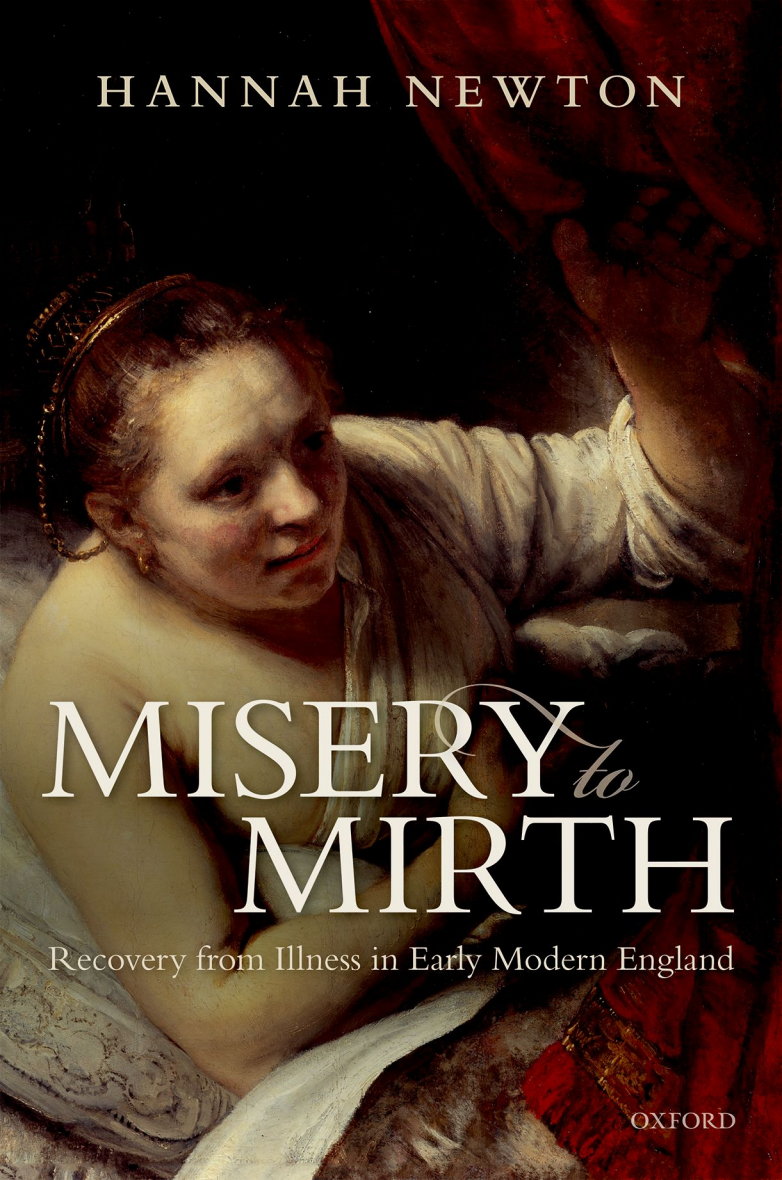
HANNAH NEWTON
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Recovery from Illness in Early Modern England
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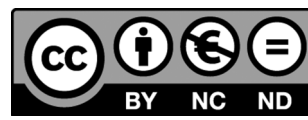

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For Dad

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Contents

List of Figures

List of Abbreviations

BL	British Library, London
Bod	Bodleian Library, Oxford
Cowper, *Diary*	Sarah Cowper, 'Daily Diary', 7 vols., 1700–15 (MSS D/EP/F29-35, Hertfordshire Archives and Local Studies), scanned onto microfilm in Amanda Vickery (ed.), *Women's Languages and Experiences, 1500–1940: Women's Diaries and Related Sources: Part 1, Sources from the Bedfordshire and Hertfordshire Record Office* (Marlborough, 1996), reels 5–7
DBI	*Dictionary of Biblical Imagery*, ed. Leland Ryken, James Wilhoit, Tremper Longman III (Nottingham, 1998)
KJV	King James Version of the Bible
ODNB	Oxford Dictionary of National Biography (www.oxforddnb.com)
OED	Oxford English Dictionary Online (www.oed.com)
POB	Proceedings of the Old Bailey (www.oldbaileyonline.org)
RCP	Royal College of Physicians Library, London
SHC	Somerset Heritage Centre, Taunton
SHM	*Social History of Medicine*
WL	Wellcome Library, London

All the quotations from contemporary manuscript and printed works retain original punctuation, capitalization, italics, and spelling. The use of i, j, u, and v, however, have been modernized, and the archaic letter 'thorn' has been transcribed as 'th'. Standard abbreviations and contractions have been silently expanded, and long titles have been curtailed. In the bibliography and footnotes, the place of publication is London, unless otherwise stated.

Introduction

The history of early modern medicine often makes for depressing reading. It implies that people fell ill, took ineffective remedies, and died. A few snippets from Roy and Dorothy Porter's classic study, *In Sickness and in Health*, encapsulate this pessimism: they speak of the 'universal sickness, suffering, and woe' of the early modern past, a time in which 'people died like flies' from infections against which 'pre-modern medicine had few effective weapons'.[1] Even those who were lucky enough to survive illness could expect nothing more than a life 'repeatedly blighted' by chronic illness and disability.[2] Indeed, the recovery of full health is sometimes said to have been so rare, that it barely existed as a concept at this time, or at least not in any form that would be recognized today. Nancy Siraisi, for instance, has stated that 'cure was not necessarily conceived of as a . . . recognizable return to total health': early modern people held 'a more vague and diffused concept of recovery'.[3] For these reasons, numerous histories have been written on disease and death, but none have been devoted to the subjects of recovery and survival. Such a focus may also reflect a more general penchant for sad topics, a tendency visible in many historiographical fields and chronologies, especially the history of emotion, an area largely dominated by the study of negative feelings.[4] Psychologists would not be surprised—they believe humankind suffers from a 'negativity bias', or 'positive-negative asymmetry

[1] Roy Porter and Dorothy Porter, *In Sickness and in Health: The British Experience 1650–1850* (1988), 1–3. See also Lucinda Beier, *Sufferers and Healers: The Experience of Illness in Seventeenth-Century England* (1987), 133. This impression has been accentuated by new work on accidental death, which implies that even in the absence of illness, one might succumb to innumerable other causes of death; for example, Craig Spence, *Accidents and Violent Death in Early Modern London, 1650–1750* (Woodbridge, 2016).

