The Illness Trajectory or the Illness Journey. What’s in a Metaphor?

La Traiettoria della, o il Viaggio attraverso la Malattia. Analisi di una Metafora

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**Background** The concept of the ‘illness trajectory’ has become familiar to health care researchers through the work of Glaser and Strauss. **Description** While it captures some of the attributes of chronic illness, and may perform better for acute illness, the metaphor is too constraining, and fails to describe the fluctuations and complexities of the subjective experience of chronic illness. It does not recognise that there is a multiplicity of selves that experience and respond to illness, sometimes in very different ways within the same individual. It conveys the message that a patient must follow a predetermined course, like that of a missile, once launched into a chronic illness. Many forces, however, influence what happens during chronic illness. Individual choice is one of these forces. Illness narratives record these other forces, and emphasise that people change course during their illnesses.

**Conclusion** The ‘illness journey’ therefore seem to work better as a metaphor which conveys a sense of what happens to a patient, what is presented to her and how the different selves in her self-complex may respond in different ways at different times.

**Index Terms** Heroic quest. Illness journey. Illness trajectory.

**Premessa** Il concetto di “traiettoria” della malattia è divenuto familiare in Medicina grazie al lavoro di Glaser e Strauss. **Descrizione** Esso coglie alcuni aspetti delle malattie croniche ma è riduttivo, nel senso che non descrive le oscillazioni e le complessità dell’esperienza soggettiva della malattia. Non riconosce le molteplicità interiori dei pazienti che rispondono in modo diverso a tale esperienza, talvolta con variazioni anche nello stesso individuo e porta a pensare al decorso clinico come ad un missile. Molti fattori, tuttavia, influenzano quanto accade durante una malattia cronica, e le scelte individuali sono una di queste. Le narrazioni dei malati portano a rilevare tali fattori ed i cambiamenti da essi determinati. **Conclusione** Il concetto di “viaggio” sembra migliore come metafora, perché svela più compiutamente ciò che accade al paziente e come la sua interiorità reagisce alla malattia con il procedere del tempo.

**Parole Indice** Ricerca epica. Traiettoria della malattia. Viaggio nella malattia.

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Introduction

Metaphors shape the way that we think about most things [1]. They provide a model which we can use to understand, and sometimes to think further about complex matters. Much of our thinking about illness is conditioned by the metaphor of the ‘illness trajectory’, a term which has gained common currency in pathography, sociology and anthropology [2-9]. Glaser and Strauss are credited with first use of the term [10]. The illness trajectory is, however, in some ways an unfortunate and constraining metaphor.

Over the last two years, we have conducted narrative interviews with patients suffering from colorectal cancer, and we have used the metaphor of the ‘illness trajectory’ when writing about those narratives [11]. Our observations, upon further reflection, however, suggest that the metaphor of the trajectory does not provide a comprehensive account of the experience expressed in these narratives of long-term illness. The metaphor may work better for acute illnesses, including the experience of intensive care (Reir, personal communication), but we believe that it fails to recognise the multiplicity of selves within the individual who experiences and adjusts to chronic illness, and that it suggests an over-deterministic role for disease in the individual life-history of the patient. It certainly does not do justice to the richness and complexity of illness narratives. We propose in this paper to examine the ways in which multiple selves reveal themselves in narratives, the specific versions of self which can be diagnosed from the narratives, and the ways in which the metaphor of the trajectory fails to account for the implications of this multiplicity. We will also examine the limitations imposed by the metaphor itself, and suggest reasons to prefer the metaphor of the ‘illness journey’.

The concept of multiple selves

Rose has criticised as over-simple the concept of the single self [12]. In his model, self-creation is a process of ‘infolding’ of cultural and biographical events into a complex structure which consists of multiple selves. This self-complex permits the multiple selves to function in parallel, and at times in conflict. The multiple selves comprise what Whitehead has referred to as a nexus of ‘actual entities’, the occasions of experience which constitute the biography [13]. Harré formulates a concept of self which recognises the multiplicity of components which make up ‘the self’. He writes ‘The self is a location, not a substance or an attribute. The sense of self is the sense of being located at a point of space, of having a perspective in time and of having a variety of positions in local moral orders’ [14]. Olafson recognises the same problem in his discussion of the nature of the human being [15].

