition, is one of fear and apprehension" (35).

In addition, he questions God's ways and appears to lament the manner in which his faith is failing him in Expostulation I: "My God, My God, why is not my *soule*, as sensible as my *body*?...why are there not always *waters* in mine eyes, to

testifie my spiritual sicknes?" (3. 1-5). Donne seems locked in a battle with chaos, struggling to find his voice. He seems to resolve to look for the voice of God and in doing so places the responsibility of his afflictions with God; if illness is a consequence of a sinful nature, then why did God not provide man with a warning system in the soul to prevent man from sinning to begin with? Furthermore, his illness experience seems to have left him shaken to a degree where he seems to question the order and control represented by God.

The fragments of chaos narrative in the *Devotions* mostly materialise in the Expostulations, which could perhaps best be described as running thoughts. Characteristic of the chaos narrative, a large number of the Expostulations exhibit a lack of narrative sequence and the first set of Expostulations exude a sense of gloom and doom forgoing any sense of control:

> O heighth, O depth of misery, where the first *Symptome* of sicknes is *Hell*, and where I never see the fever of lust, of envy, of ambition, by any other light, then the darknesse and horror of *Hell* it selfe…and where the first notice, that my *Soule* hath of her sicknes, is *irrecoverablenes*, *irremidablenes*… (3. 16-24)

Donne struggles with the paradoxical nature of illness; if illness is a punishment for sins committed, did the soul corrupt the body or vice versa? If man was born sinful, then how can he be held accountable for his sins? If physical illness is a sign of an afflicted soul, then how can the soul only come to this understanding when the "first notice" the soul has occurs when all seems already irremediable?

Ultimately, Donne's quest is based on his paradoxical focus on physicality, which through the employment of an array of corporeal metaphors serves to demystify something less tangible than the body: his "best part" (2. 29), his soul,

which reflects his relationship to God. This is why his quest is a journey about finding his true self, which inadvertently is an endeavour to reconnect with God, since he asserts: "I am more than *dust and ashes*; I am my best part, I am my *soule*. And being so, the *breath* of *God*" (2. 29.30).

Towards the end of this first Expostulation, Donne takes on a self-reflective stance:

> But, O my God, Job did not charge thee foolishly in his temporall afflictions, nor may I in my spirituall. Thou hast imprinted a *pulse* in our *Soule*, but we do not examine it; a voice in our conscience, but wee doe not hearken unto it. (3)

In the end he seems to find reason, chaos reverts to the background as he concludes: "Wee have received our portion, and misspent it, not bin denied it" (4. 7-8). With this "portion" Donne's is referring to God's "first grace" (2. 3), which was infused in every man, but not implemented accordingly by man himself. In other words, man was given the instruments to be virtuous, but failed to use them appropriately, if at all. Finally, the conversion/cure motif resounds in his final sentence, as he asserts that God is merciful, "but wee will not understand, least that we should bee converted, and he should heale us" (4. 11-13).

Donne struggles to escape his chaos narrative, because he is not yet ready to embrace his suffering and the paradoxes of his quest trouble him. In Meditation II, he laments how instantaneously his symptoms occurred: "In the twinckling of an eye, I can scarce see, instantly the taste is insipid, and fatuous; instantly the appetite is dull and desireless: instantly the knees are sinking and strengthless" (6. 18-21). Donne displays characteristics of the monadic body, which views the body as separate from the self: instead of speaking of *his* taste, *his* appetite, *his* knees, he reverts to using

definite articles. However, in spite of being preoccupied with his own suffering, his dyadic body is already materialising at this early stage, as he ends this station touching upon the misery others must endure who, unlike him, have an appetite but no food: "Miserable distribution of *Mankind*, where one halfe lackes meat, and the other stomacke" (7. 2-3).

Although Donne's dyadic qualities will prove useful towards making his suffering purposeful, he must cross the first threshold into the second stage of the quest narrative, which leads to the initiation. Before he can progress to that stage, however, the cause of his illness calls for further scrutiny. Expostulation 2 reflects Donne's struggle to find sense and order in the experience of his illness and he is inclined to believe that "the diseases of the body" (8. 15) are "from the hand of Satan" (8). While Donne is inclined to perceive his illness as a punishment from God, as in Meditation II he relates the profuse sweating he experiences to "Adam's punishment, *In the sweat of thy brows thou shalt eat thy bread*" (6. 25-26), he has trouble uniting his perception of a merciful God who breathed life into him, with a God who could be the cause of such horrible afflictions, as he exclaims in Expostulation II: " My God, my God, thou wast not wont to come in whirlwinds, but in soft and gentle ayre" (8. 5-7). If God's first breath gave him life and "breathes communion and consolation" (8. 9-10) in the church, but now seems to "breathe dissolution and destruction" (11), then Donne is inclined to conclude that "surely, it is not thou; it is not thy hand" (12-13).

As soon as Donne entertains the thought of God having delivered him over to Satan, reason seems to intervene once more, as he imagines it must be God: "It is thou, thou *my* God…thou wilt not correct me, but with thine own hand" (8. 16-18). Through this line of reasoning, Donne's illness reinforces his relationship with God. Furthermore, he finds reassurance in the knowledge he is not alone in this experience,

for he asserts: "I am *fallen into the hand of God*, with *David*, and with *David* I see that his *Mercies are great*" (8. 20-22). Once Donne resolves to link his illness to God and finds assurance in likening his experiences to events portrayed in the Bible and the suffering of Christ, the paradox of his illness experience can be explored further and his suffering becomes purposeful: his illness becomes both a punishment and a promise for salvation (Goldberg 512).

Donne employs the Early Modern English tradition of translating emotions to somatic affairs, in order to render emotions bound up with pain and illness more tangible. His suffering becomes an opportunity to rethink and renew his relationship to God, while he forges a link between physicality and religious discourse through the employment of corporeal metaphors contributing to making his suffering meaningful.

Paradoxically, Donne's culturally disposed focus on physicality becomes problematic when his illness prevents him from physically acting out his devotion to God, such as attending church or simply kneeling in prayer. In Expostulation III, part of the Devotion subscribed "The patient takes his bed," Donne struggles to relate to the biblical quotation "*Suffer little children to come to mee*" (11. 29-30), for he is suffering, but his immobility is keeping him bedridden. It is not just the illness which is experienced as a punishment, but also the ramifications thereof. His inability to attend church is:

> Not a *Recusancie*, for I would come, but it is an *Excommunication*, I must not. But *Lord*, thou art *Lord of Hosts*, and lovest *Action*; Why callest thou me from my calling? (13. 7-10)

The Early Modern focus on physicality seems problematic, because it invites very literal interpretations and leaves little room for symbolic readings. However, Donne's construction of metaphors through corporeal language signify the body/soul

relationship and serve to express the pain and sense of anguish both body and mind endure in illness. The body retains its symbolic function in an attempt to counteract the loss of the body's (sacramental) signifying power, a loss instigated by a mechanistic science threatening to render the body a meaningless piece of flesh (Kuchar 36).

Donne's loss of control drives him to focus on spiritual and symbolic links to God, which he translates into corporeal metaphors. Although the question of bafflement pertaining to the cause of his illness seems resolved, Donne still struggles to find meaning in his illness experience. Thus, the question of bafflement changes and Donne no longer wonders *why* he should suffer, but *how* his suffering should be interpreted in order to make it purposeful. In Expostulation I Donne claims that "the first *Symptome* of the sicknes is *Hell*" (3. 17-18) and imagines no other possible outcome than death. However, in Expostulation III Donne's sickbed becomes a symbol of Christ's cross and his former likeness of sickness to hell offers the promise of resurrection: "Thou callest the bed *Tribulation*, great *Tribulation*: How shal they come to thee, whom thou hast nailed to their bed?" (12. 20-21).

Towards the end of this Expostulation, Donne again finds a way out of his chaos narrative by likening his present tribulations to those Christ had to endure:

> Thou carriest me thine own private way, the way by which thou carryedst thy *Sonne*, who first lay upon the *earth*, and praid, and then had his *Exaltation*, as himselfe calls his *Crucifying*, and first *descended into hell*, and then had his *Ascension*. (13. 19-23)

However, he struggles with the uncertainty of his place in the order of things and seems to deem his faith undecided: "As yet God suspends mee betweene *Heaven* and *Earth*" (13. 27-28). Donne's following statement illustrates how he seems to view

body and soul as dependent upon each other: "I am not in Heaven, because an earthly bodie clogges me, and I am not in the Earth, because a Heavenly *Soule* sustaines mee" (13. 29-31). Because Donne is inclined to view body and soul as partners, and his sole focus is not the restoration of his former healthy self, he is able to view his illness as more than an interruption: his illness becomes a lived experience through which returning to the former self becomes impossible from a moral perspective.