[2] Mary Lindemann, *Medicine and Society in Early Modern Europe* (Cambridge, 2010, first publ. 1999), 11. See also Keith Thomas, *Religion and the Decline of Magic: Studies in Popular Beliefs in Sixteenth- and Seventeenth-Century England* (1991, first publ. 1971), 6.

[3] Nancy Siraisi, *Medieval and Early Renaissance Medicine: An Introduction to Knowledge and Practice* (Chicago, 1990), 136–7. See also note 31 in this chapter.

[4] Here is a small selection of high quality studies: Jennifer Vaught (ed.), *Grief and Gender, 700–1700* (Basingstoke, 2003); Karl Enenkel and Anita Traninger (eds.), *Discourses of Anger in the Early Modern Period* (Leiden, 2015); Joanna Bourke, *Fear: A Cultural History* (2006); Erin Sullivan, *Beyond Melancholy: Sadness and Selfhood in Renaissance England* (Oxford, 2016). On guilt and despair, see Chapter 4, notes 11, 12. Even histories of love often take a negative angle—for instance, Aurelie Griffin, 'Love Melancholy and the Senses in Mary Wroth's Works', in Simon Smith, Jackie Watson, and Amy Kenny (eds.), *The Senses in Early Modern England, 1558–1660* (Manchester, 2015), 148–64. Notable exceptions to this focus on negative emotions include the intellectual histories by Ruth Caston and Robert Kaster (eds.), *Hope, Joy and Affection in the Classical World* (Oxford, 2016); Darrin McMahon, *In Pursuit of Happiness: A History from the Greeks to the Present* (2006). Michael Braddick and Joanna Innes' new edited collection, *Suffering and Happiness in England 1550–1850* (Oxford, 2017), was published when *Misery to Mirth* was already under publication, and therefore, unfortunately, it has not been possible to evaluate its contribution to the history of positive emotions.

effect'.[5] This trend was noticed in the early modern period too: 'Tis strange that we should be more ready to mourn than to rejoyce; and that our Sorrows should be more . . . fluent than our joys', mused the London clergyman Timothy Rogers in 1691.[6]

Such a gloomy picture of the past does not adequately capture the diversity of human experiences, however. While preparing my first book, *The Sick Child in Early Modern England*, I found, scattered amidst the heartrending stories of suffering and death, joyful recoveries. One in particular stood out. In 1652, eleven-year-old Martha Hatfield from Yorkshire fell gravely ill of 'Spleen-winde', a disease characterized by 'violent vomiting' and 'rigid convulsions'. For nine months, her parents and other relations were 'continually under sadnesse, and their sleep broken'; they longed for God to 'raise her up . . . to health', and 'ease . . . her pain, [so] that [their] eares . . . might not be filled with such dolefull cries, nor their hearts with those fears and amazements'. At nine o'clock one December evening, Martha suddenly felt strength returning to her limbs. She told her father, 'It trickled down, and came into [my] thighs, knees, and ancles, like warm water'. Seeing her mother by her bedside, she 'rejoyced . . . with laughing . . . and clasping her armes about her neck' in an embrace. The next morning, Martha 'took some food without spilling', and told her parents she'd had 'a very good night', not waking until 'seven a clock'. In the afternoon, she 'played with some . . . toys . . . which Neighbours had brought her in a . . . Basket', and towards the evening, her older sister Hannah, who had been 'very tender of her' during her illness, 'took her up, and set her upon her feet, and she stood by herself without holding, which she had not done for three quarters of a year'. Over the following weeks, Martha 'encreased in strength' beyond 'all expectation', and finally announced to her family, 'me is pretty well, I praise God . . . I am neither sick, nor have any pain'. A day of thanksgiving was arranged to praise the Lord for 'such a glorious end to this affliction': one of the guests recalled that the sight of Martha 'com[ing] forth into the Hall to . . . welcome us . . . was wonderfull in our eyes, so that our hearts did rejoyce with a kind of trembling'.[7]

Martha's story was penned and published by her uncle, the Sheffield minister James Fisher, to celebrate and commemorate his niece's restoration to health (Figure 1). Although it is partly didactic in nature, designed to 'teach . . . all that hear of it to depend upon the Lord', the author portrays recovery in a way that would have made sense to many people at this time.[8] Getting better is depicted as a 'happie motion' from anguish to elation, a trajectory marked and measured by a number of key milestones, such as sleeping through the night, eating solid foods,

[5] Paul Rozin and Edward Royzman, 'Negativity Bias, Negativity Dominance, and Contagion', *Personality and Social Psychology Review*, 5 (2001), 296–320; G. Peeters and J. Czapiniski, 'Positive-Negative Asymmetry in Evaluations: The Distinction between Affective and Informational Negativity Effects', in W. Stroebe and M. Hewstone (eds.), *European Review of Social Psychology* (New York, 1990), 33–60.

[6] Timothy Rogers, *Practical discourses on sickness & recovery* (1691), 265.

[7] James Fisher, *The wise virgin, or, a wonderful narration of the various dispensations towards a childe of eleven years of age* (1653), 138–50.

[8] Ibid., 144.

Figure 1. Martha Hatfield, from James Fisher, *The wise virgin* (1653); reproduced by kind permission of Cambridge University Library.

and standing unaided. The account inspired the subject of the present study not only by revealing that recovery *was* thought to be possible in early modern England, but by showing that descriptions of this outcome of illness have the potential to shine light into practically every corner of life in the past. In times of health, people were often too busy to remark on such things as breakfast routines, bodily sensation, and family relationships; in severe sickness, they were usually too unwell to be able to do so. But, the transformation from sickness to health propelled all the normally unnoticed facets of human existence to the forefront of people's minds and personal writings. As a result, this book is able to advance knowledge in a range of fields within cultural and social history, while acting as a bridge between medical history and other areas traditionally excluded from this arena. Lately, a number of scholarly centres for medical humanities have been restyled as centres for 'health humanities', a linguistic adjustment indicative of a growing desire to expand the remits of the research to encompass a much greater array of physical and mental states, including health itself.[9] It thus seems an opportune moment to produce a book that traces the patient's journey back to health. The ultimate goal

