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Searching for wisdom: A phenomenological investigation of women's perspectives following participation in an ovarian cancer supportive care group


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ABSTRACT

This study used a novel methodology of hermeneutic-poetic-phenomenology to explore perspectives of women living with ovarian cancer. Each had participated in a supportive care group process *Soul-Medicine* prior to volunteering. Three women, Beth, Carrie, and Denise contributed to this study. The methodology was grounded in Gaston Bachelard's philosophy of poetic-phenomenology. Data was analyzed with attention to image-centred knowledge; material imagination; reverie; and horizons of hope to elucidate their implicated aspects of wisdom and the ways participant's formed their personal wisdom integrating feminist theories of embodiment and bioethics.

Findings are framed through three images of a uniquely formed inner 'wisdom-compass', an 'inner navigator' who heuristically creates the compass and uses it for navigating daily life, and a 'magnetic north' of wisdom-*poiesis* orienting the individual towards embodying a wise life, revealed in dying. The embodiment lens frames an understanding of wisdom where embodiment, itself, forms a wisdom-labour creating a 'hand-made' compass used to guide wayfinding towards a wisely lived life.

Discussion on Embodiment includes: embodied relationality with 'other'; embodied relationality with 'self'; embodied relationality with nature; embodied relationality in wise care; embodied relationality with 'ethical sensibility' as including *empathy, agency, subjectivity, epistemic power, (re) embodying lost*

knowledges; embodied 'knowing'; embodied temporality; embodying wisdom's invisibility; embodied reflectivity.

This study responds to the contemporary appeal study of the more intuitive, creative and holistic dimensions of wisdom often termed the *sophian* forms of wisdom. Discussion on findings for imagination and its role in wisdom includes four *sophian* dimensions of wisdom: (a) embodied-intuiting; (b) embodied-creating; (c) embodied-spirituality; (d) embodied imagining.

Implications are discussed for medical education, study and preservation of clinical *phronesis* in health care practitioners cultures of care, wisdom-activating conversations that elicit less legitimate forms of knowledge in patient and clinician such as 'embodied knowing'.

It also invites the reader to reflect on their own wisdom and how, perhaps, this lies submerged from view amidst daily life with its tensions and struggles. The novel methodology is proposed as a possible path towards creating poetic renderings of a personal 'wisdom-compass'.

Keywords: *wisdom, ovarian cancer, psycho-oncology, phenomenology, embodiment.*

THE CO-AUTHORSHIP

While each of the professors and co-authors listed below made important contributions to this work, I am the principal author of all the work represented in the manuscript, including study design and conduct, participant interviews, data analysis and representation of findings in this monograph. For the published scoping literature review, consultation and critical review were provided by the co-authors:

Dr. Glenn Bauman, in his role as my supervisor and the principal investigator, provided strong leadership and doctoral supervision for the study analysis phase and manuscript preparation, as well as clinical mentorship in the research-candidate's clinical practice in the oncology program in which the supportive care groups took place.

In addition to Dr. Bauman, **Dr. Carla Garcia**, **Dr. Elizabeth Anne Kinsella** and **Dr. Jeff Nisker** provided assistance with intellectual and editorial input on the published article *Psycho-Oncology: Searching for Practical Wisdom?* (Butlin, 2015). Dr. Nisker and Dr. Kinsella guided the initial doctoral process in study design, methodology, and research proposal development. Dr. Kinsella provided crucial theoretical and methodological guidance, intellectual and editorial support for the methodology chapter, critical development of a well-honed research question and guidance through REB and data gathering. **Dr. Sandra DeLuca** provided advisory committee support and a critical review of the research proposal. **Dr. Valerie Wright-Sinclair** gave expert guidance on

phenomenological inquiry and development of the Interview Guide, along with **Dr. Anna Park Lala** who gave the Interview Guide an insightful review.

DEDICATION

To my children

Meagan and Aaron

for your
unfailing love
and for weathering
the storms
as I searched
for wisdom

To Beth, Carrie, and Denise

for your generosity
and wisdom-labour
to gift us
with your

wisdom

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Wise leaders and mentors that embody the dimensions of *episteme*, *phronesis*, and *sophian* aspects of wisdom are, in my view, generally rare. I have been a privileged recipient of each of these embodied in Dr. Glenn Bauman's clinical support in my oncology practice as well as in his guidance, supervision,

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Dr. Joel Vos has also had a critical role from 2010. It was Dr. Vos who first suggested that the Soul-Medicine supportive care group process needed to be published and who has afforded this doctoral journey with enormous support, expert reading and critical review of early drafts of papers and chapters and who has also been 'incepting' articulation of what dwells 'in-between' within psycho-oncology and meaning-centred therapy constructs. Some of his key concepts are taken up in this work in the true spirit of academic 'conversation' and I offer sincere gratitude for all the support you've so generously extended to me and this manuscript.

If it takes a village to raise a child, it takes a tribe to nurture a PhD thesis... and support the student. A doctoral student enters a labyrinth with many minotaurs lurking that might defeat the quest. It taken a labour of love, dedication, a generosity of expertise, mentorship, and friendship in '*communitas*' to bring this manuscript to completion. Special mention goes to Dr. Julie Clarke for her tending to my health and well-being in a true embodiment of wise care and to Dr. Douglas Cann, the wisest possible guide into the inner life whose wisdom has been a wealth imbued into my life as a woman and mother, a practitioner, and is woven throughout this doctoral journey to be deeply inscribed in these pages.

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“Co-conspirators” play a necessary role when one is trying to breach discourse norms and, as in this thesis, open spaces for dialogue such as for poetics to speak to science. My deepest gratitude to Dr. Carla Garcia who has been such a co-conspirator with literally thousands of hours of ‘wise dialogue’ over ten years giving time for my philosophical and clinical cogitations on our clinical practices in psycho-oncology from your psychiatry practice and mine, as a psychotherapist-spiritual care practitioner. Without your nudge that a PhD ought to produce something original and can take more than the specified four years to do that, I might have succumbed to the easier path. Without your truly brilliant encyclopaedic mind that could integrate my lengthy expounding on the philosophical and scientific dimensions of this study and clarify them in seconds to spur me on, I'm not sure I could have honed the concepts in this study as I did... at least not as enthusiastically. As well, your unfailing belief in Soul-Medicine and my clinical practice in the cancer program, referring patients, lending credibility to the work, I'm not sure this work, or myself, would have

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LIST OF ABBREVIATIONS

CRPO, College of Registered Psychotherapy in Ontario

GP, General Practitioner (of Medicine)

HSREB, Health Sciences Research Ethics Board

IPOS, International Psycho-Oncology Society

LHSC, London Health Sciences Centre

LHRI, Lawson Health Research Institute

MAID, Medical Assistance in Dying

MORE, Mastery, Openness, Reflectivity, Emotion

PRISMA, Preferred Reporting Items for Systematic Reviews and Meta-Analyses

REB, Research Ethics Board

WISEWOMAN, Well-Integrated Screening and Evaluation of Woman Across the
Nation

CHAPTER 1

INTRODUCTION AND LITERATURE REVIEW

Some portions of this chapter were published in Palliative and Supportive Care 2017, vol. 15(3): 383-400, Palliative and Supportive Care 2015, vol. 13(5): 1495-500, Community-Based Healthcare: The Search for Mindful Dialogue, Sense Publishers 2017, pp. 164-174, and Poetic Inquiries of Reflection and Renewal: Poetry as Research by McIntyre Purcell Publishing, 2017, pp.22-32. Reproduced with permission.