Although Donne ultimately depends on God for his final judgement, he takes responsibility for his road from suffering to atonement and desires to be an active agent in the remaking of his own world during illness. His predicament may be a punishment, but submitting to that punishment and embracing his suffering will be rewarded with salvation: "Thy hand strikes mee into this bed; and therefore if I rise againe, thou wilt bee my recompence, all the dayes of my life, in making the memory of this sicknes beneficiall to me" (14. 3-6). Again, Donne's communicative body reappears in his request of making his illness a beneficial memory; a request clearly echoing the quest narrative ethic of recollection, in which past actions might be disapproved but are not sought to be disowned. Put differently, the self is reborn after illness but the former self is not denied.

Donne's illness and consequent immobility compel him to examine his relationship with God from a different perspective. He is no longer able to physically express his faith by bending his knees in prayer or joining his congregation in church, but in Prayer III he comes to realise that these are merely extrinsic attempts at reaching a power that through the concept of immanence is already present within each person:

> O most mightie and most merciful *God*, who though thou have taken me off my feet, hast not taken me off my foundation, which is *thy selfe*, who though

> thou have removed me from that upright forme, in which I could stand, and see thy throne, the *Heavens*, yet hast not removed from mee that light, by which I can lie and see thy selfe, who, though thou have weakened my bodily knees, that they cannot bow to thee, hast yet left mee the knees of my heart, which are bowed unto thee evermore…(14. 11-19)

This "knees of my heart" metaphor is a perfect example of how Donne focused on the physicality of his illness in order to make sense of something that did not clearly have a pulse: his mind. The "sinking and strengthlesse knees" (6. 21) he lamented in Meditation II now figure as a metaphor and serve to display how the Galenic focus on physicality can be interpreted symbolically, thus offering a way for the "lexicon of the Galenic body" (Kuchar 30) to coexist with the science of early modern anatomy. Through his metaphors, Donne displays a metaphysical awareness which is not driven by a concern for a loss of the self as a physical entity, but by a fear of losing "the symbolic function that the body performs in the constitution of identity" (34).

Donne is closing in on the second stage of his illness quest, the initiation, as he resolves to embrace the embodiment of illness with body and soul. Again he draws a parallel with Christ by requesting: "make me thy *Sacrifice*" (14. 20-21) as God "hast made this *bed*, thine *Altar*" (14. 20). Conferring that the heat of his fever has burned away the sins of his bed, that the bed is "washed…in these abundant sweats" (15. 12), he requests: "make my bed againe, *O lord*, and enable me according to thy command, *to commune with mine owne heart upon my bed, and be still*" (15. 13-15). Donne's chaotic body, which struggled to find purpose in his suffering, slowly attempts to make his suffering meaningful by equating it to the concept of *imitatio Christi* and has found in God the ultimate witness to the remaking of his world.

3.2 The Initiation: From Suffering to Atonement

Many of Donne's Meditations represent a way of considering man in the grander scheme of things, not so much in relation to God, but more so to nature and in terms of other-relatedness. The part of the illness narrative that can be classified as the initiation pertains to "the various sufferings that illness involves" (Frank 145), not simply regarding the physicality of suffering, but also taking into account the emotional and social aspects thereof (145). In Meditation III, Donne surmised that the only thing that sets man apart from other creatures, is that man is of "an upright form" (10. 7-8). This advantage is taken away in sickness, when man is forced to lie down. In Meditation IV, Donne implies man's inferiority to other animals when coping with illness, noting how humans lack the "innate instinct" (17. 19-20) animals possess: "we shrinke in our proportion, sink in our dignitie, in respect of verie meane creatures, who are *Physicians* to themselves" (17. 8-10), such as the dog who "knowes his grasse that recovers him" (17. 14).

Donne touches upon one's helplessness when it comes to overcoming illness, animals are their own physicians, but "wee have a *Hercules*" (17. 4) to cure us: the *Phisician*" (17. 5). This particular attitude towards physicians is striking because it echoes the position of doctors in restitution narratives; they are the active agents in a patient's recovery and the patient is to submit to this medical hero. Furthermore, because of the chasm between physical and mental health that exists in the present day, seeking a cure for the body in effect cancels out attending to any psychological distress, since the two are not considered to be interconnected. For Donne, conversely, illness becomes an occasion to contemplate his spiritual (or in today's world perhaps rather mental) health, since his reasoning leads him to believe the neglect thereof is what intrinsically caused his sickness.

Expostulation IV offers yet another enlightening view on the role physicians play during one's illness, which touches upon the objection Frank expresses regarding the restitution narrative and its expectations for patients to submit themselves entirely to a doctor:

> Is not the curse rather in this, that onely hee falls into the hands of the *Phisician*, that casts himself wholly, intirely upon the *Phisician*, confides in him, relies upon him, attends all from him, and neglects that *spirituall phisicke*…(19. 1-5)

In Prayer IV, Donne speaks of "the necessity of two *Phisicians*" (20. 11); one to attend to physical health and one (God) to tend to spiritual health. In accordance with his preference for inclusiveness, as alluded to earlier on in this chapter, Donne seems to express the importance of not only man's relation to God, but also how God "hast afforded help to man by the Ministery of man" (20. 15).

While Prayer IV exhibits a desire to be healed, this desire pertains more to Donne's spiritual "phisicke" than his bodily health. Donne effectively leaves the matter of his "temporall health" (22. 8) up to God's "*Ordinance"* (22. 8). Whatever the outcome, assuming the role of a communicative body that is concerned with the wellbeing of others, Donne desires for God to

> prosper thine *Ordinance*, in their hands who shall assist in this sicknes, in that manner, and in that measure, as may most glorifie thee, and most edifie those, who observe the issues of thy servants, to their owne spirituall benefit. (22. 8-12)

Whereas before Donne was preoccupied with his own suffering, the speaker in Prayer IV can be described as a communicative body that seeks for its contingency to be

productive to others. Donne appears less concerned with the outcome of his illness and more so with the effect the process will have on others.

Meditation V ponders an important social side effect of illness: solitude. According to Donne, the "greatest misery of sicknes" (22. 13-14) does not pertain to anything physical. Rather, the greatest misery affects one's social and emotional condition, as he infers this most absolute of miseries is solitude. Ironically, Donne surmises society has a remedy to contain the potential infection a dead body might spread: burial. However, if the same threat applies to someone who is sick, the only remedy is "absence, and my solitude" (22. 24). Once again the ramifications of his assertion point to the body/soul link and the superiority of the soul over the body, as the state of the former seems the most important part of him:

> That is a *disease* of the mind ; as the height of an infectious disease of the body, is *solitude*, to be left alone : for this makes an infectious bed, equall, nay worse then a *grave*, that thogh in both I be equally alone, in my bed I *know* it, and *feele* it, and shall not in my grave : and this too, that in my bedd, my soule is still in an infectious body, and shall not in my grave bee so. (24. 10-17)

Without the soul one cannot know or feel anything, without the soul the body is dead. Thus Donne's pain and suffering become the link between body and soul.

Donne's answer to overcoming his loneliness is found when he draws a parallel to Christ once again in Expostulation V: "thy *Son*, refused not, nay affected *solitarinesse*" (25. 6). Donne demonstrates "the phenomenological efficacy of devotional language" (Kuchar 22) applied to the embodiment of illness as he writes: "*I am not alone*, saies he, *but I*, *and the Father that sent me*. I cannot feare, but that I

shall always be with thee, and him" (25. 10-12). Donne desires not to fear whatever fate awaits him, but this desire is yet to become a reality.

Part VI of the *Devotions* is concerned with the interpretation of fear. In Meditation VI, Donne speaks of how his doctor's attempt at disguising his fear only results in rendering it more transparent: "because he disguises his fear, and I see it with the more sharpnesse, because he would not have me see it" (28. 5-6). This observation leads to a reflection on the concept of fear, on how "feare will counterfet any disease of the *Mind*" (28. 14); fear can turn "a love of having" (15) into a "suspitious feare of losing" (16). At times, Donne seems to struggle for answers that satisfy both his religious and philosophical mind. Donne expresses an uncertainty about the true meaning of fear and even is unsure of what exactly it is that he fears: "I know not, what fear is, nor I know not what it is that I fear now; I feare not the hastening of my *death*, and yet I do fear the increase of the *disease*" (28. 27-30). To fear death would be problematic, for it would be to "belye God" (29. 1).