[9] A landmark article on this issue is Paul Crawford, Brian Brown, Victoria Tischler, and Charley Baker, 'Health Humanities: The Future of Medical Humanities?', *Mental Health Review Journal*, 15 (2010), 4–10.

of the study, however, is to rebalance and brighten our overall impression of early modern health, demonstrating that recovery did exist conceptually in this era, and that it was a widely documented experience.[10] In so doing, I seek to promote a 'positive turn' in the discipline of history at large.[11]

Misery to Mirth is about recovery from serious physical illness in England between the late sixteenth and early eighteenth centuries. It investigates medical perceptions and personal experiences of the return to health. How was recovery defined and explained? What physiological processes were involved? Was there a concept of convalescent care? How did patients and their families respond emotionally and spiritually to the escape from death, and to the abatement of physical suffering? What was it like returning to normal social and working life after a severe illness? Through these enquiries, a variety of specific historiographical contributions will be made. In medical history, the study fills a glaring gap in our knowledge of the patient's story, enabling us to complete the 'cycle of illness', which hitherto had ended mid-sickness or at the point of death.[12] Since recovery occupies a liminal space, 'floating betwixt' disease and health, and dying and living, an analysis of this concept necessarily sheds fresh light on perceptions and experiences of these other crucial states. The book also unearths a number of far less familiar medical concepts, such as the 'neutral body', 'analeptics', and the internal healing agent, 'Nature'. By exploring religious, as well as medical, interpretations of recovery, *Misery to Mirth* reveals the links between spiritual and bodily health in early modern culture, and adds to the growing literature on 'lived religion'.[13] A recurring theme is gender—medical theories and personal experiences of recovery were shaped by ideas about femininity and masculinity.[14] The study also yields insights into family bonds and friendships, and the connections between sensory stimuli and emotions, as it attempts to reconstruct loved ones' reactions to the sounds and sights of the patient's improving health.[15] Particular scrutiny is accorded to verbal and gestural manifestations of joy and praise, along with the relationships between individual passions; these discussions will demonstrate that emotions were conceptualized and classified rather differently in the early modern period to how they are understood today. Finally, the accounts of the return to normal spatial and working life illuminate such topics as house layout, attitudes to employment, and perceptions of the outdoors.

[10] For the historiographical exceptions—historians who *do* acknowledge recovery was possible—see notes 34–5 in this chapter.

[11] This term has been coined by Darrin McMahon in 'Finding Joy in the History of Emotions', in Susan Matt and Peter Stearns (eds.), *Doing Emotions History* (Urbana IL, 2014), 104–19.

[12] See the 'Historiography' section in this chapter for this.

[13] For a particularly rich study of the 'lived experience' of religion, see Alec Ryrie, *Being Protestant in Early Modern England* (Oxford, 2013). For the literature on medicine and religion, see Chapter 4, note 6.

[14] See note 17 in this chapter on the historiography of gender and medicine.

[15] For historiography of family and friendship, see pp. 18–19 in this chapter. For an introduction to the emotions–senses relationship, see Herman Roodenburg, 'The Senses', in Susan Broomhall (ed.), *Early Modern Emotions: An Introduction* (Abingdon, 2016), 42–5.

HISTORIOGRAPHY

A whistle-stop tour of the historiography of early modern medicine helps to situate this book within the landscape of existing literature. In the scholarship on disease and bodies, historians have examined contemporary understandings of illness causation, and the ways in which the sick body was conceptualized.[16] Particular attention has been paid to the category of gender, and the extent to which male and female bodies were distinguished in medical theory and practice.[17] In the last decade, scholars have become increasingly sensitive to other categories of bodily differentiation, such as age, disability, beauty, and weight.[18] There has also been an upsurge of work on 'the body in parts'—specific bodily organs, diseases, and fluids.[19] In these studies, however, neither theories of recovery, nor depictions of the convalescing body, feature.

Another area of historiography relevant to the present study concerns patients and their practitioners, a field spearheaded by Roy Porter in the 1980s.[20] Scholars

[16] The literature is vast, but key texts include Barbara Duden, *The Woman Beneath the Skin: A Doctor's Patients in Eighteenth-Century Germany*, trans. Thomas Dunlap (1991); Gail Kern Paster, *The Body Embarrassed: Drama and the Disciplines of Shame in Early Modern England* (Ithaca NY, 1993); Andrew Wear, *Knowledge and Practice in English Medicine, 1550–1680* (Cambridge, 2000); Lindemann, *Medicine and Society*; Olivia Weisser, 'Boils, Pushes and Wheals: Reading Bumps on the Body in Early Modern England', *SHM*, 22 (2009), 321–39; Michael Stolberg, *Experiencing Illness and the Sick Body in Early Modern Europe*, trans. Leonhard Unglaub and Logan Kennedy (Basingstoke, 2011, first publ. in German in 2003), Part II.

[17] For a summary of this literature, see Wendy Churchill, *Female Patients in Early Modern Britain: Gender, Diagnosis and Treatment* (Farnham, 2012), 2–4. The pioneering text on sex difference, now much criticized, is Thomas Laqueur, *Making Sex: Body and Gender from the Greeks to Freud* (1990).

[18] On elderly medicine, see Daniel Schäfer, *Old Age and Disease in Early Modern England*, trans. Patrick Baker (2011). For a survey of scholarship on children's medicine, see Hannah Newton, *The Sick Child in Early Modern England, 1580–1720* (Oxford, 2012), 10–13. On babies, see Leah Astbury, ' "Ordering the Infant": Caring for Newborns in Early Modern England', in Sandra Cavallo and Tessa Storey (eds.), *Conserving Health in Early Modern Culture* (Manchester, 2017), 80–103. On disability studies, see David Turner and Kevin Stagg (eds.), *Social Histories of Disability and Deformity* (2006); David Turner, *Disability in Eighteenth-Century England: Imagining Physiological Impairment* (Abingdon, 2012); Emily Cockayne, 'Experiences of the Deaf in Early Modern England', *Historical Journal*, 46 (2003), 493–510. On beauty/ugliness: Anu Korhonen, 'To See and To Be Seen: Beauty in the Early Modern London Street', *Journal of Early Modern History*, 12 (2008), 335–60; Naomi Baker, *Plain Ugly: The Unattractive Body in Early Modern Culture* (Manchester, 2010). On weight, see Lucia Dacome, 'Useless and Pernicious Matter: Corpulence in Eighteenth-Century England', in Christopher Forth and Anna Carden-Coyne (eds.), *Cultures of the Abdomen: Diet, Digestion, and Fat in the Modern World* (New York, 2006), 185–204. Thinness has mainly been addressed in the context of religious fasting.