The concept of multiple selves is well accepted by many within the discipline of psychology. Rosenberg, for example, has developed a ‘Multiple Selves Exercise’ from which ‘Identity Maps’ can be constructed [16]. Ewing has found evidence that suggests that the experience of multiplicity of selves is transcultural [17]. Harter and Monsour have found that adolescent development is marked by increased skill at handling conflict between multiple role-generated selves [18]. This skill remains important throughout adult life [19]. Hermans and Kempen have elaborated a model of ‘self’ in which multiple selves interact with each other in dialogical fashion [20]. Epstein [21] and Elliot et al [22] see the concept of multiple selves to be a particularly postmodern construct. Epstein sees multiplicity of selves as a useful model in understanding narratives. Wilson and Wilson have used the concept in family therapy [23], drawing particularly on Apter’s reversal theory [24]. Apter’s theory derives from an understanding of the ways in which people may change their modes of interaction with the environment within quite short spaces of time. Davies concludes that tensions between the multiple selves are a part of normal living [25].

Not all psychiatrists agree that the person should be seen as multiple selves [26]. Nevertheless, in our own work we have found it useful to identify a self which might be construed as the origin for each ‘discourse unit’ in the narratives we analyse. Using this method, we have identified a number of selves within each person which speak of their experience, their existential states and their adaptations with separate and sometimes conflicting voices.

The selves in the narrative

Patient narratives perform four basic functions. They provide a chronology. They give a history of causes and meanings. They formulate explanations and assign meanings. They provide a means for the process of self-construction and reconstruction in response to the illness. In other words, people use their narratives to construct a meaning for the experience of their cancer and its medical management. They also reconstruct themselves within their narratives, using the told story to examine the ways in which the episode of illness has changed the person who was before the illness. In examining their biographies, they construct dramas in which they play the lead role. They use dramatic structure because drama has a public domain in which meaning is assigned by the audience and those who study drama as text. They use language in particular ways to signal the particularities of experience through which they pass. Their narratives reflect
not only their own experience, but also their views of the health system which deals with them. Finally, they con-
sciously and unconsciously generate a hermeneutic space within which they seek the meanings assigned by others
to their experience and plight. Much of this has already been dealt with by others.

We have noted that patients attach immense impor-
tance to chronology at different stages of their illness. The
onset, in particular, is commonly presented in almost puzz-
lng detail. The sequence of events is told, dates are giv-
en, even times of day. The narrator will correct herself
over details, seek confirmation from others or from writ-
ten records. It is as though this period encapsulates the
last period of a time before the illness, which is gone for-
ever. The quality and contents of lived time seem to have
changed. Other episodes in the evolving illness narrative
may reflect this same preoccupation with sequencing and
accuracy, but times of convalescence seldom convey
the need for this precision.

Importantly, the narrative is used to assign meaning in
many ways. Causal meaning is sought by every possible
means. The cause of the cancer may be approached from
several directions of inquiry – physical, genetic, moral,
nutritional, infective. But all things need causes, and ex-
planatory frameworks need to be constructed in order to
achieve this [27]. Thus, a number of patients seem to rea-
son that inadequate explanation stems from the secretive-
ness of the mystery of health workers. Untoward events in
management are the results of incompetence. A lack of
caring manifests the deficient ideologies of the public ser-
vice. There are spiritual causes as well. The moral defi-
ciences of others explain loneliness and isolation. These
are relatively simple explanatory mechanisms. But there
are more complex hermeneutic schemes, in which expla-
nation, understanding and application move in a reflexive
circle which incorporates work and power, in a way
which parallels the ‘deep hermeneutic process’ identified
by the Gadamer-Habermas controversy [28]. One of our
patients and his wife, for example, use this process in as-
signing cause and meaning to the stigma and apartness
of the cancer experience. The diagnosis of cancer sets a per-
son apart, and changes his relationship with others, with
friends and family. But this ‘sorts people out’, and lets
you know who your real friends are. So cancer makes you
re-value people, just as it makes people re-value you.