Expostulation VI is significantly more extensive than any of the devotions thus far, only Expostulation XIV and XIX are lengthier. This could be due to the fact that Donne's Expostulations reflect the struggle between his religious and philosophical mind, resulting in his uncertainty and confusion inviting a narrative of chaos to the foreground. Donne struggles with the question of fear with relation to God: must he fear God, if so, at all times? He is mystified by "the right use of feare" (31. 16), but inspired by the Scriptures concludes fear should be considered a guide, not a misery: "*Wee shall understand the feare of the Lord? Have it*, and *have benefit by it*; have it, and stand under it; be directed by it, and not be dejected with it" (31. 18-21). Resembling the purported body/soul relationship, "*feare* and *joy* consist together: nay, constitute one another" (32. 25-26).

Prayer VI illustrates Donne's acceptance of fear; fear is not something to be overcome, but something to be embraced. To accept fear is to prepare oneself for "the worst that may bee feared, the passage out of this life" (34. 8-9). Not only does Donne transform the fear evoked by illness into something positive through the power of inclusiveness, it also becomes a tool in the experience of illness and an exercise in the practice of facing the question of mortality. Furthermore, one need not be "ashamed of these feares" (34. 18), for he concedes: "Many of thy blessed *Martyrs,* have passed out of this life, without any show of *feare*; but thy *most blessed Sonne* himselfe did not so" (34. 9-12).

In Meditation VII, Donne deduces that his physician's need of help is a sign of his disease progressing. However, he appears to find consolation in the fact that although he might not survive the disease, the disease cannot survive him: "whether an *Autumne* of the *disease* or *mee*, it is not my part to choose: but if it bee of *mee*, it is of *both*; My disease cannot *survive mee*, I may *overlive it*" (35. 3-6). Entertaining the thought of outliving his disease, Donne concludes that a multitude of physicians does not necessarily connote heightened danger, rather "the providence is the more, wher there are more *Phisicians*" (35. 19-20). In addition, Donne surmises illness should not be cause to fear death, for there is "scarce any thing, that hath not killed some body…the best *Cordiall* hath bene *deadly poison*" (35-36. 30-3). In the same station, Donne wonders:

> But why doe I exercise my Meditation so long upon this, of having plentifull helpe in time of need? Is not my Meditation rather to be inclined another way, to condole, and commiserate their distress, who have *none*? (36. 30-33)

By relating his predicament to that of others, who may be worse off still, Donne

seems to have found a way of putting matters in perspective and making his own suffering bearable.

Prayer VII contains a clear instance where Donne is creating, not simply perceiving, order in experience when he states: "Let me think no degree of this thy correction, *casuall*, or without *signification*; but yet when I have read it in that language, as it is a *correction*, let me translate it into another, and read it as a *mercy*" (41. 20-23). This is how death becomes both a correction and a mercy; it is a correction for obvious reasons, but a mercy in that death unites one with Christ, who died for all of man (41). Thus, as Donne's communicative body embraces illness, he effectively embraces salvation.

For Donne, illness has become an occasion to examine both the body and the soul; to bare his body to physicians and his soul to God. By Meditation X, Donne describes how he has seemingly recovered from his illness, yet now the danger lies in what cannot be perceived: "yet they see, that invisibly, and I feele, that insensibly the *disease* prevailes" (56. 11-12). The disease is hiding as one hides one's sins from God by not confessing, but one's eyes and ears, as Donne imagines, are "the entrances, and inlets of our *soule*" (57. 2-3).

The main focus of Mediation XI is man's most vital organ, and according to Donne one of the best examples "that all the *Greatnes* of this world, is built upon *opinion* of others, and hath in itself no *reall being*, nor power of substance" (60. 21-23): "the *heart of man*" (60. 23). If the soul is one's best part, the heart is one's weakest, as Donne asserts it is "the soonest endangered, the soonest defeated of any part" (60. 27). The heart is employed as a metaphor to underscore the fact that something, or someone, who is weak is not less important: the heart should be treated with "prinicipall care…though it bee not the strongest part; as the *eldest* is oftentimes

not the strongest of the familiy" (61. 8-10). The heart is likened to a king, whose strength and importance depends on those who support him, for "those *Superiours*, bee not of stronger parts, then them selves, that serve and obey them that are weaker" (61. 17-19).

The dynamics between the heart and other organs; how a physician defers the examination of other organs to look at the heart first and foremost because "there is no possibilitie that they can subsist, if the *Heart* perish" (62. 6-7), causes Donne to consider other-relatedness. His conclusion appears fairly cynical:

> And so, when we seem to begin with others, in such assistances, indeed wee doe beginne with ourselves, and wee ourselves are principally in our contemplation; and so all these officious, and mutuall assistances are but *complements* towards others, and our true end is *ourselves*. (62. 7-12)

This line of reasoning leads to the assertion that there are no selfless good deeds, but this deduction is nuanced when he states:

> And as the noblest, and most generous *Cordialls* that *Nature* or *Art* afford, or can prepare, if they be often taken, and made *familiar*, become no *Cordialls*, nor have any extraordinary operation, so the greatest *Cordiall* of the *Heart*, patience, if it bee much exercis'd, exalts the *venim* and the *malignity* of the *Enemy*, and the more we suffer, the more wee are insulted upon. (62. 25-31)

Donne surmises that when a king is obeyed voluntarily, it need not be construed as an act of virtue, but more as an act of self-preservation (62. 12-15). Thus Donne seems to imply there are many 'good' deeds which cannot be considered selfless, which effectively makes one question the extent to which they were morally driven. This is how Donne can truly be considered the unwilling hero of his quest.

In Expostulation XI, Donne directs his thoughts to God and wonders: "Am I thy *sonne*, as long as I have but my *heart*?" (63. 16-17). At the onset of this station, he is concerned that his heart is not "cleane" (64. 14), yet it is not like "*Judas heart*" (64. 27). Donne asserts his heart is a "middle kinde of *Hearts*, not so perfit as to bee given, but that the very giving mends them" (65. 2-3). Donne's emphasis on the heart, a word "derived from the Galenic lexicon" (Kuchar 36) demonstrates how Donne not only employed corporeal language to illustrate how the corporeal and the spiritual, i.e. the body and the soul, make up the self, but in addition how physicality represents the "symbolic order of God's Word" (Kuchar 34).

In Prayer XI Donne clearly resolves to embrace his suffering and to embrace whichever fate awaits him. Like the communicative body from the quest narrative, he no longer seeks to change whatever contingency awaits him. This does not connote a total disregard for the matter of responsibility, for Donne remarks: "as thou hast not delivered us, thine *adopted sonnes*, from these infectious tentations, so neither hast thou delivered us over to them, nor withheld thy *Cordialls* from us" (66. 25-28). Similar to the inspirational qualities of quest narratives, Donne is inspired by the narrative of the suffering of Jesus. Evocating Jesus unequivocally submitting to the will of God, Donne proclaims: "a silent, and absolute obedience, to thy will, even before I know it, is my *Cordiall*" (67. 16-17). Thus, from agony to atonement, Donne no longer equates suffering with fear and evil, but rather perceives it as forging a new bond with God through penance in order to become the most cordial person one can be to others in this life, and worthy of serving God in the "kingdom of Joy and Glory" (67. 21).

Due to Donne's own transformation, going from questioning God's ways to recapturing his faith in God to the extent that he submits to his will, Donne has

recognised that he might not be able to physically change anything about his illness, but he can control how he copes with the illness experience in terms of making it meaningful. Whereas before he was concerned about his illness being no longer physically discernable, behaving like a hidden enemy, in Meditation XIII it is revealed his illness has caused marks on his body like an enemy declaring himself, knowing he can no longer be defeated (74. 18-26). The gloom and doom of Donne's monadic body has disappeared and he comes to see the value of suffering: "I must bee poore, and want, before I can exercise the vertue of *Gratitude*; miserable, and in torment, before I can exercise the vertue of *patience*" (75. 20-23).

In Expostulation XIII, Donne views the spots caused by his illness as a positive sign; they represent the purging of sin and he refers to his marks as a "*Confession* with a gracious interpretation" (76. 33). Donne speaks of the effects of his illness in both physical and spiritual terms, as he states: "these spotts upon my *Breast*, and upon my *Soule* shal appeare to mee as the *Constellations* of the *Firmament,* to direct my contemplation to that place, where thy *Son* is" (77. 18-21). His illness is no longer a cause to fear death, but rather a stark reminder of God's grace. Donne views his illness as a mercy, an occasion to redeem oneself and perceiving it as a mercy allows him to deem his illness experience as a meaningful and comforting experience.

3.3 The Return

Within the quest narrative trope, especially in quest narratives where suffering bears religious connotations, returning to the same self and the same life before the illness seems even more impossible from a moral perspective. After all, remembering one's suffering appears to be an important reminder of God's mercy and an important

incentive to not make the same sinful mistakes due to the ubiquitous link between sin and illness in early modern England. As a man marked by illness, Donne has come to recognise that the focus on spirituality is perhaps even more crucial than the focus on physicality.