[19] For the body parts approach, see David Hillman and Carla Mazzio (eds.), *The Body in Parts: Fantasies of Corporeality in Early Modern Europe* (1997). The following organs/parts and diseases have received most attention: feet, stomach, heart, skin, womb, and kidneys; venereal disease, mental illnesses, women's diseases, skin ailments, plague, fever, and cancer. For example, Alanna Skuse, *Constructions of Cancer in Early Modern England: Ravenous Natures* (Basingstoke, 2015); Jeremy Schmidt, *Melancholy and the Care of the Soul: Religion, Moral Philosophy and Madness in Early Modern England* (Aldershot, 2007); Philip Wilson, *Surgery, Skin and Syphilis: Daniel Turner's London* (Amsterdam, 1999). The most studied fluids are the humours, sweat, tears, blood, faeces, and breastmilk; for example, Helen King and Claus Zittel (eds.), *Blood, Sweat and Tears: The Changing Concepts of Physiology from Antiquity into Early Modern Europe* (Leiden, 2012).

[20] Roy Porter, 'The Patient's View: Doing Medical History from Below', *Theory and Society*, 14 (1985), 175–98; Roy Porter (ed.), *Patients and Practitioners: Lay Perceptions of Medicine in Pre-Industrial*

have examined the eclectic 'medical marketplace' of services accessed by the sick, the roles of women in healthcare, and the relationships between patients and doctors.[21] Important themes include the gradual commercialization and professionalization of medicine over time, the cultivation of networks of medical knowledge between laypeople, and the dissemination of 'medical secrets'.[22] Recently, scholars have paid greater attention to the work of nurses, together with the special treatment provided to different groups of patients, such as the elderly, disabled, children, surgical patients, pregnant women, and the healthy.[23] The care of convalescents as a cohort, however, has been overlooked.[24]

Over the last twenty years, the field of patient studies has been revitalized by the rise of the histories of pain and emotions. Scholars have uncovered unpleasant sensations that occurred 'beneath the skin', and analysed patients' physical and emotional experiences of pain, surgery, and disability.[25] This research has been complemented by studies of death and bereavement, a branch of literature that has

Society (1985). An earlier call for a history of patients is D. Guthrie, 'The Patient: A Neglected Factor in the History of Medicine', *Proceedings of the Royal Society of Medicine*, 37 (1945), 490–4.

[21] For a critique of the 'marketplace' concept, see Mark Jenner and Patrick Wallis (eds.), *Medicine and the Market in England and its Colonies, c.1450–c.1850* (Basingstoke, 2007). The doctor–patient relationship is a theme in much of the historiography in the 1980s–1990s; for example, Roy Porter and Dorothy Porter, *Patient's Progress: Doctors and Doctoring in Eighteenth-Century England* (1989). On women/lay healthcare, see Chapter 3, note 7.

[22] For example, Roy Porter (ed.), *The Popularization of Medicine, 1650–1850* (1992); Michael Stolberg, 'Medical Popularization and the Patient in the Eighteenth Century', in Willem De Blecourt and Cornelie Usborne (eds.), *Cultural Approaches to the History of Medicine: Mediating Medicine in Early Modern and Modern Europe* (Basingstoke, 2004), 89–107. On lay medical networks, see Elaine Leong and Sara Pennell, 'Recipe Collections and the Currency of Medical Knowledge', in Jenner and Wallis (eds.), *Medicine and the Market*, 133–52. On medical secrets, see Elaine Leong and Alisha Rankin (eds.), *Secrets and Knowledge in Medicine and Science 1500–1800* (Farnham, 2011).

[23] On nursing, see Margaret Pelling, *The Common Lot: Sickness, Medical Occupations, and the Urban Poor in Early Modern England* (Harlow, 1998), 179–202; Anne Stobart, *Household Medicine in Seventeenth-Century England* (2016), 20–2, 157–9. On surgical patients, see Seth Stein LeJacq, 'The Bounds of Domestic Healing: Medical Recipes, Storytelling and Surgery in Early Modern England', *SHM*, 26 (2013), 451–68; Katherine Walker, 'Pain and Surgery in England, *circa* 1620–1740', *Medical History*, 59 (2015), 255–74. On pregnant/lying-in women, see Linda Pollock, 'Embarking on a Rough Passage: The Experience of Pregnancy in Early Modern Society', in Valerie Fildes (ed.), *Women as Mothers in Pre-Industrial England* (1990), 39–67; Sharon Howard, 'Imagining the Pain and Peril of Seventeenth-Century Childbirth: Travail and Deliverance in the Making of an Early Modern World', *SHM*, 16 (2003), 367–82; Adrian Wilson, *Ritual and Conflict: The Social Relations of Childbirth in Early Modern England* (Farnham, 2013). For the care of the elderly, children, and disabled people, see note 18 in this chapter. On health preservation, see Sandra Cavallo and Tessa Storey, *Healthy Living in Late Renaissance Italy* (Oxford, 2013); Cavallo and Storey (eds.), *Conserving Health*.

[24] A few notable exceptions are given in Chapter 2, notes 9–11.

[25] Here is a little selection: Raymond Anselment, ' "The Wantt of Health": An Early Eighteenth-Century Self-Portrait of Sickness', *Literature of Medicine*, 15 (1996), 225–43; Lisa Silverman, *Tortured Subjects: Pain, Truth, and the Body in Early Modern France* (2001), ch. 5; Jan Frans van Dijkhuizen and Karl Enenkel (eds.), *The Sense of Suffering: Constructions of Physical Pain in Early Modern Culture*, Yearbook for Early Modern Studies, vol. 12 (Leiden, 2008), 19–38, 323–45, 469–95; Lisa Smith, ' "An Account of an Unaccountable Distemper": The Experience of Pain in Early Eighteenth-Century England and France', *Eighteenth-Century Studies*, 41 (2008), 459–80; Stolberg, *Experiencing Illness*; Newton, *The Sick Child*, ch. 6; Walker, 'Pain and Surgery in England'; Olivia Weisser, *Ill Composed: Sickness, Gender, and Belief in Early Modern England* (2015); on disability and chronic illness, see Turner, *Disability*, esp. ch. 5.

successfully debunked the older view that grief was rare in this period.[26] The outcome of such work is that we now know a considerable amount about what it was like to succumb to a painful or life-threatening disease or disability, or to suffer the loss of a loved one, in the early modern period. However, the question of how the sick and their families responded emotionally to relief from pain and illness, or to the escape from death, has received scant notice.