There are also deeper, and more spiritual meanings to
be explicated. The cancer episode needs to be fitted into
the biography of the sufferer. The sort of person who got
the cancer needs to be made manifest in the narrative, so
that the uniqueness of the meaning of this cancer can be
made manifest to the listener. The meaning of the threat
posed by the cancer needs also to be explained, the threat
to the pattern of the pre-existent life and the sense of
boundedness that the cancer brings to the life. The notion
of witnessing deserves to be more fully explored, because
we think that it encapsulates an important part of the re-
dempeive process that may take place in liminality. We
think that it finds a counterpart in the survivor’s response
to her ordeal, the ‘will to testify’ that apparently sustained
many survivors of the Holocaust [29].

Narrative serves also as an outlet for uncondoned emo-
tion. Patients will tell of their hatred of the system that
‘looked after them’, of the shortcomings of their ‘loved
ones’, of their ‘cowardice’, their anger. While their social
fronts may not show these emotions, their narratives re-
veal how these ‘unacceptabilities’ have played their parts
and been woven into the fabric of their reconstructed
lives. Similarly, narrative serves to educate listeners and
tellers alike. ‘You can never really understand unless
you’ve experienced it’ is a common way to express the
need to communicate the awfulness of certain types of ex-
perience, the need to educate others in the nature of suf-
fering. Narrative connects narrator and listener, but dis-
tances them because the experience which generates the
narrative is unique to one and one alone.

The narrative is about the person narrating, and is inevi-
tably self-relating. Furthermore, as one of our informants
has so graphically told us, the narrative changes with
time. ‘I’m telling a different story to the one I told a few
years ago’ is a common observation made by narrator-pa-
tients. The narrative constructs the adaptation for the per-
son narrating the experience of illness and its treatment.
But the self cannot be construed as a single entity. It is
rather as complex infoldings of the social environment in
which it develops [12]. The narrative therefore moves
from self to self. It is thus more correct to think of the nar-
rative as dealing with the many selves of which each per-
son is constituted [30].

We do not claim that the following classification
system is exhaustive, nor do we make claims for its onto-
logical significance. It is offered as a practical device by
which to distinguish the origins of the different discourses
that are detectable in illness narratives.

**Manifest self** This is the self which is presented at the
outset of the narrative, and returned to at various points of
the developing story. This is the self who (to draw exam-
les from the narratives given to us) is a blunt, gruff soul,
who calls a spade a spade; the self who has always had
this secret dread of a colostomy; the self who has always
been so clean and orderly; the self who is a Christian; and
who returns at different stages of the narrative to establish
the continuity of the story.

**Physical self** The physical self is embodied. The body’s
transparency is always modified by the cancer experi-
ence. While the ‘healed’ person may return to a relatively transparent rapprochement with the body, some of its functions have usually been laid bare for a while during the illness and its treatment, and the body’s owner has an insight which may be impossible to communicate fully to another. For the colostomy or ileostomy, the reminders of previously transparent body function are permanent and usually unpleasant. They add to the other alienations of the cancer illness, and reinforce the iterative nature of the cancer experience.

The physical self is also gendered and sexed. Gender roles are closely connected to social roles, but emerge in narratives as special preoccupations. Returns to ‘normal’ (housewifely cleaning, for example, or manly pursuits like working and physical sport) are stressed as measures of adaptation or lack of it. The loss of control central to the cancer experience is also experienced differently by gender. For women, the imagery is of loss of the domestic environment; for men, it is more often the loss of the environment of control, of expression in work.