In Expostulation XIV, Donne considers how fleeting time is and thus remarks: "So far then our daies must be criticall to us, as that by consideration of them, we may make a J*udgment* of our *spiritual health*; for that is the *Crisis* of our *bodily health*" (81. 21-24). For Donne, the links between body and soul are undeniable, for "if the *Soule* wither, the verdure and the good estate of the *body*, is but an illusion, and the *goodliest man*, a *fearfull ghost*" (81. 27-29). In Expostulation XV, it becomes clear Donne is no longer confused about his condition and he has stepped away from the focus on physicality which played a central part in his earlier devotions. In Meditation XV, Donne mentions how man has come to perceive sleep as a *representation of death* (87. 1). However, in Expostulation XV, Donne asserts that the likening of sleep to death is a result of translating too literally what the eyes perceive, after all, no one sees the act of sleep with his eyes (89. 1-2).

Although Donne has not yet recovered from his illness completely, the experience thereof has clearly changed his outlook on the subject of physicality. Although his body is still in "a sick wearinesse" (90. 5), he contends his soul is in a "peacefull rest" (90. 5) with God and while his eyes are open, they "see nothing of this world, but passe through all that, and fix themselves upon thy *Peace*, and *Joy*, and *Glory* above" (90. 9-11). Donne finds hope and assurance in his faith, hope and assurance which are based on the body/soul relationship that forms the foundation for Donne's relationship to God.

For Donne, other-relatedness is a part of the human condition, for in Meditation XVII he states: "No man is an *Iland*, intire of it selfe" (98. 2). Within Donne's religious framework, every human is connected because "All *mankinde* is of one *Author* (97. 7). The tolling of a bell alerts Donne to the passing of a fellow man, and causes Donne to profess: "any man's *death* diminishes *me*, because I am involved in *Mankinde*; And therefore never send to know for whom the *bell* tolls; It tolls for *thee*" (98-6-8). If illness is a punishment for lacking morality, but also holds the promise of salvation if one transforms that punishment into an opportunity to become a better moral person, then "*Tribulation* is *Treasure*" (98.19).

In Donne's narrative death is not deconstructed, but it rather becomes a life lesson; to be confronted with death should be an occasion to better one's life. Donne desires his death to have a purpose for others, as he states in Expostulation XVIII: "It is a *second death*, if none live the better, by me, after my *death*, by the *manner* of my death" (107. 12-14). The illness might be a punishment for sins, but death is a delivery from that bodily state, as Donne surmises in Prayer XVIII: "Thou presentest mee *death* as the *cure* of my *disease*, not as the *exaltation* of it" (109. 11-13).

As much as Donne puts faith in God and explains his recovery as God's mercy, he does take responsibility for his road to recovery. Through the concept of immanence, God acted as his conscience, his moral counsellor, but Donne figures as the active agent in his recovery. In Meditation XX, he surmises: "Without *counsel*, I had not got thus farre; without *action* and *practise*, I should goe no farther towards *health*" (121. 16-18). The paradoxical purpose of illness is to provide strength by increasing weakness (121. 22-23). Donne's recovery, both physically as well as spiritually, marks his resurrection: "This *Resurrection* of my *body*, shewes me the *Resurrection* of my *soule*" (129. 2-3). Thus, like a Phoenix, Donne rises up from the

ashes of his misery with a better understanding of that miserable condition of man. The insights he has gained on his quest from agony to atonement, not only offer hope, they also exemplify his change into a communicative body. Thus, Donne uses his illness as an occasion to examine not only man's relationship to God, but also the condition of man.

4. Timothy Rogers: *Practical Discourses on Sickness and Recovery*

When it comes to fighting the belief that one is either affected by mental or physical pain, David Morris would almost certainly agree with Timothy Rogers' view on depression: those who suffer from it "are wounded in both soul and body" (qtd. in Coyle 181). Timothy Rogers, a Puritan pastor born in the second half of the 17th century, suffered from a serious case of depression which left him physically unable to join his congregation for a period of two years (Coyle 179). Rogers describes depression as a "painful disorder" (qtd. in Alexander 55) of the mind and those affected are like "persons whose bones are broken, and who are incapacitated for action" (55). Furthermore, Rogers expressed a belief which mental health advocates even in this day and age sometimes find is met with resistance: "the disease is a real one" and not simply "an unfounded whim" (55).

Practical discourses on sickness & recovery, in several sermons, as they were lately preached in a congregation in London, was published in 1691 and marks Rogers' return from sickness. In these sermons, Rogers addresses his own illness experience, but also devotes his time to "the understanding and consoling of sickness" (Schmidt 118) framed within the religious tropes of his time and centred around Protestantism. Rogers undeniably promotes religion (or conversion) as the ultimate cure, but beneath the surface of his doctrinally influenced narrative emerges a fellow-sufferer who approaches illness, and the ill, from a phenomenological and experiential point of view; an approach bearing many similarities to the more secularised contemporary illness narratives Arthur Frank categorises as quest narratives. Rogers' sermons reveal a man marked and affected by the lived experience of (mental) illness. He endeavoured to inspire others to have hope of salvation and offered advice on how one might best approach those suffering from illness.

Rogers displays a very strong sense of other-relatedness and a great sense of empathy. Furthermore, while he reiterates his gratitude for having risen from the grave, the desire to have one's life extended does not connote a deconstruction of mortality as it does in the restitution narrative. Moreover, Rogers believed the value of one's life was not to be "measured by the number of Years, so much as by our Proficiency in Heavenly Wisdom" (112). Rather, he considered death and recovery from illness both great mercies. Permitted of course, one departed from this life as a devout and moral person who dedicated his life to the service of God. Those who desire to "live long that they may with more Freedom indulge and gratify their Appetites" (121) or hope to be remembered by their "stately Buildings and Houses…are little acquainted with the Nature of Religion" (121-122). Rogers sermonised that religion "will teach us to make the glory of God, the Edification and Profit of our Neighbour, and the Welfare of our own Souls" (122) and should be the sole motivation in one's desires for a long life (122).

The *Practical Discourses* can be classified as a quest narrative containing elements of both the quest automythology and the manifesto. It is a manifesto in the sense that Rogers seems adamant to profess a certain "truth about suffering" (Kleinman 147), the experience of which seems to have left him inspired to "move others forward" (147) with him. His illness experience has garnered such profound insights that his narrative at times contains a call for "social action" (147), which relates to how people are to treat the sick, but also goes as far as to suggest how people are to dress soberly and not take too much pride in their housing facilities as both are merely temporary "habitats." In addition, the terms 'sickness' and 'recovery' are applied to political affairs relating to the state of the country.

Rogers' sermons contain clear elements of the quest automythology as well, as he refers to his recovery as a "Spiritual Resurrection" (Rogers 113); typical for the automythology, his narrative symbolises the Phoenix who has risen from the ashes as he proclaims to have "as it were risen from the Grave" (268). In addition, much resembling Donne's notion of being reborn, Rogers professes: "We that have recovered from Sickness that was almost unto death, have received two Lives from God" (205). Comparable to the manifesto, the automythology is a call for change, but the latter focuses more on personal rather than social change (150), thus imploring everyone in his congregation to be a better moral person.

Preceding the discussion of the *Practical Discourses* in light of their quest automythology and manifesto qualities, Rogers' views on the body/soul relationship will be addressed, as these offer an important framework through which to regard the *Practical Discourses* as a quest narrative embracing mortality and embracing life's vicissitudes by making suffering meaningful for the self and for others. For Rogers, illness, pain and suffering represent the shadow of death; it confronts one with a sense of mortality every human being must face. Moreover, illness becomes an occasion to prepare for death. The narrative Rogers has created contains important elements lacking or deconstructed in the dominant present-day restitution narrative: body and soul are not disconnected and the question of mortality is not reduced to a matter of physicality. Recovery after illness might be desired, but it is not the ultimate goal, for Rogers acknowledges that it is "but a delay of certain death" (97). Thus, recovery is not a chance to continue the same life one had before the illness struck. The pastor views recovery not as being given the same life, but a second life in which one has been blessed with the opportunity to reflect on life's true virtues, conceded by new insights induced by the illness experience.

Although Rogers' belief that only God had the power to cure the sick could arguably be deemed a dangerous stance from a modern point of view, Coyle asserts that he "anticipated contemporary cognitive therapy by encouraging the afflicted to have hope" (181). Rogers' thoughts on how to treat an ill fellowman, in the non-medical sense of the word, are in line with what Frank advises when one is confronted with an illness narrative: to be prepared to become a witness to the story (Frank 137). As a witness, one must be prepared to "listen to the voices of those who suffer," for "listening is…a fundamental moral act" (52). Rogers surmises it is "the duty of those that are acquainted with the sick…to Minister as far as they are able to their Spiritual Wants; to direct, instruct, and any other way to help them" (17). Dreher asserts Rogers advocated an affective approach to those suffering from (mental) illness, encouraging "kindness, acceptance, and compassionate listening" (48).