While recovery has rarely been addressed explicitly by historians, it has featured implicitly in several contexts. Firstly, when explaining the theory of disease and medical treatment, historians have alluded to the physiological processes through which recovery occurred. It is generally agreed that the cause of disease was the imbalance, obstruction, or corruption of the body's 'humours', the four special fluids from which living creatures were thought to be composed, and medicines 'worked' by removing this surplus or morbid matter.[27] By implication, recovery involved the rebalancing or unblocking of the humours, through the use of purging medicines. These insights are valuable, but they only convey part of the story—by focusing on the role of medical intervention, other crucial agents and mechanisms have been overlooked. This book slots in the missing pieces, drawing attention to the vital agency of 'Nature', and the forgotten processes of 'concoction' and 'retention'.[28]

Recovery has also been mentioned in discussions of patients' motives for seeking medical treatment, and their expectations surrounding the efficacy of remedies. Historians have often been pessimistic on these fronts, suggesting that 'people did not actually expect . . . medicines to cure them'.[29] Instead, the sick are said to have wished for an evacuation of humours, analgesia, or the partial restoration of bodily function.[30] David Gentilcore, for example, states that:

> The complete recovery of health, in the modern sense, [was] not necessarily the sick person's main desire or expectation. There is a gap between 'health' as defined by modern biomedicine and what people of other societies . . . are prepared to put up with, while considering themselves free from sickness.[31]

Misery to Mirth revises this view. It contends that while patients were certainly grateful for any improvement brought by medicines, they did not consider themselves *fully* recovered until their disease had been entirely removed, and strength

[26] See Chapter 5, note 4 for this historiography.

[27] Selected examples include Beier, *Sufferers and Healers*, 31; Wear, *Knowledge and Practice*, *passim*; Lindemann, *Medicine and Society*, 17–18; Michael Schoenfeldt, *Bodies and Selves in Early Modern England: Physiology and Inwardness in Spenser, Shakespeare, Herbert, and Milton* (Cambridge, 1999), 16; Alisha Rankin, 'Duchess, Heal Thyself: Elisabeth of Rochlitz and the Patient's Perspective in Early Modern Germany', *Bulletin of the History of Medicine*, 82 (2008), 109–44, at 130, 133; Siraisi, *Medieval and Early Renaissance Medicine*, 117, 145. Michael Stolberg revises this model of causation, arguing that in most cases, it was more often the morbid quality of the humours, than their imbalance, that was blamed*: Experiencing Illness*, 25, 72, 94, 99, 114, 133; Michael Stolberg, *Uroscopy in Early Modern Europe* (Farnham, 2015), 51.

[28] 'Concoction' also referred to the digestion of food: see Chapter 1, note 88.

[29] Beier, *Sufferers and Healers*, 5.

[30] For instance, Duden, *The Woman Beneath the Skin*, 88, 91–4; Rankin, 'Duchess, Heal Thyself', 112, 135, 142; Silverman, *Tortured Subjects*, 148.

[31] David Gentilcore, *Healers and Healing in Early Modern Italy* (Manchester, 1998), 186, 196–7.

restored. In more tangible terms, this meant feeling better, and being able to resume normal life, unimpeded by bodily weaknesses or blemishes.[32] Doctors also distinguished between medicines that brought a partial and a complete recovery, as can be evinced from the use of the word 'palliate', which was defined in a medical dictionary from 1657 as, 'when a disease is not eradicated, but only mitigated or covered, whereby… the pain, or trouble… is somewhat eased'.[33]

Several scholars have addressed recovery more directly. James Riley's book, *Sickness, Recovery and Death* (1989), deploys an interdisciplinary, quantitative approach to show that 'risks posed by illness and injury [have] changed'. Whereas in early modern Europe, 'most sicknesses were resolved quickly' by either death or recovery, 'during the nineteenth century, protracted ill health began to take over'.[34] Riley is thus one of the few historians who have acknowledged explicitly that illness did not always result in death in early modern times.[35] However, his principal aim is to use past patterns of health to influence current and future policy-makers, rather than to find out how early modern people understood or experienced recovery.[36]

Another scholar who has discussed recovery explicitly is Gianna Pomata, in her important monograph, *Contracting a Cure: Patients, Healers, and the Law in Early Modern Bologna* (1994). The book charts the evolution and decline of the 'cure contract', an economic arrangement between the practitioner and patient, whereby the latter paid for medical services only when the treatment had been successful. Drawing on the records of Bologna's medical tribunal, Pomata proposes that 'In sharp contrast to modern medicine, illness and recovery were defined not by the physician but by the sick.'[37] Pomata's interest lies chiefly with power relations, rather than with perceptions or experiences of getting better. She does, however, offer some insights into how recovery was conceptualized, stating that it meant 'be[ing] able to do things just as one had done them before falling sick—slicing bread and eating, walking and talking normally'.[38] Building on Pomata's findings, *Misery to Mirth* shows that it was not just function that mattered, but feeling—to be recovered meant feeling better, an elusive term that will be interrogated in one of the chapters in this book.

A more recent study that resonates with this investigation is Olivia Weisser's masterful monograph, *Ill Composed: Sickness, Gender, and Belief in Early Modern*

[32] See, for instance, Caryl Joseph, *An exposition… upon the thirty second, the thirty third, and the thirty fourth chapters of the booke of Job* (1661), 416.

[33] *A physical dictionary, or an interpretation of such crabbed words… used in physick* (1657), image 80. See also Thomas Blount, *Glossographia, or, a dictionary* (1661), 231.

[34] James Riley, *Sickness, Recovery and Death: A History and Forecast of Ill Health* (Basingstoke, 1989), xi.

[35] Others who agree recovery was possible are Stolberg, *Experiencing Illness*, 22; Stobart, *Household Medicine*, 22–3; Weisser, *Ill Composed*, 37, 51, 122.

[36] See Margaret Pelling's book review in *Economic History Review*, 44 (1991), 566–7.