Themes of sexuality are common in references to relationships and marriages. They are less explicitly discussed in the sorts of general narratives we have sought, but they are there in the narratives of change and loss. The repulsive stoma, that forcible reminder of normally transparent bodily function, is sensed as a sexual turn-off. For men, surgery on the rectum may cause impotence. It is very likely that this has been discussed before hand, to be filed away as another threat of diminution. Impotence in a male can be both loss of a potency and potential, although its impact varies greatly from person to person.

Existential self The existential self exists within the primary categories of time and space. We move in space transparently, seldom conscious of constraints and handicaps. In hospitals, we inhabit someone else’s space, aware of its limits and its alien functions. Pain limits the capacity to handle and use space. A colostomy dictates spatial movements and relationships in ways unimaginable, and probably inexplicable, to someone who has not had the same experience. A free use of space requires a restoration of the body to its intact state. Bodily handicap limits the assumed and fundamental right to move as we wish within the space that is available. Recovering space is a part of adaptation. This recovery may be symbolic (cleaning the floors, travelling on circular voyages around Sydney), or literal (getting back to golf or bicycle riding).

Perceptions of time change in illness [31]. The patient presenting to the doctor details precisely the narrative of the onset of illness. Doctors take this data and eliminate much of the detail, keeping what they need and ignoring the detailed, minute by minute account that is of such subjective importance to the patient who experienced the story. The time leading into the illness differs from the heavy, hanging time of the diagnostic process, its threats and unpleasantness. There is the ‘lost’ time of the operation, the pain-filled time of recuperation, the strange time of: the return to home, the unreality of the time when one returns to work. These experiences of time, so different and so subjective, again are very difficult to communicate to others.

The existential state which we have called liminality is common to all our narrators who have experienced the colon cancer [11]. It consists of an adhesiveness of the cancer labelling, an awareness of boundedness in time and space, and an awareness that the illness experience is impossible to communicate to those who have not undergone similar experience.

Meaning-making self Each person has to reconstruct meaning to incorporate the experience of the cancer. Each person has a different way of doing this. Some regain control by work, while recognising that their capabilities and actualities have changed. Others redevelop roots in their homes and domestic environments. Some seek meaning in repetitive tasks and enterprises (circular travelling). Some struggle to assign meaning, but give clues to how they feel by their linguistic habits. One narrator used the words ‘virtually’ and ‘actually’ repeatedly in his story (Virtually I went straight into hospital; actually the registrar laid it on the line). The adverb chosen, however, revealed that he attached ‘actually’ to events and sequences to do with bad news about recurrent cancer, ‘virtually’ to the life before the cancer recurrence. The self that makes meaning may speak on some occasions in a cognitive discourse, on others in a spiritual discourse, assigning logical meaning or spiritual meaning to events and perceptions.

Modal self Modal self experiences the subjective moods which accompany lifeworld experience. It is this self which recounts the fear, depression, elation and so on that patients record as part of their experience of illness, its diagnosis and treatment.

Social self The social self moves in various circles of sociality. Social self relates to family and friends in particular ways, both structured and unstructured. Social self depends to some extent on empowered self and working self, but is the product of family and biographical forces of far wider reach. It is social self that moves within and helps to sustain circles of support, and it is social self which suffers the stigmatisation and alienation of the cancer diagnosis and its consequences. The degradation of social self gives particular poignancy to the experience, and is felt keenly as a central part of the abjection experienced by those whose suffering is unresolved.
The social self experiences relationships with intimates, friends and acquaintances. The social self expresses itself in context by facework. Social self is also empowered and working. Empowered self. This is the self which handles and deploys the powers that have enabled the person to develop their modus operandi and their position in social and working hierarchies. This is the possessor of authority, the self which determines the direction of social and working relationships. This version of self is variably threatened by the ways in which the health system takes over control of the ill person’s life. It is this part of self which registers emotions like anger, resentment or wonder at the power of the health workers. It is also the self which constructs the redemptive enterprise of ‘successful’ adaptation.