While it cannot be denied that Rogers clearly uses religion as a promise for the ultimate cure, he also seems to have been motivated by a great sense of compassion and other-relatedness; a treatise published shortly after his *Practical Discourses*, titled *A Discourse on Trouble of Mind and the Disease of Melancholy*, was mainly driven by his aspiration to "assist others who suffered from the same affliction" (Coyle 179) and offers advice on the best emphatic mode of conduct around those suffering from a case of melancholy (Coyle 180-181). Despite the ubiquitous link between sin and illness, Rogers implores his congregation to regard their "afflicted Friends with great tenderness and pity, for whatsoever their Case is, your sins may bring you as Low" (15). In caring for the sick, Rogers recognises what Frank refers to as a "mutuality of need" (52): according to Rogers, being confronted with the pain and suffering accompanied by illness "would give you a new taste of

Health" (141). Thus, as Frank asserts: "in listening for the other, we listen for ourselves" (52).

For Rogers, a good moral person takes great pride not in his body, but in the care of his soul. The pastor is a firm believer of the relationship between body and soul, to paraphrase Donne; he unmistakably asserts the soul is one's best part. This reverts back to what was mentioned earlier about dressing the body soberly and not overly valuing material things; like a house is one's temporary abode on earth, so the body is the soul's temporary dwelling as according to Rogers what is left of you after death is the soul, which is still to be judged (51). According to Rogers "he that is proud of his *Body*, is as foolish, as if he should doat upon a Flower" (222), because like a flower the body will eventually wither and die and "all the Care we can use will not preserve them from the grave" (222).

In his Epistle, Rogers evokes an image of a soul with corporeal qualities, thus metaphorically linking the spiritual to the physical, when he states: "the Soul pants and breaths for the living God" (xv). Then Elaine Scarry's notion about pain being inexpressible resounds in the following passage: "In these Discourses you will find a Relation of some part of my Affliction. It is impossible to relate the whole of it, for my Sorrows were beyond expression" (xxviii). However, Rogers does seem to make a distinction between conveying mental and bodily pain, the former being seemingly impossible to put into words as he continues: "I have not here insisted on that, which was the Trouble of my Trouble, my Spiritual Distress, my Anxieties and my Fears, which were vastly more afflicting to me than my bodily Pains, which yet were both sharp and long" (xxviii). Thus the "trouble of his trouble", i.e. the problem of his spiritual distress, was that he could not express the anguish it provoked, as opposed to describing his physical pain as "sharp and long."

Rogers' belief that God "tyed our Bodies and our Souls together" (8) shaped his view on medical science and as Schmidt has noted he "showed a great deal of reservation about the efficacy of medicine" (118). Throughout his sermons, Rogers reiterates God's authority in matters of life and death, and suggests that to endeavour to dissect the workings of the faculties could be regarded as undermining the power of God:

> Though the manner of his Influx is very Mysterious, and it becomes not the weakness of our Minds daringly to determine which way it is, we that are extremely in the dark about many of the motions of our own Faculties, ought not any way to Limit Him, whose Wayes are Unsearchable, and who is so far above us. (8-9)

After all, "all Sicknesses are at his disposal, for it is he *that kills, and that makes alive*" (11).

Rogers does not explicitly advise against seeking the help of a physician, but he certainly does not promote it as he believes one must first and foremost "by serious Prayer go to God himself" (33) upon the emergence of the first symptoms. For Rogers, this is a crucial detail, for he believes that those who seek help from a physician and only turn to God as a desperate final measure "have but little Reason to hope for help from God" (17). He seems to consider such a course of action perfidious, as he states: "For they shew that if they could have had Relief without him, they cared not to be beholden to him for it" (17). The "Learned Art" (34) of doctors, according to Rogers, is "like all other Humane Sciences, full of Imperfections" (35), subsequently declaring how "a Thousand things may hinder your having any Relief from Physitians" (35).

While Rogers views the soul as the most important part of the self, not in the least because the soul is everlasting, this does not connote an utter disregard for the fate of the body after death. Illness, and thus the prospect of death, signifies a threat for "the Union that is between the body and the Soul to be dissolv'd" (44). The thought of the "Body turn'd into a Carkass without Life and Motion…to have this Body in which we have slept and liv'd at Ease, laid into the cold Grave, and there in a loathsome manner to putrifie and consume away" (44) certainly is a cause for "very great Commotions" (44). This is one of several paradoxes regarding notions of pain, suffering and death in Rogers' sermons: illness confronts one with mortality, an occasion to mourn the loss of the body, but it also holds the promise of a joyous immortal life in the presence of God, if the soul is deemed gracious enough by the ultimate judge. Alluding to the relationship between body and soul, death is a time when "two Friends who have been so long acquainted, and so dear to one another must part" (45).

Body and soul may be partners in life, but in Rogers' view they are not equally dependent upon one another; without the soul the body is but an empty vessel, but after death the soul will continue to "Understand, to Will, to Remember" (67). Moreover, according to Rogers the body even impedes the soul as he imagines how wondrous the soul's thoughts would be "when it is without any hindrance from these material Organs that now obstruct its operations" (68) as the soul contains ideas "purely intellectual, and which have in them nothing Material" (67). The body is depicted as a burden to the soul, for illness fills the "body with uneasiness and pain, and his soul by its sympathy with its dear Companion with Anguish and Vexation" (98-99).

Rogers appears to connect sin purely to the body, the material, as he proclaims:

> A Soul under the Dominion and reigning Power of Sin, is in a far more deplorable Condition than a Body that is consuming in the Grave: the one suffers under a sort of innocent Misery which it cannot help, the other suffers under a wilful Obstinacy and Impotence contracted by its own fault. (113-114)

A sinful person is separated from God, which Rogers deems "far more terrible than the separation of the Body and the Soul, which yet is painful and sad enough" (114). This is why he considers the state of the soul to be so much more important than that of the body.

Rogers's belief that the soul represents a man's true self and his focus on the spiritual rather than the physical enabled him to embrace mortality. Despite the strong link between illness and religion in Rogers' time, he alludes to what Frank considers one of the most significant side effects of the dominant restitution narrative in modern-day society: foregoing mortality by the obsessive pursuit of a remedy at all costs, and thus depriving patients of what he refers to as a good death. In the following passage, Rogers touches on a very relevant restitution trap many health care professionals who are only capable of viewing matters from a medical, rather than human perspective, often fail to avoid:

> I cannot but think that Patient very ill advis'd, who thinks it not time to entertain thoughts of death, as long as his Doctor allows him any hopes of Life; for in case they should both be deceiv'd, 'twould be much easier for the mistaken Physitian to save his Credit than for the unprepared Sinner to save his Soul. (39)

When the restitution narrative fails to have a happy ending and all available treatments only rendered the ill person sicker and incapacitated up unto the point of passing, has he then not fallen victim to the restitution plot even more so than to the actual illness?

Within the trope adhered to by Rogers, death might signify the end of one's life on earth, but it is not final. Rather, death is the "beginning of Eternity" (50) either in Heaven or in Hell. Rogers views illness as a mercy, because facing the question of mortality induces new insights which enable one to prepare for death and the opportunity to "put our Houses, and our Minds in Order" (57). Thus, suffering signifies a punishment for sins, but a mercy in the sense that it offers new perspectives which allow one to become the moral person changed by the illness experience. In Rogers' quest narrative, morality is the antidote to sin and sickness and Rogers presents himself as the communicative body who desires to save all beings from a life of sin and sickness.

4.1 *Practical Discourses* as a Manifesto

In the manifesto, a complete recovery from illness is deemed a "naïve illusion" (147) and the insights gained through the quest are prophetic (147). In his Epistle, Rogers mentions plans to publish other works which offer "some Directions to those that are long afflicted, and more especially to melancholy People, to whose Case there is very little said by those that have long been so themselves" (xxix). This endeavour is indicative of the communicative body of the manifesto who displays a great sense of responsibility through the ethical voice of solidarity and commitment. As discussed in chapter 2, this voice presents itself as a "fellow-sufferer" (159) who seeks to garner awareness for those who cannot be heard. As is the case with Rogers, this ethic is

oftentimes present in narratives composed by people who are able to reach a wide audience (Frank 159).