[37] Gianna Pomata, *Contracting a Cure: Patients, Healers, and the Law in Early Modern Bologna* (1998, first publ. 1994), 28. The word 'cure' also appears in the title of Elaine Leong and Alisha Rankin's Special Issue, *Testing Drugs and Trying Cures*, *Bulletin of the History of Medicine*, 91 (2017). This excellent volume highlights the role of testing in the development of drugs in pre-modern Europe. Its aim is not, however, to consider the meaning of 'cure' or recovery.

[38] Pomata, *Contracting a Cure*, 28.

England (2015). Although mainly concerned with the gendering of sickness narratives, Weisser mentions recovery when examining the perceived effects of joyful emotions on the body, and the occasions which led doctors to record patients' voices in their notebooks. She reveals, for example, that the happy news of a loved one's restored health was thought to cure a sick relative, a phenomenon also observed in this book.[39] Weisser helpfully identifies various differences between women and men's experiences of illness, some of which we will see are equally applicable to recovery, such as the tendency for heads of households to express relief when they were able to resume their economic roles as providers.

Finally, recovery has been discussed in the context of childbirth. David Cressy's book, *Birth, Marriage, and Death* (1997), contains a section on the ritual of 'lying-in', the month-long period of convalescence recommended for women after labour, which ended with a thanksgiving service called 'churching'.[40] Taking a more medical perspective, Leah Astbury has explored the physical complaints of newly delivered mothers, and argued that these women only deemed themselves recovered when they were able to return to their normal tasks.[41] My book occasionally draws parallels between recovery from childbirth and sickness, and suggests that there may have been considerable overlap, especially in the care provided during convalescence. In short, recovery has rarely been examined in a sustained or direct manner, and when it has been mentioned, scholars have tended to imply that it did not mean the full return to health, an assumption this book repudiates.

SUMMARY OF ARGUMENTS

Misery to Mirth takes several perspectives. The first is medical or physiological, asking what recovery meant, and how it was thought to happen according to doctors and laypeople. As will be revealed below, recovery denoted the transition from disease to health, and it comprised two stages, the first of which was the removal of disease, the subject of Chapter 1.[42] This action was carried out by the combined efforts of three forces: God, Nature, and the medical practitioner. While scholars are familiar with the first and last of these agents, the vital role of Nature has been largely overlooked.[43] Like it does today, the word 'nature' held many meanings in the early modern period, but in the context of Galenic physiology, it denoted a divinely endowed power in the body that performed various essential tasks, including recovery. Personified as a hardworking housewife, Nature removed disease through

[39] Weisser, *Ill Composed*, 37, 99, 107–8. See also Olivia Weisser, 'Grieved and Disordered: Gender and Emotion in Early Modern Patient Narratives', *Journal of Medieval and Early Modern Studies*, 43 (2013), 247–73, at 260, 264.

[40] David Cressy, *Birth, Marriage, and Death: Ritual, Religion and the Life Cycle in Tudor and Stuart England* (Oxford, 1997), 82–6. See also Wilson, *Ritual and Conflict*, ch. 4.

[41] Leah Astbury, 'Being Well, Looking Ill: Childbirth and the Return to Health in Seventeenth-Century England', *SHM*, 30 (2017), 500–19.

[42] See p. 15 in this chapter for this definition of recovery.

[43] See the introduction to Chapter 1 for the historiography of nature.

processes that resembled cooking and cleaning—'concoction' and 'expulsion'. In theory, the three agents operated in a strict hierarchy: Nature was God's instrument, and the physician, Nature's servant; but in practice, the power balance was rather more complicated, with the doctor sometimes appearing more like Nature's partner, or even her commander. I suggest that these ambivalences reflect wider cultural attitudes to womankind: female Nature was kind and caring, but also weak and 'exorbitant', requiring rescue and restraint from the male physician. By placing Nature at the centre of early modern therapeutics, the book casts off the last vestiges of earlier generations of whiggish medical histories, which focused mainly on the achievements of doctors. The whole rationale behind medical treatment rested on the premise that 'Nature is the healer of the disease, the physician only the servant'—medicine was designed to promote what this agent was already attempting. This new understanding will help transform our attitudes to pre-modern medical practices, rendering more explicable those treatments which at first glance seem utterly ludicrous, such as giving a laxative to a patient who is weak from vomiting. Nature's role is also relevant to religious history, serving to clarify the relationship between natural and supernatural events: if we study what Nature *could* accomplish in the body, we will be in a better position to understand happenings that were classed as 'above' this agent, such as miracle cures.

Serious illness often left the body 'sicklish & shattered'; it was not until full strength and flesh had returned that the patient was pronounced back to health.[44] After the removal of disease, the second stage of recovery could take place: the restoration of strength, or 'convalescence', the subject of Chapter 2. What were the signs of growing strength, and how did this process occur? I argue that both the measures, and the mechanisms, for the restoration of strength were intimately connected to the 'six non-natural things', the various dietary and life-style factors that were believed to affect the body—excretion, sleep, food, passions, air, and exercise.[45] Patients' sleeping patterns, appetites for foods, and emotions, along with other inclinations and behaviours that related to the non-naturals, were used to track their progression on 'the road to health'. Doctors and the patient's family sought to regulate each non-natural to promote the body's restoration, and to guard against possible relapse. It is suggested that this regulation, together with the assiduous monitoring of the patient's growing strength, constituted a concept of convalescent care, or to use the contemporary term, 'analeptics'. Convalescence has rarely been addressed in the historiography of early modern medicine, perhaps because scholars have assumed that it was a later, Victorian invention.[46] As this study shows, however, the concept has much older origins: it was rooted in ancient Hippocratic–Galenic medical traditions.[47] Convalescents were placed in the 'neutral' category of human bodies, alongside other individuals who were deemed 'neither sick nor sound', such as

[44] Royal College of Physicians, London, ALS/F136 A-I, letter c (letter from John Freind to Henry Watkins concerning the illness of Mr Hill).

[45] See Chapter 2, note 3 for the historiography on the non-naturals.

[46] See Chapter 2, notes 9–11 for historiographical exceptions.

[47] See note 83 in this chapter on these traditions.

the elderly, newborn babies, and lying-in women. The interpretive value of this forgotten category is substantial: it brings us to a closer appreciation of how early modern people judged ambiguous states of health. The discussions also shed fresh light on the meaning of 'health', showing that it was not just the absence of disease, but the presence of strength.