PROLOGUE

The Legacy

Part I – The spiritual counseling office in oncology

and here another sits
in front of me
beneath georgia's glorious
red splashes
opening libidinous petals
gushing life

she's young
with small children

dying

I can't get out of bed
tears falling

I ought to get up.
I just can't

flowing rivers
apologies
kleenexes
breath held

why do we dam very life force
seeking its way
into the dark recesses
of our anguish?

what forces were driven into our bodies
to dam our tears
apologize for our weeping

.....even when a mother
is dying?

deathlessness

a realm touched?

if ever such an anguish
can be cradled

a seeming impossibility

yet

here and there
it creeps in
silently...

a forest glimpsed
between breathes

children playing

essence realized

timelessness touched
connecting all

can we teach our children
about timeless time
its river beneath us
through us
in us
before we die
so they can truly live?

i hope so

what else is a dying mother to do?

for... are we not

in the end

all dying?

Part II – at the bedside

“I’m ready to go,”

it was around ten a.m.

the doctor, making her hospice rounds

beside his bed

on her knees

leveling her position

meeting him eye-to-eye

human-to-human

he glanced at the doctor

efforting

concentration pulling

away from his body

nauseous and dying

great effort

he could only give this much

but it was enough.

“I’m ready to go,” he told her.

At six fifteen p.m.

he died.

Two facts of a medical process, the ones the medical chart will have recorded.

Facts of an expected death:

- 1) 10 am: Patient stated, "I'm ready to go", second blood transfusion declined.
- 2) 18:15: Patient ceased to breathe.

Between those facts... sacred ground. A whole world between the words, a whole mystery of a process rarely ever associated with the word 'death'.

Yet, in the world's top one-per-cent of health care systems many twists and turns lie in a person's path through the medical experience of an "illness" and its "treatment". There can be startling turns of events even in the so-called end-of-life' process (as death and dying is called) that can mean the person does not end up in anything like 'sacred' ground or mystery. More often there is bafflement at how complicated dying can be and a numbing shock from too little, too late or, as can also be the case...too much, for too long.

"Grandad," a grandchild says leaning over to hold his hand, "You're simply the best!" A man dying, his family surrounding him, singing beloved songs from his world of faith. A party the night before, a "Sherry and Crunchy Bar Party", so named because all he could eat for the past two months since his stomach cancer diagnosis, were basically those Crunchy Bars...the melt in your mouth kind, and sherry and whisky mac's, his favourites as the staple to wash them down! The party consisted of the whole family that could be there, grandchildren ranging from ten to almost thirty years old telling him the qualities they admired in

his life. He heard how his impact reached forward through his four daughters into the next generation. "Loving and caring." "Wise and patient." "You got me off my butt to apply for a new job." Tears, laughter, stories. The rituals of humans around the dying for millennia, lived, for him, with him. He got to hear it from those bearing his future, his legacy, before he died.

The next morning was when he said, "I'm ready to go."

The grandchildren saying goodbyes, his wife of almost sixty years sitting, quietly, and pulled by a deep inner current, an unreachable solitude within, steadying herself for the letting go now approaching. Sixty years. Now emptying out into a silence from which there is no return. A private last communion ritual with one daughter, whose job three thousand miles away is to do this for families just like this, in emergencies only, and who had tried very, very hard to get two others ministers to provide this last rite for this couple, who took communion together for sixty years. She was a practical sort and in the absence of any available ministers or any suitable communion elements, and used to the make-do life of a hospital chaplain, rolled up her sleeves and offered their last communion with the leftover sherry and the last of the Crunchy Bar from words in liturgy long since left behind in her personal path. The last prayer of his beloved wife breaking a silent pause at the end, "I let him go, God. You take him. He's yours now." Words he needed to hear as the man who had cared for her and bordered her life. The brave prayer some can manage, and some cannot. There is no map for dying.

The daughter seeing the familiar approaching end, her instincts well honed to the flow of these moments, endings of lives lived, gathers the family again. They sing him into the beyond, songs rising and falling, dredged from childhood memories, sons-in-law and daughters blending voices for the first time since their weddings, now singing for the beloved dying man.

She has lost count of how many deaths she has borne witness to. Traumatic deaths in Intensive Care units, emergency rooms, lonely deaths on medical inpatient units, quiet deaths in palliative care, deaths shortly after 'just one more chemotherapy treatment' ...the endless sourcing of hope medicine, at times, ceaselessly offers... angry deaths, sad deaths, peaceful deaths, deaths with love, deaths with noone....not all deaths feel sacred, some are an outrage. God died for her in those deaths at some point along the way. From the teenagers dead from road accidents, midnight calls for babies dead at birth, mothers leaving children in long, slow agony... loving while dying. From all these over the years, a different kind of path was born.

His breathing is steady, it could be a while. She settles in for the vigil.

Faces drift into her mind's eye, stories rise and fall with his breaths. Stories she's lived in, through and with, present in the interstices of peoples' most private moments with loved ones, her job ...to provide 'something'. Offering a balm of some nature, between concrete walls and behind curtains of crowded hospital rooms....and strangers on the other side of the curtain, trying to be invisible.

Her thoughts weave and flow, like weft and wharf in a tapestry of reflections and images that have been forming over years on the front lines. His breathing steady, he is now deep in that inside place somewhere between life and death where no one knows what happens but those who have borne witness over and over, know something does... to everyone. The silence is hallowed, a familiar silence at the side of the dying in the presence of love around a bedside.

Unwelcome or welcome, our dying is not a passive victimhood, it is our human rite of passage. Many times she has contemplated this thought. How death is perhaps a last teaching we all face from life and a last legacy our children and grandchildren might witness. Many times she has wondered if dying is a lost wisdom of our society, having been at bedsides of those who seem to face dying with and for us. Painful or not, tragic or not, it is an end that inevitably happens and as familiar to the fabric of human life as air and breathing. It is the one thing that human sciences have not conquered and the one thing that human science cannot tell us anything about, despite its great efforts to do so. Death is the one thing that still, at least for now, remains a mystery. A great unknown.

Many times has she wondered about health care institutions that are supposed to have the sacred 'knowledge' of the scientific gods, yet, story after story, face after face rises up etched with the pain of what has become called 'iatrogenic suffering', suffering, inflicted by the very treatments and system that is bound to the Hippocratic Oath, "Do No Harm." A system that can inflict such unbelievable

barriers in such obtuse ways, always in the 'gaps', difficult to excavate into the light of day...and it seems, almost impossible, to change. Despite caring experts and despite their best efforts.

The death pallor is settling into his face and neck. She knows it so very well. He is leaving. Such a mystery... dying.

Three faces are starkly in her mind's eye, three children weeping., just a week ago on a busy hospital floor. She held two of them in her arms. She can almost feel their racking sobs still, because they didn't know their mother was dying. The health care team had known for months. She was diagnosed with stage four lung cancer three months earlier but because she did not want to believe she was dying and could ask for *and* receive chemotherapy right to the day she died, she had never told them. She doesn't hold the mother culpable. Who wants to leave one's children? Have we collectively forgotten that this kind of death, such as the one she is now witnessing *is* possible. And...the daughter adds in the well-worn script of these thoughts.... so desperately needed.