Arthur Frank describes the manifesto as "the least gentle" (147) quest story within the quest paradigm. Not only does Rogers embrace suffering and consider illness as an occasion to become the ideal moral person who as a consequence has no reason to fear mortality and every reason to fear God, at times he does not shy away from painting a rather disenchanting picture of life. In the Epistle he states:

> Since I have been so long sick, I cannot look upon any of my Fellow-Creatures but with great pity, when I think how many thousand Pains and Troubles may be their Portion before they die. I could not have thought there had been in the World so many and so great Miseries as those are which I my self have felt… (xxix)

Still, the pastor offers hope by presenting the story of Jonas as a metaphor in which the whale represents illness: "the same Creature that had swallowed him up should be the vessel that should Convey him to the shore" (4) is paralleled to how Rogers' illness experience "swallowed [him] up with amazement and fear" (3) yet the "Waves of Trouble" set in motion guided him to "dry land" again.

Pain and suffering become meaningful because they reflect the will of God: sore afflictions must be endured with patience for his "indignation" (26). In Rogers' view, embracing suffering is tantamount to demonstrating one's faith in God's mercy and the "Righteousness of Christ, the Merits of his Sufferings…for without Faith in Christ there is no Hope" (27). Embracing illness and suffering are the only option, since fighting it would denote defying God; the "Evils" one must endure are considered "the effect of an Holy Providence, which though it is many times very severe, yet is always very just" (27). Ironically, reminiscent of the restitution narrative

in which the patient is expected to completely submit himself to the physician, Rogers surmises embracing suffering does not imply submitting to one's miseries, but submitting to God (30).

Rogers poignantly articulates the power of true faith when he states:

> Several Men will with great hardiness and resolution bear very great pains, so long as there is the least hope of Life; but to be patient and submissive in the deepest Sorrows, and in the view of certain death, this is what none can rightly attain to but those that Believe…(29)

The pastor underlines and illustrates this statement with a reference to Christ's hardships and the resolve with which he endured them because God's will must be done (29). Rogers explicitly implies that one's ability to bear pain depends on one's trust in God, yet even this will not safeguard anyone from enduring long and violent distress. Rogers suggests to take pain and suffering in stride; to carelessly undergo affliction would indicate contempt for God's "Justice and his Wisdom" (31), but to "sink, and altogether to dispond is as great a Crime" (31). If death is the fruit of sin, then a resignation to suffering as an acceptance of the will of God is "the fruit of a mighty trust in God; for without it lingering and continued pains are not to be born" (30).

Rogers regards his return from a "long and doleful sickness" (97) as a "Resurrection" (97). As a consequence of the insights he gained from his illness experience, the world looks anew to him (97). His description of that new world is less than gentle: "But alas what is this World that at the best is a Region and a state of death" (97). Recovery from illness might be as a resurrection in a certain sense, yet it is "such a one as that of *Lazarus*; after which I must be sick again and dye, for Recovery is but a delay of certain death" (97). However, if the soul is in the right state

at the moment of death, an eternal (second) death can be avoided. Since Rogers considers the mercies that God bestows upon the soul to be "much more valuable" (113) than those pertaining to the body, he values his "spiritual Resurrection" (113) because "temporal Deliverance and Salvation would not be so great a mercy" (113) without it.

The picture Rogers paints of a God who has the power to destroy or save, but is always just and merciful, does not seem a God of all people. As much as Rogers believes life must be dedicated to the service of God, so God seems to act in service of those adhering to Protestantism. Not only has God brought Rogers from the grave, he has "brought *every person here from the Grave*" (215) as God has "mercifully saved and helped us" (215) from the schemes of their enemies (215). In addition, God has helped their "Brethren in *Ireland*" (215), kept a "Fleet of our Enemies" (216) at bay and those in "*London* have seen your Civil Liberties rescued from the Grave, in which they might have laid very long, had not he raised up our present *Protestant King* to be that glorious Instrument that should give them a Resurrection" (216). The language Rogers used to discuss illness is used verbatim with relation to political matters in order to demonstrate the power of God and the power of faith, for as long as "we repent, we shall not perish" (216).

Not merely religion, but more specifically Protestantism is offered as the cure for a country which "after a long Sickness and Indisposition, under which a few years ago, we were afraid it would have languisht quite away, has begun to recover" (216). However, Rogers professes a full recovery can never be effectuated as long as the "ill Symptoms" (217) such as the "Blasphemies and execrable Oaths to be heard in our streets…heedlessness and irreverence in our Assemblies…Injustice and Deceit

in our Shops…so much Omission of Prayer in our Families" (217) remain. Rogers continues:

> Oh what a Joy would it be, if God would save *England* with Spiritual Deliverance; if he would save us from those Sins that expose us to his Wrath? And if we would in our particular stations do all we can to promote such a Salvation which would be much more glorious than what we have yet seen. (217-218)

Despite the fact that the country's recovery is not yet complete and is still plagued by symptoms, Rogers surmises: "we are much better than we once were" (217).

Rogers' employment of the word 'recovery' should not be confused with the connotation it has within the restitution paradigm: within Rogers' narrative recovery does not imply a restoration of the self before illness, consequently pretending the illness never occurred and thus effectively denying any suffering. In the pastor's view, desiring recovery in order to simply extend one's life is meaningless. Rather, one should be thankful to have been "brought up from the grave…because by that means they have more opportunity to be serviceable to the Glory of God, and to be useful in the World" (73). For Rogers, life an sich is not very desirable, for as he less than gently describes it: "Meerly to live is not a thing very desireable, considering how many Miseries there are in Life, to what Evils and Inconveniences our Bodies are obnoxious" (73). Thus life, especially the second chance one is given at life after recovering from illness, can be marked as a moral enterprise. Life is desirable when one "can thereby obtain the Ends that are truly Great and Noble" (74).

According to Rogers, life, especially life after having been on the brink of death, must be solely dedicated to religion and other-relatedness:

> *A man may do good to others*. He may teach the Ignorant, reduce the wandring; and by the zeal of his Prayers, and the Lustre and Holiness of a good example, advance the power of Religion…Not onely Ministers but every private Christian is obliged by the Name he bears, and by the Relation that he has to the holy Society of Believers, and to the Kingdom of Christ, whereof he is a Subject, to enlarge it by all good ways that he can; and every man is the more obliged to this when God has bestow'd a new Life upon him. (74)

Within Rogers' illness narrative, illness becomes an occasion to transform into a moral person who "takes as his cause the life or wellbeing or dignity of another human being"' (Frank 121). It becomes the duty of this moral person to "tell the Healthful what Sickness is, what we have found it to be by our own Experience…how it makes very uneasie and troublesome Companions of our now beloved Bodies" (75). Illness is a reminder to be prepared for a good death, a reminder of one's mortality and the recovery thereof is a chance to become a moral person who does what is right for "the World, the Church, the Nation to which he belongs" (76) for "the Converted and the Unconverted, his Relations and Friends, the good and the bad do all need and require his help" (77). Thus, Rogers truth about suffering is that "by suffering we may learn to suffer" (33): it teaches us how to suffer in order to set things right in this life, before one is to suffer forever in eternity.

4.2 *Practical Discourses* as an Automythology

As alluded to in chapter 2, illness narratives are often comprised of a combination of types fading into the background and reappearing in the foreground. Although Rogers' sermons predominantly seem to fit the quest narrative model, they also

contain hints of the chaos narrative paradigm. In addition, the different quest manifesto and automythology facets seem to merge at times as the rising Phoenix metaphor, which Frank ascribes to the automythology, repeatedly reverberates in his more prophetic and political proclamations. Given the fact that "like the manifesto, the automythology reaches out" (Frank 150), this merging of facets is to be expected. The greatest difference between manifesto's and automythologies is that the latter display a more personal language (Frank 150).

Apart from relating the experience of illness and suffering in terms of social, political and of course religious matters, Rogers touches on what his illness imposed on him personally. These more personal accounts are undoubtedly related to his faith, but this need not make his account less unique or personal, for the interpretation of all personal experiences are hinged on "shared cultural resources that provide words, meanings, and the boundaries that segment the flow of time into episodes" (Frank 14). In the case of Rogers' illness narrative, words such as *sin*, *glory*, *mercy* and *resurrection* are employed to describe his experience of illness and recovery and illness and suffering become meaningful by assimilating it to religion. In Rogers' view, the flow of time is divided into two clear segments: an alterable and transient life on earth, and an unchangeable state of eternity after death.

Rogers displays a great sense of responsibility, which goes beyond that of the self in the restitution narrative, whose sole responsibility is simply to get better. Since Rogers considers his illness a punishment for his sins, it seems only natural to thus take responsibility for his illness. Moreover, Rogers seems driven by a sense of responsibility towards his fellow man when it comes to preventing others from having to endure the same ordeal and inspiring the afflicted to not give up hope when faced with illness and suffering. When responsibility lies with the self, and not as it does

within the restitution narrative with the physician, the self can be considered a "reflexive project" (Frank 41) in order to better oneself as opposed to restore the old self. Frank surmises that "defining the self in terms of responsibility for the other is the core ethical impulse in most religions" (41).