The working self is the self situated in the working role. While the working role and the empowered self share attributes in common, work is separate, since the validating and supportive functions of work have less to do with the exercise of power than the validation of identity as ‘worker in such and such an occupation.’ Working self may be unaffected, threatened or totally destroyed, and the impact of the cancer upon working self has much to do with the way in which the outcome of medical management is perceived.

Symptomatic self is the locus of suffering and medicalisation. Suffering has much to do with loss of transparency. Pain, bodily function made conscious in sense perception, failings in bodily, cognitive or social functions, alienation (whether self-imposed or imposed by others) are all causes of suffering. Suffering is, in a sense, always alienation, whether from the self or others. Whether the suffering was in the past, or is in the present, it represents an experience which is hard to share, and which most people do not want to share. Suffering-self is therefore alienated, conscious that those who have not had the same experience cannot fully understand what it is that suffering-self has experienced or is experiencing.

When someone hands themselves over to the medical system, they have to construct a move which moves within the medical framework. This is an unnatural domain in which to move, since most people have no desire to enter it. The medical domain has different meanings for terms like shock, different concepts of time and space, different priorities over pain and discomfort, different views of inconvenience and threat, different conceptions of outcome. It has its own power structures and orderings, its own geography. It inherits institutions which can be vast, impersonal, driven by protocols. Medicalised-self is asked to adapt to some degree to these other demands, but if core-self is a controlling, self-determining being, that adaptation will be hard and imperfectly achieved.

To have the diagnosis of cancer made is to have a self constructed as cancered-me. Again and again, narrators repeat that the diagnosis of cancer never really leaves the person, regardless of the outcome of treatment. Whatever stigma the word and its implications may have, the liminal state its attachment as label induces remains for life. We have examined this in detail in an article on liminality [11]. The iterative nature of the cancer follow-up reinforces the stigmatising effect of the diagnosis. The cancer patient cannot put the illness out of mind. Repeated surveillance is a repeated reminder.

The ways in which these selves speak, act and interact are not made clear by the metaphor of the illness trajectory.

The illness trajectory

For most people, a trajectory means the path of a launched or fired missile. The metaphor of the trajectory, therefore, implies the following things:

1. a history of the project which culminates in the launch, a history which is clearly causal. A missile which follows a trajectory is caused by a natural (eg volcanic) event, or is man made;
2. a missile, a something which is projected by an agency;
3. a launch pad or starting point, a sufficiently firm base from which the launch is possible;
4. a propellant which initiates and perhaps maintains the trajectory;
5. a course for the missile to follow;
6. guidance systems which stabilise, direct and correct the course of the missile on its way to
7. a target; and
8. a mission, which may vary from something like destruction or conquest of the target, to establishing communication with it or commencing exploration of it.

Inherent drawbacks of the trajectory metaphor

The implication of this metaphor is that a trajectory is something which is determined for the missile by outside forces. Even smart missiles are smart only because they are programmed to behave in certain ways by missile experts. It is certainly true that an ill person does not chose their illness, but the concept of the person as missile is not particularly satisfactory. The person’s history works well enough, but what is the launching pad for something like cancer? The very idea that there is such a structure implies a causal explanation which may be hard to sustain, and which can cause significant confusion and distress if pushed too far. The same vagueness and ambiguity applies to the metaphor of propellant. Is it the illness,
the ill person themselves or their life force, or the medical [32] or even social systems (Parsons’s sick-role, perhaps [33]) that propel the person-missile into the trajectory and onward? The course of the missile again suggests that there is a degree of determinism to the illness course which neglects the vagaries of illness, the effects of treatment and the variability of human beings. It is true that, statistically speaking, patients with particular cancers follow similar courses viewed from a particular and narrow point of view, but prognosis is notoriously difficult. If this is missile science, it is an extraordinarily primitive version.