As well as examining medical understandings of recovery, this book is concerned with the personal experiences of recovering patients. It investigates the physical, emotional, spiritual, and social dimensions of getting better. Four areas of experience have been identified for analysis, each of which forms the focus for a chapter: 'Feeling Better' (Chapter 3), about the abatement of bodily pain and suffering; 'Thanking God' (Chapter 4), on religious responses to the belief that it was God who had ordained recovery; 'Escaping Death' (Chapter 5), on reactions to the realization that the danger of death was over; and finally, 'Resuming Life' (Chapter 6), which examines attitudes to the return to normal life, society, and work. The main argument running through these chapters is that overwhelmingly, recovery was experienced as a transformation from misery to mirth.[48] 'Scarce any misery equal to *sicknesse*', declared the poet and Dean of St Paul's Cathedral, John Donne (1572–1631), when convalescing from 'purple fever' in 1623.[49] This misery included pain and sleeplessness, loneliness and confinement, boredom and monotony, anxiety about money, spiritual guilt, and the fear of death and damnation. The return of health reversed these feelings, bringing ease and rest, company and freedom, stimulation and variety, financial improvement, spiritual unburdening, and joy to be 'back in the land of the living'. Thus, at the heart of recovery was contrast, as the Oxfordshire clergyman Robert Harris (*c.*1581–1658) confirmed: 'this motion from sickenesse to health[,] from sadnesse to mirth, from paine to ease, from prison to libertie, from death to life, must needs be a happie motion, worthie [of] thankes [to God]'.[50] Ultimately, the clue to the experience of recovery lies in the word itself: the verb 'recover' derives from the Anglo-Norman and Middle French, *recuvrer*, which means to repossess.[51] Patients regained not just their physical faculties, but all the other things they loved about life of which they had been deprived during sickness, such as visiting friends, strolling in the garden, and undertaking engaging work. Recollecting his own recent illness, Harris mused:

> Sicknesse put me out of possession of all, but with health all is come back againe; my stomach is come to mee, my sleepe, my flesh, my strength, my joy, my friends, my house, my wealth[:] all is returned.[52]

[48] The word 'misery' was one of the most common terms used in descriptions of illness, hence its appearance in the title of this volume. It incorporated both the emotional and physical dimensions of suffering, as confirmed by the physician James Hart, who stated, 'tormenting *griefe* with . . . paine, is called *aerumna*, or *miserie*': James Hart, *Klinike, or the diet of the diseased* (1633), 343. The word 'mirth' is used in the book's title because it captures multiple aspects of the experience of recovery, including bodily ease and pleasure, emotional and spiritual joy, and social jollity and celebration.

[49] John Donne, *Devotions upon emergent occasions: and severall steps in my sicknes* (1624), 177, 92.

[50] Robert Harris, *Hezekiahs recovery. Or, a sermon, shewing what use Hezekiah did, and all should make of their deliverance from sicknesse* (1626), 36–7.

[51] OED, 'recover' (verb), etymology.

[52] Harris, *Hezekiahs recovery*, 31.

Through this argument, the book revises current ideas about early modern 'sick roles', suggesting that withdrawal from normal life and work to the sickbed was more common than has often been supposed.[53] Since recovery from serious illness was usually experienced as the re-covery of daily activities and employments, disease necessarily involved an element of retirement.

A recurring theme in these four chapters is the way getting better is often described as a 'double delight' of patients' bodies and souls. Upon recovery, both parts of the human being were healed together, since the disappearance of bodily disease was a sign that God had forgiven spiritual sickness—sin. Depicted as 'loving playmates', the patient's body and soul rejoiced in one another's newfound ease and health, and felt relieved that they would no longer have to part in death. Such accounts enhance our understanding of how early modern people conceptualized their own beings—they saw themselves as two, intimately connected parts. This double healing commonly inspired the outpouring of delightful spiritual emotions called 'holy affections', cheerful responses to divine deliverance which help to counter the largely negative picture dominating the scholarship on the psychological culture of early modern Protestantism.[54] The expression of these holy feelings was part of the 'art of recovery', a set of religious duties incumbent on recovered patients explored in Chapter 4, akin to 'the art of death' with which historians are familiar; it included resisting sin, praising God, and joining together in collective thanksgiving. This forgotten art was the spiritual equivalent to analeptics, the branch of medicine discussed in Chapter 2: it was designed to strengthen the soul against sin, and prevent relapse into spiritual sickness. These findings confirm the close ties between the body and soul, bodily and spiritual health, and medicine and religion in early modern culture.

Besides investigating medical perceptions, and patients' experiences, of recovery, this book examines the reactions of relations and friends to their loved one's restored life and health. This is the third and final perspective adopted in the study. I argue that these individuals usually shared the experiences of patients, undergoing a transition from agony to ecstasy. 'My griefe[s] . . . are vanguished and . . . wholy swallowed up into joy', wrote Dr John Hildeyard when his dear friend Robert Paston escaped death in 1675.[55] This mirroring of experiences was known as 'fellow-feeling' in early modern England, a concept which has not attracted much attention from historians.[56] Contemporaries attributed this response to the passion of love, a 'true sign' of which was that 'friends rejoyce & grieve for the same things'.[57] Unlike the related terms of sympathy and compassion, fellow-feeling encompassed happy feelings as well as suffering, and it was physical as well as emotional. This meant that during illness, loved ones frequently claimed to *feel* something akin to the patient's bodily pains, and upon recovery they too experienced 'sweet ease'.

[53] See Chapter 6, notes 3–5 for this historiography.

[54] For this historiography, see Chapter 4, notes 11–13.

[55] Robert Paston, *The Whirlpool of Misadventures: Letters of Robert Paston, First Earl of Yarmouth 1663–1679*, ed. Jean Agnew, Norfolk Record Society, vol. 76 (2012), 167.

[56] For the exceptions, see Chapter 3, note 136.

[57] Nicholas Coeffeteau, *A table of humane passions*, trans. Edward Grimeston (1621), 103–5.