She thinks of how even in this case, what it took this family to get him to hospice instead of a very un-peaceful, crisis driven death in his home or in the rush to a hospital. Even this man, palliative at diagnosis, offered five radiation therapy treatments almost did not get access to *this* dying experience. The treatment, was never stated as 'palliative', simply offered as a 'treatment' that 'may help him eat,' holding out, and heard as, the never-ending carrot of a future without death

in it.... except she'd prepped her father, who was a man who faced things head on and wanted truth, first and foremost, to ask, "Is it treatment with an aim to cure or to provide comfort measures?" He was given the answer. The truth. A different journey was embarked on with that question. He turned to face the inevitable, took it up in his soul, tackled it head on, as he had everything else in his life. He almost wasn't given the chance to do so, not with such clarity, while he still had energy and some life left, were not for one simple question forcing the truth into the room. And the story on the night of his collapse could have been one of the many she has witnessed. The rush to hospital admitted on the oncology floor...if they were lucky, or the emergency room filled to overflowing, if they were not, and waiting for the on-call doctor to assess, the family shocked, worried, squashed in a shared room with some other person not really wanting to be exposed to a stranger dying. So many deaths have most definitely not been like this one. And not because medical colleagues are blind or heartless. They try their very best to prevent such endings and yet, still, they happen.

During a week-long visit two weeks earlier, thankfully, she had discussed with her father the thorny DNR issue. "Do Not Resuscitate". How many papers published on this one? Her father was always clear, for years, "no life extending measures". She was able to suggest that at his discharge appointment from palliative radiation he request a DNR on his chart to make sure his wish was fulfilled. Up until she raised it with him, and at this remembering, she could feel her anger flickering into a flame from the ceaseless ember that front-line health care can keep stoking, *no one* had thought to ask an 83 year old man with stage

four stomach cancer, metastases to liver and lymph, whether or not he wished to be resuscitated and have all measures possible, including breathing tubes, if his heart were to stop, until this daughter raised, “Dad, you need to think about your wishes should your heart stop,” and he asked for a DNR on his chart. No blame being laid. It’s such a familiar story, despite, bafflingly, the heroic best efforts of many physicians and team members. Yet this scenario still happens. And this time it was personal. This was her father.

Good thing as it turned out. Apparently, one of the sisters had met the paramedics and barred them at the door, the night of her father’s second fall, the crisis that triggered his unplanned rush to the hospice, with her cell phone showing them her text from Canada stating: “Do NOT, DO NOT let them take him to the hospital. He has a DNR, AND a bed in the *hospice* at eight am. They MUST get him to the hospice.” She knew, if he went to the busy emergency room to get into hospital, his death would not be “good”, there would be no sacred ground and time for the effects of palliative care at its inpatient best to give balm to the tearing of the heart which their, already fraying, mother was living. And this daughter was three thousand miles away, trying to book a plane with two children who really wanted to be there with the family for their Grandad’s dying. Her sister had refused to let the paramedics in the house waving the text at them until they assured her they’d do everything they could to NOT take him into the hospital. It took two hours to find the admitting family doctor as the resident on-call for the hospital could not admit him. He was dying, he did not need anything but the bed he was due to be admitted into eight hours later.

He almost did not have *this* dying.

He would have joined the ranks of the many stories piled up in her heart, one on top of the other like chapters in a book that cannot be written on the effects of death avoidance in its quiet but toxic invisibility on absolutely everyone involved... the dying, the family, the health care providers, the children walled off by its cone of silence. How many times has she mourned, with patients, their families and especially, privately, many colleagues, the lost wisdom of the elders we have met in our practices who know how to die, who show us, when they can, when life streams into a process that is not violent or tragic, and teach us something about dying and returning into that great letting go of everything that dying forces us into, right down to the very last breath. We have met them. We have touched the sacredness at the heart of dying through them. Where is their wisdom in our systems?

But he did get it. His family's last gift to him. The advocacy for a quiet bed, often enacted for patients by many a clinician, sometimes succeeding, often failing for a thousand reasons, for once, in this most personally crucial dying, worked.

She pulls herself back from these thoughts, none new, and watches his breathing.

And then, the final staccato breaths, and in just moments, his passing, One of the most natural, almost morphine free deaths she's ever seen. Even now, that thought comes from the so many experiences shaping the contours of this one. His wife letting go of his hand, quiet and steady, knowing he needs to go by himself, her last act of love so he does not need to feel her holding on to him so he can pass through that mysterious veil we call 'death'.

"I saw a picture," he had told his family at the sherry and crunchy bar party, "I saw God at the end of a corridor with his arms open, ready to welcome me. I'm not afraid of dying," choking with some tears as he told them. The children, listening. God or not....just his story to tell and his comfort. Ours too. Believers or not, the comfort being his peacefulness. His grandchildren's memories etched forever with a dying not filled with fear. She thanks him silently from the bottom of her heart for that. They will remember their Grandad's quiet words for all their future letting go's.

And his final last breaths. No struggle, no laboring, just a quiet disappearing into stillness.

Then the tears and grieving. Children coming back to say their last goodbye to the man who now 'was' their grandfather and no longer 'is'.

A change of tense in a few breaths. 'Is' becomes 'was'. The journey in between a lifetime lived. Then a final emptying... god or not....he died comforted.

She looks at her children, hugging them through their tears. Gifted with a wise elder's death, all she'd ever hoped her children might experience some day for a touchstone in their lives about letting go, about dying. So many ways it could have been something so entirely different. But here it was, the sacred ground she'd shared with other families, now the soil under her children's feet. She feels deeply, deeply grateful. This wise man, her father, knowing he was dying, showing them how to let go. From youngest to eldest, for their first time bearing witness. Intangible, powerful threads of silent, shared connection in front of a death that broke open love, tears, a sense of family....even if for only a few hours, moments...

"I'm ready to go,"

it was around ten a.m.

the doctor, making her hospice rounds

beside his bed

on her knees

leveling her position

meeting him eye-to-eye

human-to-human

he glanced at the doctor

efforting

concentration pulling

away from his body

nauseous and dying

great effort

he could only give this much

yet it was enough.

"I'm ready to go," he told her.

At six fifteen p.m.

he died.

Two facts in a medical chart: (1) 10 am: Patient stated he was ready to go, second blood transfusion declined (2) Patient ceased to breathe at 18: 15.

A whole mystery of a process lived in between.

My father's final gift to me.



CHAPTER 1: INTRODUCTION – FRAMING THE RESEARCH

“Is there, as a matter of fact, any better truth about the ultimate things than the one that helps you live?” - Carl Jung (1966)

As a spiritual care practitioner and registered psychotherapist, and as a clinical member of the supportive care department for the London Regional Cancer Program, I have had the privilege of working with people living with cancer for almost twenty years, with 10 years as a specialist in psychotherapy and spirituality in a regional, urban, tertiary care oncology program.

During the past 10 years, I have designed and implemented supportive group and psychotherapy sessions, one being the supportive care group, called ‘Soul-Medicine’ (section 1.2.2.1 and Appendix II). The explicit aim of sessions, in the groups and individually, is to investigate with participants the question Carl G. Jung (2009) implies (see the beginning of this chapter, p. 17) that asks, ‘What helps me live?’. I have had the privilege of witnessing the personal wisdom that people have cultivated and shared, often under great duress, from their experiences of cancer. Reflections on this work are offered in the autoethnographic text (section 1.1.2.2), which served as a reflexive “outing” (Finlay, 2002, p. 531) of my insider perspective, yet with a critical lens afforded by my role in spiritual care within a biomedical context. Reflections and the process of my clinical work with one young couple can also be found in a coauthored book entitled ‘*Just Stay*’ (Fazakerley, Butlin-Battler, & Bradish, 2012). The aim of this doctoral research was to foreground patients’ wisdom, specifically

women's wisdom, as a potential, untapped resource and submerged knowledge in clinical conversations and research in oncology care.