In Rogers' case, the truth about suffering has affected him so profoundly on a personal level, that he takes it to be his duty to warn others of the perils that might await them while offering a story of hope based on the mercy and glory of God. No matter how terrible or insuperable one's predicament may seem, "that Almighty power to which nothing is impossible" (4) can save anyone who is willing to dedicate their life to God and their neighbours. While Rogers professes the ultimate power lies with God, he attributes his recovery to the people of his congregation as well: "The Mercy of God which alone could help me, and that was implored and fought by your prayers has brought me from the very Grave" (20). Using his own case to illustrate the power of faith he adds: "In all future occasions try this method for you know it is available and successful" (20).

Rogers appears before his congregation with "such a remaining pain as makes me not to know what a Total Ease is" (5) and confesses how he has struggled with waves of "Impatience and Anger" (4), feelings he so ardently warns against when reiterating how one must be patient when enduring whichever affliction God's wrath provokes. This illustrates how Rogers presents himself as the quest narrative's "unwilling hero" (Frank 150); the moral insights gained from his illness experience are a result of his initiation process from agony to atonement. Bearing in mind Rogers' philosophy that illness is a cause to renounce all sins, he points out how the physical effects of illness intrinsically remove the sin of vanity: "In their broken feeble expressions, in their wan and pale looks and in their fallen Countenances, you

behold that *man in his best Estate is altogether vanity*" (18). This view implicitly conveys one of Rogers' recurring messages: the best and most important part of oneself is found within, everything else is secondary and meaningless without good health.

Despite Rogers' emphasis on the link between sin and illness, he does acknowledge that not all illnesses are a product of sin; he refers to "outward Accidents" (143) such as "the breath of a cold Wind, or too much or too little Exercise…or even a sudden Fright, or ill News" which "are able to produce Sickness, and perhaps Death" (143). Rogers makes no distinction between the effects of physical or mental distress as he implies both can lead to illnesses. Moreover, he declares: "what a damp the Pains and Indispositions of our Bodies, put upon the motions of our Souls" (144). Rogers points to the paradoxical nature of illness in the sense that it turns "Those very Senses which let in Comfort to the Healthful" into "an occasion of a new Sadness" (144). The pastor notes how under the duress of illness one may have a mouth, yet cannot speak, one has feet, yet cannot walk and the sight of medicine is an ungrateful one, as is the smell of food and the taste of drink (144-145). Thus, one of the paradoxes of illness is that it transforms "Comforts into Crosses" (145). Rogers infers that without health the best reputation, most beautiful house and even one's most loyal friends are all "dead Comforts" (145).

What Rogers conveys is a recurring message in many contemporary illness narratives: those who have lived through an illness experience often express how it changes one's outlook on life and how it makes one more appreciative of the simplest things in life (Buckley 43). In addition to displaying the ethical voice of solidarity and commitment and an ethic of inspiration, the pastor employs the voice of ethic recollection. This voice is important for the moral change to occur and demonstrates

his sense of responsibility as it might disapprove of certain actions in the past, but does not disown them (Frank 159). This voice contributes to the notion of the self as a reflexive project and presents one with the opportunity to redeem oneself.

Because Rogers considers illness an occasion to better oneself, the ethic of recollection plays an integral part within his quest narrative. As discussed earlier in chapter 2, within the quest paradigm illness and suffering can be considered a sacrifice one unwillingly endured in order to get a new perspective on life. These new views on life are meaningful when contrasted with the pain and suffering one endured to acquire them, or as Rogers voices it: "The hideousness of Obscurity sets off the beauty of Light; and the sweetness of Health is best represented by considering the bitterness of Sickness" (147). Recollecting the distress and perhaps even peril one was in before recovering from illness "heightens the Mercy of Deliverance and Salvation" (148).

Before relating part of his personal experience with illness, Rogers alludes to the significance of stories of illness, noting how it is "better sometimes to hear sad, than always pleasant things" (148) because quest narratives do not forego the reality of pain and suffering being a part of life. Furthermore, Rogers appears to infer that illness narratives are some of the most genuine stories, for although they might be sad at times, it is the poignancy of this sadness and pain "that requires not Ornament or artificial setting off" (148-149). Accordingly, he continues: "I shall without affecting to be thought eloquent, give You A Plain Relation of some part of my sore Distress" (149).

Indirectly claiming responsibility, Rogers remarks how "*it pleased God at length in his just and righteous Judgment, to suffer my growing Distemper to arrive to a most formidable height*" (149). The pastor speaks of how his illness resulted in

sleeplessness, which left him feeling a "*general Weakness and decay of Spirits, a general Listlessness, and a total Indisposition*" (149). His illness experience eventually grew so distressing, it left him convinced the end was nigh. These thoughts of death were prominent in his mind for the duration of a year and he notes how the experience of being confronted with death cause a "mighty Change" (150) in his thoughts.

Rogers relates how nothing could abate his anguish, as "*none of the Methods that were used to remove it, though painful enough, were of any value*" (151). It even haunted him in his sleep, leaving him "*disturb'd with terrible and amazing Dreams*" (151). He describes how his "*Fears, and sad Apprehensions*" (151) hit him like a whirlwind, "*as a universal Storm, from which there was no retreat*" (152). Thus far, Rogers' personal account could best be classified as a chaos narrative: Rogers paints a grim picture of a life in disarray, with no signs of matters ever improving and a voice who considers himself to already have one foot in the grave. There is no prospect of a cure, there is no hope and the storm metaphor indicates the sense of a loss of control.

What seems most striking about Rogers' employment of the voice of chaos, is what chaos narratives typically forego: any sense of purpose to suffering. This demonstrates that the (mostly) psychological and physical effects of pain and suffering were detrimental to him in such a way that not even a devout and God-fearing pastor such as Rogers was able to discern any meaning or purpose in his lived experience of illness. The experience of his "*most* terrible Convulsions" (152) is described as being in the "*very Jaws of Death. They were to me as a Den of Lions, and are as painful and terrible as if a Man were actually torn to pieces*" (152).

Paradoxically, it appears the severity of his suffering opened the door to (divine) solace:

> *I was in Death often, often as in the very Agonies and Pangs of Death, but I could not die: I seemed to have the strength of Brass; it seemed to me as if I had been raised up by Almighty Power only, that I might be capable to suffer Pains very strange and very terrible.* (153)

Retrospectively, Rogers considers his doleful thoughts a sign of "*inexcusable Infirmity*" and "*Unbelief*" (155), but this should not be taken as an attempt to discredit the reality of those feelings at that time. Echoing Frank's observation that medical professionals are often inclined to label chaos narratives as expressions of depression, as such accounts are considered anxiety-provoking, Rogers surmises:

> *Those that are in Health will scarcely perhaps credit what I say, they will think I am a melancholy Man, and aggravate my Trouble, and set it out more than it needs, or than it was, and that in the whole there was a great deal more of Fancy than of Reality; but I pray God they may never taste one drop of that bitter Cup whereof I was made to drink, for if they should, they'l find it whatever Names they now give it, to be then full of real Miseries.* (155)

Thus, Rogers's employment of the chaos narrative, and utilisation of metaphors in general serve to assimilate real life events and experiences.

While he does not eschew sharing this chaotic and perhaps even flawed side of himself, his main purpose in summoning the voice of chaos seems to be to prevent others from experiencing the same sense of gloom and doom. One may never be able to avoid pain and suffering, but the mind-set one (reflectively) adopts may prove pivotal during and after the illness experience and in coping with the possible personal and social effects, even when one is considered cured from a medical perspective. Rogers turns his narrative of pain and suffering into one of inspiration and hope, as he states:

> *As I have spoke nothing but what I fully believe to be true, so I have spoke the more of it, that it may be of some use to others, that though Trouble and Distresses fall upon them which are very strange and very perplexing, or such as rarely happen, that they would hope even in the Depths, for they may see by me that* nothing is too hard for God. (155)

As somewhat of a pioneer, Rogers reflects how few people "*are willing to speak of what they then saw and felt…People are unwilling to speak of such things as these, because others are unwilling to hear such doleful Relations*" (156). Thus, Rogers' illness transformed him into an unwilling hero.

5. Conclusion

For both Donne as well as Rogers illness entails significantly more than a mere physical or mental breakdown. While Donne's disease is physical in nature, and Rogers suffered from a disease of the mind, both narratives reflect that the experience of being ill affects both body and mind. Due to the link between body and soul and the near interchangeability of sin and illness, illness in early modern England was inextricably bound up with morality. The emphasis on physicality did not reflect a chasm between body and soul, but rather served as a discernable indicator of the condition of something less tangible yet more important: the soul. Furthermore, the impetus behind the early modern English focus on physicality sprung from a desire to live a good life, which from Rogers' point of view is not measured in the quantity of years but in the quality.