The image of guidance systems is also vague. Are these internal guidance systems determined by individual biology, or even morality? Or are these external systems manned by health professionals? Or perhaps a rather variable mixture of the two? It is doubtful that this part of the metaphor-chain provides much insight. And what about the target? Who sets that target, and who decides what is a legitimate target? A cancer patient wants to be cured. A surgeon wants to cure it, but may find a need to change that target because of what he finds at operation. He may know that the missile is headed in a different direction, but his patient may resolutely try to turn toward the target of cure by seeking help from alternative medicine. What target does the illness trajectory head for now? And what is the missile’s mission when it does reach an end-point? It can scarcely be described rationally by terms like ‘destruction’ or ‘communication’ with the target. How does one effectively ‘destroy’ death or ‘communicate with’, ‘conquer’ or even ‘explore’ cure?

The metaphor does not sustain its helpfulness beyond conveying the notion that an illness follows a course of some kind. Trajectories are computable, pre-dictable, determined. They have length and height in space and duration in time. The illness course has these characteristics in only a weak way. What is missing from the metaphor is the human element. It defines a course with limited dimensions. It is hard to know what parameter the points on the curve might define. Quality of life? Physical activity? Cognitive performance? Mood? Or a synthesis of all these on some composite scale? Or should each parameter have a scale of its own, and the illness course be depicted as a family of curves?

The trajectory metaphor downplays too much the subjective and interactive components of illness. It tells us nothing of sustaining relationships, and effectively rules out choice. It is hard to reconcile any concept of autonomous individuality with a set course from which there is no departure, except by system failure, which is the fate of a missile. It tells us nothing of the subjectivity of the ill person, and nothing about the experience of embodiment in illness. The ether through which the ill person moves is richer in complexity and event than the predictable atmosphere of the missile.

The metaphor of the illness trajectory is thus unsatisfactory on two counts. First, it locks us into the deterministic and reified associations of the fired missile. Second, it takes no account of the multiplicity of the selves that constitute the self-complex [12, 13]. The journey metaphor is richer and more flexible in dealing with the differing directions taken by the constituent selves (the travelling party), the changes of direction that the selves take during the journey, the adaptive pathways that are chosen, and the negotiations that the travelling selves undertake in order to construct order and meaning for their experiences.

The illness journey

We have argued that the cancer illness (at least for those with colorectal cancer) begins with a phase of acute liminality, and continues in sustained liminality [11]. Liminality is an existential state of awareness of three things—the ‘adhesiveness’ of the cancer diagnosis, boundedness in time and space, and communicative alienation. In other words, colon cancer patients become and remain aware that they are cancer patients for life; they remain aware that their bodies and their lives are finite and fallible; and they cannot communicate to those who have not had the extreme experience of cancer the nature of the experience. In the acute phase, these existential realisations produce a sense of confusion and chaos—expressed in the ‘chaos narrative’ so well characterised by Frank [34]. In sustained liminality, the subject reconstructs meaning and adapts to the changes dictated by the existential state and the changes in relationships dictated by the liminal state and the physical constraints imposed by the illness and its treatment. We have dealt with the existential state of liminality elsewhere [11]. In this paper, we are concerned with the processes of adaptation by which the patient reintegrates into a social network in the phase of sustained liminality. We liken this adaptive process to a journey undertaken by a party of travellers. The travelling party represents the complex of selves. We wish only to explore the metaphor as a means of communicating the insights we have gained from our interviews with patients and their carers.

Acute liminality The acute phase is a time of confusion. It represents the start of an enforced journey, a displacement, an evacuation. The urgent dictates of necessity dominate this phase. There are officials to see, bureaucracies to be negotiated, papers and forms to complete, money to be paid and passports to be secured. Other people and agencies dictate the agenda. They say when and where the traveller is to be. There are smatterings of new languages to be
learned, other cultures to be anticipated and negotiated. Bureaucracies dehumanise travellers, process them, record their details, stamp their papers. These are the chaotic elements of the acute liminal stage of the journey. They are well covered by the metaphor of the enforced journey. In this paper, we are more concerned with the ways in which travellers manage their journeys in the phase of sustained liminality when they must renegotiate relationships and processes in their social networks.