1.1 BACKGROUND: SITUATING THE RESEARCHER AND THE RESEARCH

Drawing on my experiences in oncology care, I propose that the wisdom cultivated by patients in the medical system, living with cancer, is an important and clinically relevant form of knowledge, which has practical implications for both living with cancer and for medical provision of care. In my oncology counseling office, for many years, I have occupied a privileged 'front-row' seat to individual's in-depth, soul-searching quest for personal wisdom-in-life when facing their mortality and experiencing deep suffering in all its aspects: physical, psychological, emotional, and spiritual. I have been deeply inspired and transformed, time and again, with a discovery of a human-shared quest for meaning, hope, inner peace, joy, equipoise in the face of radical grief, loss, pain, heartache, fear, loneliness. In the dialogue and within my practice a steadfast belief grew over the years that there can, sometimes, be a richness of wisdom mined in suffering experiences that can enable deeply courageous living and dying. My clinical work has changed me and steered my own life as a woman and mother raising children, in relation to mortality and living life to the full, despite obstacles. This context of my clinical practice and its deep influence on my personhood and perspectives on the many narratives heard about 'finding a

way' through formed the basis for embarking on offering some empirical support through doctoral research for that which I'd borne witness to in my lived experience as a practitioner.

As a starting place for my research, I set out on five related inquiries 'in search of wisdom in oncology care' to set a foundation for the research. The first inquiry was a theoretical investigation entitled '*Psycho-Oncology: Searching for Practical Wisdom?*' (Butlin, 2015a) (Section 1.1.1.1). The aim of this paper was to highlight the voices of clinicians who assert a loss of 'soul' and 'wisdom' in practices of medicine and to highlight the field of psycho-oncology as one clinical discipline that attempts to redress this imbalance in practices of care for those living with cancer. At this stage, the doctoral research was aimed at an outcomes-based study, to show the effectiveness of the *Soul-Medicine For Living With Cancer* supportive care groups. It was through a long and considered writing process for this theoretical paper on 'soul' in 'medicine' within western forms of health care that it became clear to me that the groups were not truly the focus. In fact, it was the *wisdom* gleaned by individual participants that was described as "more peaceful" and "no longer afraid of dying", "my relationships are better", "I can find hope in today" in their narrative evaluations that was of greater interest. How did they find this salient, in my view, life-wisdom? It seemed to me that the richness of their own hard-won wisdom was worth investigating and tipping the notion of 'expert' on its head to offer patient's wisdom back into the oncology context for whole person living with a life threatening, and in many cases a life-shortening cancer. The writing of this paper produced the concept of

wisdom as a key submerged phenomenon that the group participants were themselves investigating (with myself more in the role of the mountain Sherpa) and it was myself and all those around them in their lives who also acquired their 'wisdom' in the process. This process seemed worth exploring and studying as a distinct phenomenon. This manuscript was published in the journal *Palliative and Supportive Care* (Butlin, 2015a), as *Psycho-Oncology: Searching for Practical Wisdom* (Section 1.1.1.1).

The second inquiry after this paper was critically reflexive (McCorquodale & Kinsella, 2015) and focused on "outing" (Finlay, 2002, p. 531) my insider perspective as a health care practitioner in clinical spiritual care and psychotherapy who had been already immersed in the study's focus on seeking, finding and embodying wisdom and finding a 'wise way through' life-altering illnesses with patients for many years. This reflexive work engaged in: (a) an autoethnography of my lived experience as a feminist informed practitioner in spiritual care within oncology attuned to subtle and overt forms of oppression, internal and external (Section 1.1.2.2); (b) a poetic inquiry from my practice of working with dying mothers and a piece I wrote on my own father's diagnosis with cancer and death (Prologue) - this piece's writing process laid the foundation for the evolution of the novel methodology used in the research and crystallized my decision to develop it within the for this study; (c) reflexive poems written 'in-between' the spaces of the research's unfolding with some shown in this thesis; (d) a reflection piece on the changing identities I was experiencing at the beginning of 'becoming a doctoral student/researcher', titled: "The materiality of

motherhood in academic research: Notes on ‘workflow’ from a mid-life doctoral mother” (Appendix III). Some of the reflexive poems are included between chapters. They are titled, “Breathing Space” to offer the reader a pause, an exhale moment, and a shift from theory based reading, to poetic-reflective reading, a ‘reverie’. This is patterned upon a practice taught in Soul-Medicine supportive care groups for giving space for feeling, reflection, rest in one function of the mind to move it into another way of being as a practice that can allow us time to reorient to our own inner rhythms, intuiting, reflecting, within the multiple complexities of a day.

In the third inquiry, I set out to systematically examine and map, through a scoping review, what has been said about ‘wisdom’ in oncology care. The aim of this investigation was to examine (a) how the concept of wisdom has been used; (b) the ways in which wisdom has been a focus of inquiry; and (c) how wisdom is characterized, when the term is used, in the context of oncology care.

This paper, titled *Searching for Wisdom in Oncology Care: A Scoping Review* was published in the Journal of Palliative and Supportive Care (Butlin, 2017) (Section 1.3). It highlighted that wisdom in oncology care has a taken-for-granted presence in published oncology literature. Nonetheless, the use of the concept of wisdom is varied and unclear. Of note, a tension in the literature seems to exist between ‘conventional wisdom’ and ‘common wisdom’, where conventional wisdom is associated with habitual practice conventions, whereas common wisdom speaks to clinical decision making, inclusive of elements based in practice knowledge. This holds implications for research aiming to further

elucidate the role of *phronesis*, practical/experiential wisdom in oncology care practices, as well as in medical education. The paper suggested that there may be benefit to recognizing wisdom as informing epistemologies of practice in oncology care and provider education. Moreover, it also highlighted the potential for culling more intentionally the wisdom acquired by those living with cancer themselves as a form of expert knowledge, with clinical value for guiding better care delivery.

The fourth inquiry is a theory paper (in progress), titled '*Assisted Dying in Canada: Finding a 'Wise-Way' Forward*', tangential but contextually related to this doctoral study. It explores and expands the feminist bioethics theory lens used in this doctoral research, in light of Medical Assistance In Dying (MAID) legislation that was decriminalized in Canada in Feb 2015, and given legislation to guide its enactment in June 2016 (Gov. of Canada, 2018). I was clinically involved with a patient who used a court order in the interim period, prior to legislative guidance, to assist the person with spiritual well-being prior to their planned MAID procedure. This brought the issue home to my clinical practice experience and provoked deep reflection on the nuanced but stark differences in our conversations during counselling sessions, when spiritual care for someone preparing to die was within a timeframe with a chosen date for an enacted death. The paper places a lens on the implications of gender for women seeking MAID. It examines the ways that earlier theories in feminist bioethics which identified the role of paternalism (Sherwin, 1998), "psychocentrism" (Rimke, 2016), and "medicalization" (Kathryn Pauly Morgan, 1998) in women's and any individual

who is subtly or overtly 'otherized' in experiences of medical care, might still have powerful, yet submerged influences on clinical interactions with those seeking MAID. This paper uses the social context of MAID legislation to argue for a crucial foregrounding of the phenomenon of 'wisdom' in clinical care interactions. It calls for more effective, clinically integrated means for clinician's wisdom *and* patient's wisdom, including embodied, empathic and subjective knowledge, to become a deliberate dimension of competency-based clinical practice, and most especially in clinical consultations for assisted dying. It offers one contextual response to the "Why wisdom?" question for this study's focus.