For Donne, God's word represents the bond between body and soul and his illness as an embodiment represents God's word. Donne's anxiety regarding the physicality of his illness is not due to the threat it represents to his bodily health, but what it connotes for his spiritual health. After all, when the body ends up as nothing more than "dust and ashes" (2. 22), is the soul not what remains? Donne's narrative, more particularly the segments voiced by his chaotic body, suggests that pain and suffering, when isolated from any social-cultural or religious tropes, bear no meaning and offer no consolation. Only when Donne relates his suffering to the suffering of Christ, and to the suffering of others even less fortunate than him, does his illness experience become meaningful. Perhaps one of the most significant insights learned on his quest is that pain and suffering are part of the condition of man, like death it is part of an eternal truth revealing a shared humanity and his own suffering rendered him more conscious to the suffering of others.

Despite the ubiquitous link between sin and illness in Rogers' narrative he also seemed aware of the dangers of linking illness to morality. When Rogers advises those witnessing an unfolding illness narrative to offer tenderness and compassion, he invites people to act as an emphatic witness to the story rather than as a moral judge. The clear correlation between morality and illness elicits a reflective stance and if one is fortunate enough to be brought back from the grave, resuming the same life preceding the illness seems irreverent from a moral perspective. If morality is the antidote to sin and sickness, then embracing pain and suffering will imprint the soul with a powerful reminder and the ethic of recollection will preserve the self from future miseries, as Rogers asserts: "The best Security from future Miseries, is to profit by the former: We cannot take a better Medicine to fortify us against Evils to come, than by remembering and improving such as are already past" (192).

To approach illness from a phenomenological perspective requires one to "empathise with the ontological problems of being in such an illness state" (Barker 22). Donne and Rogers recognised that to suffer is to be human: they remade their world not by letting the pain define them, but by defining what that pain meant to them, a pain that is "felt as much as it is thought" (Smith 496). Quest narratives attempt to address subjects such as suffering and mortality, issues inherent to the human condition yet which restitution narratives prefer to eschew. The chasm between the physical and the mental, and the restitution narrative's obsessive focus on physical wellbeing, has resulted in a deconstruction of mortality.

Ultimately, this modus operandi is harmful because it renders one unprepared and unequipped to deal with loss and bereavement. Moreover, for the person suffering from a potentially fatal illness, the experience is "exacerbated by our incapacity as a society to address, accept and communicate openly about fear of our

own mortality" (Petrone 35). Instead, "we choose to ignore this eventuality, until it is forced upon us" (36), thus amplifying the impact. Death cannot be escaped, merely temporarily avoided, but to live through illness may yield a "a sweeter relish" for life (Donne 212). Through quest narratives pain and suffering become meaningful because they are a reminder that life comes with a mortality deadline that will eventually expire. Petrone surmises that "feelings of fear, pain, disbelief and anger only give more importance to the feelings of love, happiness and the value of life" (36).

Donne's, as well as Rogers' illness narrative, expose illusions which illness confronts. Donne's illness confronts him with his own vulnerability, with the realisation that even the best men suffer. Perhaps David Morris best voices the illusion of health when he states:

> Tragedy, like a dark alter ego, strips away the illusion that living well or eating well offers any protection against the destructive forces within ourselves and within our world that we cannot control or defeat but only endure, until endurance itself becomes too terrible to bear. (265)

Even in a world where medicine did not yet claim its omnipotence, Rogers was very much aware of the illusion of restitution, as he surmised that "Recovery is but a delay of certain death" (97). Unlike the restitution narrative, which attempts to circumvent suffering and deconstructs mortality, these early modern English illness narratives reveal that suffering is part of what it means to be human.

Prior to addressing the continuities and discontinuities between early modern English and contemporary views regarding the experience of illness, the consideration of which fundamentally focusing on the matter of linking morality to illness and the body/soul relationship, the question of morality must be addressed.

The use of morality in the context of illness narratives can, as alluded to before, lead to stigmatisation. Therefore, it is imperative to offer a clear definition of the concept of morality within contemporary illness narratives, which differs from the early modern English connotation morality bears.

The link between sin and illness implies "moral culpability" (Thomas 16) and Thomas infers the "stigma that in modern times attaches to those who indulge themselves at the expense of their health is the latest version of an age-old association between illness and sin" (16). The fact that AIDS was once an illness associated with the "deviant and the criminal" (Brandt, Rozin 5) is only one of many instances of how a society's perception of illness is constructed through a culturally influenced set of moral conventions (5). The contention that the stigmatisation of smoking can effectuate a "positive impact" on one's well-being if it leads to one terminating the habit only points to the obsession with physical wellbeing and the chasm between the physical and the mental, as it leads to something Brandt and Rozin refer to as "victim-blaming" (1).

Not only is the perception of illness fundamentally founded on socio-cultural and moral conventions, urgent medical conditions can indeed lead to urgent moral dilemmas. Zigon illustrates one such example by referring to a study of the decision-making process of doctors faced with complicated childbirths resulting in a choice between risking the life of a newborn or its mother: the study concluded that the preferred choice of saving the newborn transcended "medical argument alone…[they] were forced to couch their own arguments in social and moral terms" (qtd. in Zigon 108).

To disentangle matters of morality and illness would mean to disentangle lived experience from illness, whereas both illness narratives discussed in the

previous chapters reveal morality contributed to the meaning of the experience of illness. Illness narratives reveal what it means to be human, and pain and suffering characterise the variable and vulnerable condition of man. Although biomedicine has contributed to a better understanding of the causal relationship between smoking and lung cancer; lung cancer is not solely caused by smoking. Thus, perhaps the "only acceptable moral position is to view everyone as being at risk of disease" (Brandt, Rozin 4).

If from a phenomenological and experiential perspective, illness is considered a personal experience revealing shared social-cultural and moral constructs, then perhaps the experiential approach to morality proposed by Zigon might offer a constructive framework in which the meaning of morality, like illness, is formed by experience. Morality from a religious point of view seems to function as a scriptural law one must abide by, but Zigon offers a different perspective on morality in which it is not considered "in terms of principles and rules" (5), but rather the product of "embodied dispositions, cultural scripts, or moral choices intimately tied with emotions and feelings" (8). Within the context of illness narratives, morality, like illness, can enter the realm of lived experiences shaped by "a continuing process of re-evaluation and enactment" (8).

If morality, in the context of the medical world, can be considered as "the acquired attitudes, emotions, and bodily dispositions of a person throughout their life" (Zigon 17) rather than a set of rules to adhere by, then morality will retain its social value while allowing to be "morally self-critical" (17). This in turn could induce the reflective stance providing one with the "moral opportunity to set right what was done wrong or incompletely" (Frank 159). The moral person of the illness quest narrative

does not take responsibility for the disease, but for the transformation of the self. A transformation initiated by the illness experience.

The moral person of the illness narrative is not what Kirklin refers to as a "doer of good" (10) if what is good is defined by an abstract set of rules. However, morality based on lived experience and alternative perspectives bearing in mind context, can lead to positive effects in terms of other-relatedness. Kirklin's reference to an incident in which doctors procured organs without permission, conduct motivated by their good intention of collecting organs for the purpose of education and research, exemplifies how this cannot be considered a "simple case of good or bad doctors, but rather a case of doctors who had lost sight of the bigger picture" (10).

Literature requires the reader to consider matters from different perspectives; it speaks to one's imagination and requires a certain level of empathy. Doctors are skilled listeners, but medical editors: they only listen for information deemed useful in arriving at a correct medical assessment (11). To conceive of illness as more than a disease, to truly understand illness, "we need to get inside the experience, we need to empathise" (Barker 23). The medical humanities offer perspectives to approaching illness other than a medical and scientific one; perspectives conducive towards the understanding of illness as a lived experience. This is not to say that doctors are to become philosophers or are expected to recite Shakespeare; they are medical practitioners principally, but through illness narratives the medical humanities may show they are first and foremost human in the way a patient is "first and foremost a *person* to whom something terrible has happened" (Kirklin, Richardson 4). These perspectives could best be described not as alternatives, but as complementary to the medical perspective: "Taking a history is black and white. Listening to the patient's story adds the colour" (qtd. in Kirklin 11).

The medical humanities could be said to enrich the predominantly clinical language of science, a language Phil Barker asserts promotes an illusory professional distance between patient and doctor (20). Barker, a professor of psychiatric nursing, surmises that

> The metaphorical wisdom of art and literature allows us to grow a compassion for our fellow women and men, by experiencing something of the inexpressibility of their experience, without risking our emotional selves in the process. (20)

Metaphors give the illness experience meaning in a manner that promotes empathy and offers an indirect, yet relatable, glimpse into the personal experience of illness (16-17). If, as Elaine Scarry claims, pain destroys language, then metaphors reassemble it to express something ineffable yet universally felt.

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