As well as revealing the depth of affection between loved ones, this argument challenges the established view, associated with Elaine Scarry, that pain is an 'unsharable experience'.[58] Taking a new, sensory approach, I argue that the main avenues to fellow-feeling were the ears and eyes: the patient's 'piercing cries' and 'deathly lookes' were replaced by the joyful sounds and sights of laughter and smiles. Such findings open up opportunities for engagement with debates in the burgeoning field of sensory history, such as the question of how the senses were ranked and linked in early modern culture.[59] Perhaps the most similar aspect of recovery for patients and their loved ones was the aforementioned spiritual 'art of recovery': family and friends regarded the deliverance as a mercy for themselves as well as the patient, and as a sign of God's forgiveness for their own sins. The structure of the book reflects these commonalities: rather than discussing patients and their relations in separate chapters, the two are integrated.

While this study presents the return to health in largely positive terms, it does acknowledge that there could be a distressing side. For some patients, getting better took a long time, with the body remaining frail and sore for weeks or months, and of course, not everyone made a full recovery. 'I am never quite at Ease', lamented the Hertfordshire gentlewoman Sarah Cowper (1644–1720) in 1712.[60] Nor did recovery always follow a linear motion: patients and their relatives fretted over the possibility of relapse, worrying that the slightest thing—even combing one's hair—could rekindle illness. This vulnerability extended to the soul: patients might return 'like pigs to mud' to former sins, with the double disaster of spiritual *and* bodily relapse. For those who disliked their work, or enjoyed solitude, sickness could be a welcome break, and the return to former employments and interactions, a source of vexation. The most explicitly negative reactions, however, came from those individuals who had, during their illness, longed for heaven. Survival for these people could be the source of disappointment rather than joy, especially if their lives were unhappy. These experiences reveal the power of religious doctrine, and the extent to which ideas about salvation shaped attitudes to both death and life. Occasionally, relatives and friends also expressed disgruntlement at the patient's recovery, though such reactions tended to be sparked by more secular concerns about delayed inheritance.

The timeframe of this study—the late 1500s to the early 1700s—has been depicted as one of dramatic upheaval. Developments were occurring in the economy; the period saw an extension of governments' powers, and religious and civil strife. Leisure activities and material culture diversified, and the middling groups of society expanded.[61] In a medical context, new theories of disease were springing

[58] See Chapter 3, note 10. [59] See Chapter 3, notes 17–19 on this historiography.

[60] Cowper, *Diary*, vol. 2, 216. This woman was suffering from chronic pains in her feet. On Cowper, see Anne Kugler, *Errant Plagiary: The Life and Writing of Lady Sarah Cowper, 1644–1720* (Stanford CA, 2002).

[61] On material culture, see Mark Overton, Jane Whittle, Darron Dean, and Andrew Hann, *Production and Consumption in English Households, 1600–1750* (2004); on leisure/social spaces, see Sasha Handley, *Sleep in Early Modern England* (2016), ch. 5; Amanda Flather, *Gender and Space in Early Modern England* (Woodbridge, 2006), ch. 4.

up in opposition to the ancient traditions of Galenism,[62] the volume of imported drugs was expanding,[63] and ready-made, 'proprietary medicines' and 'specifics' were being introduced.[64] Some scholars purport that changes were also occurring in the realms of religion and philosophy: by the close of the seventeenth century, fervent spiritual emotion—'enthusiasm'—was apparently being discouraged,[65] belief in providence and Hell may have been fading,[66] and the body and soul were no longer seen as so closely connected.[67]

Choosing this time-period therefore provides opportunities for the reassessment of some of these changes. It is argued that, despite the wider developments, the fundamental ways in which recovery was perceived and experienced remained relatively static. In Chapter 1, we will see that while there was some disagreement over the precise physiological mechanisms through which disease was removed, doctors of diverse theoretical perspectives concurred on the tripartite agents of recovery. Likewise, in Chapter 2, it is argued that the convalescent's growing strength was measured and promoted in similar ways throughout the period, even down to the staple ingredients in convalescents' broths. The experience of recovery was also characterized by continuity: relief from physical suffering, the escape from death, and the resumption of normal life, provoked similar emotional and spiritual responses in patients and their loved ones across the period, though there may have been subtle changes in the activities and venues to which patients returned after illness. This was partly because the philosophical and religious concepts that held most significance during sickness and recovery—the perceived sympathy between body and soul, and the providential origin of health states—actually remained prominent throughout the years.[68] While 'enthusiasm' may have been disparaged in some contexts, it seems that recovery was regarded as a legitimate cause for hyperbolic religious rapture, even amongst Anglicans.

[62] For discussions of these various theories and transformations, see Roger French and Andrew Wear (eds.), *The Medical Revolution of the Seventeenth Century* (Cambridge, 1989); Charles Webster, *The Great Instauration: Science, Medicine and Reform 1626–1660* (Oxford, 2002, first publ. 1975).

[63] Patrick Wallis, 'Exotic Drugs and English Medicine: England's Drug Trade, c.1550–c.1800', *SHM*, 25 (2012), 1–27; Patrick Wallis and T. Pirohakul, 'Medical Revolutions? The Growth of Medicine in England, 1660–1800', *Journal of Social History*, 49 (2016), 510–31.

[64] Harold Cook, 'Markets and Cultures: Medical Specifics and the Reconfiguration of the Body in Early Modern Europe', *Transactions of the Royal Historical Society*, 21 (2011), 123–45; Louise Hill Curth, 'Medical Advertising in the Popular Press: Almanacs and the Growth of Proprietary Medicines', in Curth (ed.), *From Physick to Pharmacology: Five Hundred Years of British Drug Retailing* (Basingstoke, 2006), 29–48.

[65] See Chapter 4, note 17.

[66] On the apparent decline of belief in providence, see Chapter 4, note 16; on Hell, see Chapter 5, note 3.

[67] The French philosopher René Descartes (1596–1650) is usually pronounced the pioneer of the new 'dualist' view of the body and soul. For recent critiques of this notion, see Charis Charalampous, *Rethinking the Mind–Body Relationship in Early Modern Literature, Philosophy and Medicine* (Abingdon, 2016); Laurie Johnson, John Sutton, and Evelyn Tribble (eds.), *Embodied Cognition and Shakespeare's Theatre: The Early Modern Body-Mind* (Abingdon, 2014).

[68] On the continuities in Protestant beliefs into the early 1700s, see Andrew Cambers, *Godly Reading: Print, Manuscript and Puritanism in England, 1580–1720* (Cambridge, 2011); W. M. Jacob, *Lay People and Religion in the Early Eighteenth Century* (Cambridge, 1996); Jane Shaw, *Miracles in Enlightenment England* (Oxford, 2006).