A fifth inquiry focused on research on wisdom to provide a conceptual and theoretical framework for the more elusive, less clinically integrated notion within medical care for the study population, women with ovarian cancer (section 1.2.1). From this immersion in wisdom research literature, it was decided to situate this study's focus on implicit theories of 'wisdom' (Baltes & Kunzmann, 2004; Baltes & Smith, 1990; Bluck & Glück, 2005; Glück, Strasser, & Bluck, 2009) within empirical conceptualization and characterization of wisdom (Ardelt, 2004; Baltes & Kunzmann, 2004; Bangen, Meeks, & Jeste, 2013; Bluck & Glück, 2004; Ferrari & Weststrate, 2013; Glück, 2017; Grossmann, 2017; Küpers, 2005, 2013; Sternberg & Jordan, 2005; Wink & Dillon, 2013; Wink & Helson, 1997; Yang, 2013; 2008). It specifically focused upon their experiences of wisdom, as women (Aldwin, 2009; Glück et al., 2009). Illuminated is the wisdom and the phenomenon of its formation through difficult life experiences and particularly participants' current experience of ovarian cancer. This focus aligns with

Montross-Thomas et al.'s (2018) premise that “assessing individuals at the end of their lives might be particularly salient for characterizing and understanding their perspectives on wisdom” (p. 2). Rather than using empirical measures for wisdom and its characteristics in the participants as in Ardel and Edward's (Ardelt and Edwards, 2016) recent study on “wisdom at the end of life” that examined “mediating and moderating relations between wisdom and subjective well-being” (p. 502). It responds to Küpers (2005, 2007) call for phenomenological investigations and Yang's (2013, 2013) call for studying wisdom's processual dimensions with attunement to its embodied and relational aspects from with participants' own, implicit, perspectives on wisdom and elucidate what their 'wisdom' might be.

This study is informed by three *theoretical* perspectives: (a) theories of imagination that recognize imagination as central to the human potential for discovering well-being in the midst of the struggle-in-life (Bachelard, 1960, 1969; Jung, 1960, 1968; Kearney, 1998); (b) theories of embodiment, including feminist perspectives, that recognize the exclusion of women's first hand accounts and the absence of validation of bodily knowledge as problematic in approaches to contemporary health care (Grosz, 1995; Shildrick & Mykitiuk, 2005); (c) feminist bioethics which invite a lens attuning to gendered experiences of women in illness related to their uniquely female organs (their ovaries) and also in their health care experiences interacting with clinical providers and the medical system itself.

The foundational clinical work (Soul-Medicine Support Groups held at the London Regional Cancer Program), is highlighted in Table 1.1 and shows the clinical, philosophical and theoretical preparatory work informing the design of this doctoral study to focus on investigating wisdom through a novel phenomenological methodology which was developed as part of the study. At the outset, it is important to emphasize what this study is *not* aiming to offer, and what its aims *are* focused on: it is not seeking to capture 'results' on what wisdom 'is', as in earlier studies on wisdom (Baltes & Smith, 2008; Baltes & Staudinger, 2000, 2000; Jeste, 2010); rather, it took up Küper's and Statler's (2007; 2008) call for studies to investigate wisdom as a phenomenon and Yang's (2008) call to study wisdom as processual. The study, in the interpretive lens and staying faithful to the philosophy of poetic-phenomenology developed by Bachelard (1969; 1994; 1983), does not, therefore, aim to generalize or speak for others in a co-opting of voice without acknowledging the influence of the researcher's own. Instead, as with poetry, the poetic representation of this study's findings, aims to *invite* the reader into his/her own reverie on wisdom through an engagement of imaginal reflection. In other words, the interpretive paradigm and poetic representation invites the reader to become a *knower of* wisdom in their own life experiences rather than someone who has knowledge, disembodied from their own lived experience, *about* wisdom as if it is a *known*.

Table 1.1 Preparatory work for the study focusing on wisdom. Clinical, philosophical and theoretical preparatory work carried out to lay the foundation for the design of the study to focus on investigating wisdom through a novel, phenomenological methodology.

Date	Project	Location
2009	Pilot Soul-Medicine group with women, mixed diagnosis	London Regional Cancer Program
2009 – 2010	3 Soul-Medicine groups, with women, mixed diagnosis refining content, based on evaluation feedback	London Regional Cancer Program
2010	Pilot Soul-Medicine group for women with ovarian cancer Stages I - IV	London Regional Cancer Program
2010	Oral Presentation: “Soul-Medicine: Targeted Therapy for the Fear Factor”.	International Psycho-Oncology Conference, Quebec, Canada.
2010 – 2012	5 Soul-Medicine groups, 3 women’s with mixed diagnosis, 2 men’s with mixed diagnosis	London Regional Cancer Program
2011	“Soul-Medicine: Targeted Therapy for the Fear Factor”, Poster Presentation	Multi-National Supportive Care Conference, Athens, Greece.
2015	Theoretical paper published, Butlin, H. (2015). “Psycho-oncology: Searching for Practical Wisdom? <i>Journal of Palliative and Supportive Care</i> . Vol 13(5), 1495-1500.	This paper examines ‘wisdom’ as a concept informing oncology care.

Table 1.1 Preparatory work for the study focusing on wisdom – con't

Date	Project	Location
2015	Book chapter. “Soul-Medicine: An Autoethnography”. [In press]. <i>Community-based healthcare: The search for mindful dialogue</i> . Ed. Higgs, J., Tasker, D. Sense Publishers.	This chapter is an autoethnography of developing the Soul-Medicine supportive care group in the context of oncology care. It includes a poem, <i>From the Heart of Healthcare</i> .
2016	Scoping literature review, Butlin, H., Kinsella, E.A., Garcia, C., Bauman, G. 2016. “Searching for wisdom in oncology: A scoping literature review”. <i>Journal of Palliative and Supportive Care</i> . [e-pub ahead of print]	This study presents findings from a scoping review examining the concept of ‘wisdom’, in the context of oncology care. done
2016	“The Legacy”. 2017. Poem and prose piece for a book, <i>Poetics Inquiries for Reflection & Renewal</i> . McIntyre, Purcell Pub. Inc., Lunenburg, NS.	Poetic inquiry written during professional and personal experiences at the bedside of people who were dying.
2016	Theory paper “Assisted Dying in Canada: Finding a wise-way forward” (in progress)	This paper calls for integration of reflective practice, reflexivity and practical wisdom, as assisted dying is integrated into health care cultures.

1.1.1 Researcher's Clinical Setting Of A Psycho-Oncology Spiritual Care Practice

1.1.1.1 *Psycho-Oncology: Searching For Practical Wisdom?*

This paper presents the first theoretical investigation to position the clinical context of “Soul-Medicine” supportive care groups within a rationale for choosing to study the concept of ‘wisdom’ in this doctoral research. It investigates a history of ‘soul’ in medicine. ‘Embodied soul’ was a concept held central to medicine, from Galen and Hippocrates to the early 1900’s, when it gave way to the separation of ‘body’ and ‘soul’ into discreet domains of science and religion (Bates, 2009; De Pablo & Evans, 1994). In contemporary medicine, there are emergent notions of ‘wisdom’ as *phronesis* in clinical practice with a return to Aristotle’s differentiation in aspects of wisdom, *phronesis*, practical wisdom, *episteme*, expert/technical knowledge, and *sophian*, philosophical/intuitive/spiritual (Kinsella and Pitman, 2012). The paper takes up a significant debate in the editorials of this journal between psychological views of ‘existential’ therapies and viewpoints representing ‘spiritual’ interventions in the field of psycho-oncology. It offers ‘wisdom’ as conceptual frame for a middle ground between those polarized debates.