**Sustained liminality** Each traveller, as the actual journey begins, must choose a direction in which to start. We believe that there are four basic directions, which we call unadapted sick role, adapted sick role, creative adaptation and supererogation. The person who adopts the adaptive sick role is one who adapts to the sick role, accepting the privileges and sanctions that attend the social recognition of illness. The person in the unadapted sick role is diminished by the illness and its treatment, lives on in the experience of illness and its aftermath, resenting the disability which has destroyed his past existence. Such an individual copes by acts of blaming, hating and resenting, picking out faults in the system that dealt with them and assigning causal blame. The person who chooses the direction of creative accommodation comes to terms with the elements of the illness, understands the limitations they impose, but reconstructs her life to give it a meaning which reaches well beyond the fact of illness. Such a person may take up new sports or cultural interests, may return to old interests with a new sense of involvement or fulfilment, and may, in short, find herself at least as adapted, and perhaps more adapted, than she was before the illness. Those who choose the direction of supererogation not only develop their own capacities, but extend their activities into creative matters which provide guidance and leadership for others. Such people form support groups, write positively about their experiences, let it be known that they have had the experience of the illness, but have been augmented by it. Both those who follow the path of supererogation and the path of creative adaptation tell versions of Frank’s ‘quest’ narrative [34], a type of narrative that can be read as a version of Campbell’s Heroic Quest [35].

We need to stress three things. First, individual selves in the self-complex may negotiate different directions in which to proceed. Second, the choice of direction for each self is constantly renegotiated, and selves may move from one direction to another. Third, while there is some tendency for the journey to proceed in stages, from unadapted sick role to adaptive sick role, to creative adaptation to supererogation, in no way do we argue that such a progression is either inevitable or normative. Nor do we wish to imply that there is any moral judgement applicable to the major directions. Supererogation can impair personal adaptation. The unadapted sick role is quite compatible with public impact and service to fellow sufferers. The moral judgements that carers and health care workers generally assign to individual adaptation are better attached to the ways in which the individual negotiates a pathway in the chosen (or enforced) direction for a particular self. The actual route followed may be partly chosen, partly enforced (by budget, travel plans, facilities for travellers, local guides and so on). The uses made of the *en route* experiences, their socially integrative or dys-integrative effects will vary from person to person.

The concept of selves negotiating different pathways for the same person may seem strange. Nevertheless, it provides insight into empirical observations. An excellent example is offered by one patient (Lynn), whose narrative was obtained three years after surgery for colonic cancer had left her with a permanent ileostomy. Her embodied self continued along the direction of unadapted sick role. The ileostomy disgusted her and interfered with her social and working life. Her social and working selves therefore followed the same direction. She had, however, managed to reconstruct her family and domestic roles, so that these selves moved in the direction of adapted sick role. Her spiritual meaning-making-self, however, had moved in a different direction. She was a deeply religious person, who had in some way felt ‘uplifted’ by the experience of confronting her mortality. The spiritual self had found new strength in the experience, which was expressed by Lynn saying that ‘she wouldn’t have missed the experience for worlds’. Her selves were thus travelling in a number of different directions, and her narrative gives the impression of a person divided, of problems unresolved, and of the unease of living with non-coherent selves. It is this quality of division within one person that persuades us of the value of the metaphor of multiple selves.

Other patients presented less divided, more cohesive ‘travelling parties’. Bert chose the direction of supererogation within a few months of his recovery from surgery and permanent colostomy. He became a counsellor for a colostomy support group, and continued in that role for 15 years. He did this in his social self, because he recognised that he could help fellow sufferers by imparting his own philosophy and his own experience. He developed a personal philosophy of adaptation summarised by his use of the word “Endure”, which helped him to bear and surmount: his physical and psychological challenges. His spiritual meaning-making-self thus followed a path of creative adaptation. So did his social self, which recreated a supportive social network within the physical constraints of increasing age and of his colostomy. He gave the impression of coherence amongst his selves. This quality of coherence has been noted by Argyle [36] to be a signal of good social adaptation.
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