1.1.1.1.1 *Introduction*

In a 2006 letter to the editor of *Psycho-Oncology*, Salander (2006) asked us to reflect on whether “spirituality” (p. 648) is a meaningful concept in the psycho-oncological discourse. He also argued that existential discourses are

more appropriate for discussing how meaning and purpose are experienced in the psycho-oncological context. In a letter to the same journal, Brennan (2006) expressed concern about conflation of the concepts *spirituality* and *existential*. Salander (2015) subsequently asserted that the question of whether spirituality is a meaningful concept remains open. These letters, as well as other conceptual and perspective articles (2002; Lazenby, 2010), have contributed to the rigorous academic debate about the meaning, definition, and potential conflation of such terms as “existential,” “spiritual,” and “psychosocial,” as well as appeals for inclusion of “spirituality” in healthcare as an integral dimension of human life, especially pertinent during illness (Puchalski, Vitillo, Hull, & Reller, 2014). Wein's (2014) recent letter responding to Salander's challenge (“Spirituality: Psyche or Soul?”) added the term “soul” to the mix. “Soul” also appeared in a May 14, 2014 email from the International Psycho-Oncology Society (IPOS) with the appeal to “help us put **body** and **soul** at the heart of cancer care.”

Salander's (2015) tongue-in-cheek suggestion that Wein's (2014) argument in favor of retaining “spirituality” as a meaningful concept within psycho-oncology “calls for no less than a new psychology of the human being!” (p. 2) might well be hitting the proverbial nail on the head. The debate about which term, *existential* or *spiritual*, is the most comprehensive for discourse in psycho-oncology is a highly academically bound discussion that loses most, if not all, relevance in clinical counseling rooms of oncology centers where we grapple with the *phenomenon* of meaninglessness, hopelessness, and purposelessness in individuals' lives with cancer.

Is it possible that these debates and IPOS's appeal for “body and soul” to be placed at the heart of cancer care reflect a growing, if tacit, quest, signposted by this term *soul*, for a more encompassing psychology, and for a medicine that *includes* dimensions encompassed by such terms as “spirituality,” “existential,” “soul,” and “body,” without setting them in opposition? Heralded by discussions on seeking new paradigms in cancer care (Breitbart & Alici, 2009), perhaps *this* is indeed the salient, challenging, and shared task of psycho-oncology.

1.1.1.1.2 A Search for “Practical Wisdom”?

Until such a new paradigm and language truly emerge, a potential guiding principle for psycho-oncology's investigations into “what helps?” when living with the impact of cancer could be drawn from recent research on Aristotle's notion of *phronesis*, or “the virtue of practical wisdom,” in practitioner and research practices (Kinsella, 2012b; Kinsella, 2006b, 2012a; Polkinghorne, 2004) Kinsella (2012a) suggested that *phronesis* “emphasizes reflection (both deliberative and that revealed through action) as a means to inform wise action, to assist one to navigate the variable contexts of practice, and as directed toward the end of practical wisdom” (p. 35). Are patients perhaps best served by researchers and clinicians working together to elicit such practical wisdom from the crucial experts, who are those living with the impact of cancer, rather than debating about which conceptual spaces have been occupied by which academic research disciplines (Salander, 2015, p. 1)?

1.1.1.1.3 *Is Psycho-Oncology on a “Soul Quest”?*

Edmund Husserl (b. 1859–1938) vigorously challenged the abstracting tendencies in objectivist sciences predicated upon the mind/body dualism by introducing phenomenology as *both* a science and a philosophy aimed at “elucidating lived experience” (Van Manen, 1997, p. 25). Van Manen (1997) suggested that such inquiry offers “plausible insights that bring you in more direct contact with the world” (p. 9). Smythe et al. (2008) contended that a hermeneutic-phenomenological approach grounds academic discussions in a focus on the *experience* of individuals that “resists being pinned down, refuses to be a set of steps, is enacted differently by each one of us, and yet shares a common quest” (p. 1390). Moreover, medical historian Donald Bates (2009) suggested that “medicine is *the* domain where soul and science are most uncomfortable, and yet most obliged to interact” (p. 70). Indeed, human interior life as well as the day-to-day “embodied reason” (Polkinghorne, 2004, p. 129) within clinical judgment in a clinician's unpredictable daily practice has a tendency to refuse being “pinned down” and rarely conforms to the “set of steps” required by academic conceptual analyses or even in evidence-based clinical guidelines (Fenwick, 2014). Perhaps due to psycho-oncology's interests being situated in cancer care where the intangible realm of human interiority meets the biomedical evidence-based paradigm, such debates might reflect the uncomfortable interaction between soul and medicine.

With cancer rates on the rise (Government of Canada, 2017) and its impact touching us all deeply, both professionally and personally, a new

psychology healing the Cartesian split of mind and body becomes deeply compelling in this clinical context. Indeed, a bio-psycho-spiritual model of care has been explicitly suggested (Sulmasy, 2002). Yet, this model, as well as the term, is a building-block approach to the separated parts of biomedicine and the psychiatric/psychological/spiritual domains. So far, this proposed concept has not generated the necessary paradigm shift and ensuing conceptual transformation for a truly integrative approach within oncology. In clinical teams, these “parts” still tend to remain separated into clinical disciplines, each with their own specialized discourses with varying domains of power and influence within the medical institutions where oncology is practiced.

An appeal arising from the impact of this separation of domains calling for a reintegration of some notion of *soul* in medicine was expressed by Anatole Broyard (1992), an editor for the *New York Times Book Review*, writing during treatment for the cancer that would eventually take his life:

I would like a doctor who is not only a talented physician but a bit of a metaphysician, too—someone who can treat body and soul. There's a physical self who is ill and there's a metaphysical self who is ill. (...) To get to my body, my doctor has to get to my character. He has to go through my soul. (...) I would hope that my doctor's authority and his charisma might help protect me against what anthropologist Richard Shweder calls “soul loss,” a sense of terrible emptiness, a feeling that your soul has abandoned your ailing body like rats deserting the ship. When your soul leaves, the illness rushes in. I used to get restless when people talked about soul, but now I know better. Soul is the part of you that you summon up in emergencies. (p. 40)

Broyard exemplifies how this emergent term of *soul* seems to function as a subtle courier for those dimensions of human life and the illness experience

remaining beyond our clinical reach even where there are bio-psycho-spiritual interdisciplinary teams functioning in cancer centers.

This point is illustrated by such physician leaders as Rachel Remen (2006), who have called for the *re-ensouling* of medicine. Remen (2008) linked this process to the need to embody and reclaim healing wisdom in medicine, and, as one means to this end, she pioneered a program for integrative training and formation of physicians as whole persons, reintegrating exposure to the humanities and the notion of the “healer’s art” within the practice of medicine (Rabow, Remen, Parmelee, & Inui, 2010) David Whyte, renowned poet and a consultant for a variety of healthcare institutions, once proposed that “the soul of medicine is on trial at the moment” (Reece, 2000). Discussions using the term *soul* in connection with medicine are being engaged in by contemporary psychotherapists (Cornett, 1998; St. James O’Conner, Lund, & Berendsen, 2013), bestselling authors (Moore, 1989, 2010), patients (Broyard, 1992), clinicians (Byrne, 1999; Harvey, 1997; Murray, 2000; Picard, 1997; Sinclair & Pereira, 2006), and medical educators (Kuczewski, 2007). Soul is thus emerging into contemporary discourses about medicine with a broad range of meanings. In some cases, it is merged with spirituality (Peteet & D’Ambra, 2011; Sinclair & Pereira, 2006), while in others it mediates distinctly intangible meanings such as articulating a need for “reclaiming the soul of medicine” (Gale, 2009; Hill, 2005). As such, this non-academically defined term – *soul* – seems to be pointing Western medicine toward an intangible “something missing” dwelling in the “in-betweens” (Kalschad, 2013) rendered inarticulate in the liminal interstices

between academically circumscribed clinical and research discourses and their vigorous debates.

This “something missing” signposted by the re-emergent *soul* was lost, according to some medical historians (De Pablo & Evans, 1994; Hacking, 1995), along with the philosophical and biomedical splitting of body and mind. Prior to the 18th century, the soul was at least a dimension of medical discourse and medical care regardless of its contested meanings and implications within medical practices (Dolan, 2007; Hankinson, 2009; Yoshikawa, 2009). Yet, questions need to be asked: “What are these discourses *meaning* when using this term *soul* within ‘medicine?’” And, more importantly, what might *soul's* meaning(s) be for those living with cancer in our treatment centres? Further, how does the term *soul*, proclaimed in IPOS's email, help or hinder the ongoing debate about human interiority when living with a disease such as cancer? Not all of these questions can be answered. However, they are currently being explored in *Soul Medicine* research studies, employing a hermeneutic-phenomenological methodology, turning to patients as the acknowledged experts in an endeavor to mine for *soul's* meaning in daily life and its potential relation to practical wisdom.

1.1.1.1.4 Soul-Medicine: A Paradigmatic Example Illuminating “Wisdom-in-Action”

Commencing in 2009, some 10 support groups with an explicit focus on eliciting individuals' personal and practical wisdom on “What helps me to live with

this cancer in daily life?” have been facilitated deliberately utilizing this term—*soul*. The groups have been given the name *Soul Medicine*, and they explore what “medicines” for this intangible dimension—*soul*—might mean in the daily lives of participants. Each group runs in 1.5-hour sessions for six weeks. *Soul* is engaged using Hillman's later articulation of its meaning(s) (Moore, 1989): First, *soul* refers to the *deepening* of events into experiences; second, the significance *soul* makes possible, whether in life or in religious concern, derives from its *special relation with death*. And third, by *soul* I mean the imaginative possibility in our natures, the experiencing through reflective speculation, dream, image, and *fantasy*—that mode which recognizes all realities as primarily symbolic or metaphorical (p. 21).

Soul has thus been given a pragmatic meaning, rather than only a religious or spiritual meaning, linking it to our capacity to imagine, create, lament, and celebrate and, most importantly, to discover a participant's own unique wisdom. Content includes art, music/meditations, story, poetry, collage, and readings from fiction and nonfiction, including diverse spiritual and philosophical writers arranged weekly around the themes that have emerged from group to group. This notion bypasses the debate about “spiritual” or “existential” for those participants, who do not relate to either of these concepts. *Soul Medicine's* intent is to engage Freeman's (1998a, 1998b) sense of the “poetic self,” where the “narrative fabric of the self that lies beyond the reach of biomedical discourses holds potentiality to “knit [the self] back together” (Freeman, 1998a, p. 48).

The benefits perceived by the participants in the first six groups were presented at two international conferences (Butlin, 2010, 2011). Doctoral research began in 2013 focusing on the notion of phronesis: practical and embodied (Johnson, 2007; Lakoff & Johnson, 2003) wisdom gleaned through the group process exploring “soul medicine(s)” in day-to-day life. Hermeneutic phenomenology is the chosen methodology due to its focus on illuminating such intangibles within lived experiences (Finlay, 2011). Participants are encouraged to be their own investigators seeking lived experiences, rather than conceptual definitions, that best source a sense of hope, peace, balance, strength, and connectedness in the day-to-day, as well as discover their uniquely personal meanings for these concepts. The groups also provide a means to give voice, if needed, in story, art, and tears, to the painful feelings of despair and hopelessness, and the struggle for meaning in life. Expressions of lament or mourning are given equal value as “soul medicines,” as well as silence and wordlessness, lest a subtle “tyranny of positive thinking” (Holland & Lewis, 2000) and pressure for verbal forms of expression forms tacitly. The group sessions provide a place to return and share stories of their findings gleaned from day-to-day life. Group sharing may or may not include discussions on spiritual matters or beliefs; rather, it is driven by *stories* as sources of wisdom and therapeutic healing of distress (Frank, 1995; Mehl-Madrona, 2007) from living with cancer. Each participant, through the telling of their discovered “soul medicines,” contributes to an imaginative “wisdom epistemology” of word and image about “what helps in the day-to-day,” gathered cumulatively throughout the six weeks.

Soul Medicine groups thus offer an alternate discourse space within biomedical “chart talk” (Mattingly, 1998; Mattingly & Hayes, 1994) that include, in our centre at least, repeated screening assessments focusing on algorithms for anxiety and depression. These algorithms can often exclude other types of assessments or discourses of distress, such as “spiritual” or “existential,” unless individual clinicians choose to invite such assessment conversations. In discussions with referring clinicians, anecdotally, the language of “soul medicine” within our center's clinical context has opened up a different type of conversation in the screening conversations with social workers, psychiatrists, physicians, and nursing and radiation therapists assessing appropriateness for each group.

1.1.1.1.5 *Inner Wisdom as “Navigator” or Compass*

Smythe et al. (2008) once suggested that “*techne* [know-how] that predefines a ‘way’ has silenced lived *phronesis*, the wisdom-in-action that knows in the moment and finds the way day-to-day” (p. 1390). “Use your inner wisdom” was highlighted in Back and colleagues' (2014) research as a statement and concept highly valued by patients at crucial points in their illness trajectory. From women living with the acute uncertainty provoked by an ovarian cancer diagnosis, the current research aims to elicit such inner wisdom. Most specifically, it aims to investigate in their lived experience(s) how *phronesis*, the virtue of practical wisdom, *functions* in their daily lives as an inner navigator for living in the here-and-now, as Vos (2014) recently discussed this concept within

his philosophical framework for meaning and existential givens in psycho-oncology (pp. 9–10).

1.1.1.1.6 Conclusion

In a personal interview, Rachel Remen asserted, “the soul of medicine is still alive in people. It’s just gone underground. We are finding what is unchanged in people, giving it a voice, giving it community, and strengthening it in order to preserve the integrity of our profession, not only for ourselves, but also for those who are coming after us” (Karolyn, 2006, p. 93). With the prevalence of cancer, surely our shared focus is on living life fully, what helps us all to do so, and how we can best serve our patients in this endeavor, carefully remembering that they are their own best “experts.” Perhaps our primary responsibility in psycho-oncology is to elicit and pass on their hard-won “wisdom” about living and dying.

1.1.2 The Researcher

1.1.2.1 Reflexivity and “Outing” Researcher Subjectivity

This section offers a reflexive work using the methodology of autoethnography conducted in preparation for the doctoral research. It was published in the book, *Community-Based Healthcare: The Search for Mindful Dialogues* (Tasker, Higgs, & Loftus, 2017). The chapter is based on an in-depth autoethnography that formed my doctoral comprehensive examination paper.

1.1.2.2 *Soul Medicine: An Autoethnography*

1.1.2.2.1 *Prologue: A Morning at 'Work' – 2007*

A young mother sits in front of me. She is thirty-six and has three children under thirteen. She's in the clinic room, with its narrow, cold table and two chairs. She's just been told she has an aggressive breast cancer. Her breasts will be taken from her within two weeks. Her hair - all her body hair - eyelashes included, will fall out during six weeks of chemotherapy. She cannot work, so she and her husband will be unable to pay their bills.

"How do we tell our children?" She looks at me with tear-filled eyes and numbness clouding her pain.

How indeed? I look at this young mother, arms crossing her breasts, holding them as if for dear life. The breasts that likely nurtured her children and now are to be sliced off.

"Tell them the truth, simply, with straightforward facts and be available afterwards, spend lots of time with them together and individually... Let them come to you with questions... ..It's ok to let them see you cry... Show them emotions aren't something to be afraid of, and share yours with them so they're not afraid of their own."

No happy ending here. No profound moment of spiritual care shining in the darkness of another's suffering. Just sitting with them in the fragments of their shattered lives.

She makes eye contact as she leaves. "Thank you."

I leave what I call 'work,' which is really a wilderness trek through a ravaged land of broken lives, full of crevasses, landmines, and sudden storms. A land also with bursts of the most glorious sunshine and stunning beauty imaginable as lives break open to deeper truths and radical transformation... Sometimes.

1.1.2.2.2 *Introduction*

This autoethnography offers an inquiry into the lived experiences of being a single spiritual care practitioner and registered psychotherapist in an urban regional cancer treatment centre in Canada. It tells a “counter-story” (Frank, 1995) of soul in medicine. Autoethnography uses the personal lens based on the understanding that culture is embedded within personal experiences and is perpetuated, resisted or transformed through persons (Ellis, 2004). It can integrate the “heartful” (Ellis, 1999) and the creative (Richardson, 1994) and so the conceptual framework at the heart of this inquiry is “poetic resistance” offered by Kinsella (2006a) in her paper entitled *Poetic Resistance: Juxtaposing the Personal and Professional Discursive Constructions in a Practice Context*. Kinsella (2006) points to the necessity of poetic resistance in response to current economic and instrumentalist drivers behind institutional and community based healthcare programs and professional education (Kinsella, 2012a). Poetic resistance uses poetic reflection to question taken-for-granted meanings, challenge dominant discursive constructions, offer alternative interpretive possibilities, and to gain new insights within a given context (Kinsella, 2006a). This chapter engages with this conceptual framework offering a paradigmatic

example of the author's experience developing an outlier service, Soul-Medicine (Butlin, 2015b), within a biomedical oncology treatment centre.

Soul-Medicine reclaims ancient philosophical meaning(s) of 'soul' in the medical context (De Pablo & Evans, 1994) rather than using its religious reconceptualization by the medieval-Christian west. It developed from individual counselling and psychotherapy sessions in 2007–2009, engaging in mindful dialogues with patients intentionally attending to their language of soul, spirit and body attuning to what helps to assuage spiritual-existential distress. I learned from these individuals what kinds of soul-full interventions nurture strength, hope, mindful attunement to the present moment in daily life to sustain them in finding some ground under their feet for today, hope for tomorrow and to “put fear second” when looking to the future. In 2010, it further evolved into a support group process incorporating poetics, art, music meditation, mindfulness practices with nature and spiritual or wisdom literature. It was titled Soul-Medicine as a means for embodying a form of 'poetic resistance' in the institutional, biomedical healthcare context and to release a submerged language of soul in medicine (Remen, 1996; St. James O'Conner, Lund, & Berendsen, 2013; Vachon, 2008).

Community care contexts, while different from institutional healthcare centres, face similar challenges in offering care at the interface of competing and at times opposing discourses between those driven by biomedicine, policy and economics and those most needed by the person in the encounter with their healthcare practitioner. This chapter fosters dialogue and offers encouragement for kindred spirits in other soul-wearying healthcare contexts. I see the fatigue of

heart and soul etched on many faces around me. Their words betoken a soul-pain arising from the ethical confrontations and emotional wounds of attempting to create a soulful, compassionate practice, within the tensions of medical dilemmas and the sheer volume of new patients. Some of the impetus for this autoethnography is to give voice to this. ‘En-souling’ medicine is our shared task (Karolyn, 2006; Reece, 2000).

1.1.2.2.3 Medicalization and “Poetic Resistance”

Kinsella (2006a) writes,

Reflecting on practice through poetic form, what I call poetic resistance, can raise questions about the link between theoretical and practical concerns within the public sphere of professional practice. (p. 39)

In both institutional and community based healthcare contexts the dominant biomedical discourse can be painfully constraining to both practitioner and client. A client’s vulnerability is exposed through a health issue forcing them to seek healthcare, yet this deeply human vulnerability tends to meet a dominant discourse inscribing the health care conversation through a process termed “medicalization” (Conrad, 1992).

Poetic resistance carves out a space for alternate discourses to these dominant discourses that may be constraining or even annex other, more needed and healing discourses in the clinical encounter. Conrad (1992) explains,

Medicalization consists of defining a problem in medical terms, using medical language to describe a problem, adopting a medical framework to understand a problem, or using a medical intervention to “treat it”. This is a sociocultural process that may or may not involve the medical profession,

lead to medical social control or medical treatment, or be the result of intentional expansion by the medical profession. (p. 211)

This medicalization of human experiences in illness, physical challenges and mental-emotional-spiritual struggles can constrain the health care practitioner's real-time encounter with the person in front of them. Economic factors also limit the amount of time that can be spent with each client potentially coercing the practitioner to engage in behaviours that embody, despite their best efforts, efficiency over efficacy. The medicalized conversation thus tends to exclude or submerge dimensions of the patient's unique narrative about their suffering and soul-pain (Mehl-Madrona, 2007).

Broyard (1992) asserts that the therapeutic relationship often requires this submerged human, person and soul-full narrative, to be engaged. As a result, practitioners are frequently ethically and morally required to skilfully allow space for these submerged discourses in order to engage therapeutically and meaningfully with their client and give them agency to describe their struggle in their own terms. These submerged discourses can include telling their story in their own way, time and with their unique, descriptive language, grief support, story-sharing, spiritual and wisdom sharing. They engage with those aspects of personhood that throughout time have been expressed through poem, story, song, and are captured in spiritual and wisdom literature, humanities and philosophical discourses. These clinical conversations may include expressions of lament, mourning, celebration, and spirituality ideographically disclosing experiences of sacredness in living and dying.

The challenge to create space for the whole person in the client/patient's clinical care such that they can express their needs, tell their story and to foster a healing therapeutic relationship as the site of giving and receiving medical care is faced by clinicians of all stripes in both institutional and community based health care settings. This therapeutic relationship, grounded in mindful attunement to the other, is the foundation of the essential meaning of health "care". Without it, there is little health and, potentially, a disturbing exile of care.

1.1.2.2.4 The Politics of Soul

Rising forces of a "politics of evidence" (Cheek, 2008, p. 278) are shaping much of the contemporary research landscape, fuelled towards an incessant economically driven pragmatism (Rossiter & Robertson, 2014). Living in these politics in front lines of healthcare, many can attest to this political force and its impact.

Carl Jung (1970) would call the social forces of the world around us 'collective forces.' And they are forces. If you have ever tried to speak about soul-suffering, or more pragmatically dying, in a multi-disciplinary "tumour board rounds", where nurses and allied health practitioners sit at the edge of the room and physicians sit at the centre table, discussing tumours and treatment options, you can understand forces of the collective. The ideological battle between the interior domain of the ensouled person and the medical-scientific domain, with its focus on a medicalized person whose body is a treatment site (Pauly Morgan,

1998), is extremely current and real. Yet, despite these fragmenting forces within treatment centres, patients' encounter deeply compassionate professionals.

1.1.2.2.5 *The Logic of Soul*

Hacking (1995) asserts,

We have learned how to replace the soul with knowledge, with science” and concludes, “Hence spiritual battles are fought, not on the explicit ground of the soul, but on the terrain of memory, where we suppose that there is such a thing as knowledge to be had. (p. 6)

A language of soul seems collectively lost, or at least forgotten.

What is ‘soul’? Not an easy notion to define. It is easier to experience than to grasp conceptually. Meanings of ‘soul’ seem far more communicable through arts, humanities, and music than through facts. Hacking offers:

One person, one soul, may have many facets and speak with many tongues. To think of the soul is not to imply that there is one essence, one spiritual point, from which all voices issue. In my way of thinking the soul is a more modest concept than that. It stands for the strange mix of aspects of a person that may be, at some time, imaged as inner – a thought not contradicted by Wittgenstein’s dictum, that the body is the best picture of the soul. (Hacking, 1995b, p. 6)

Christos’s (1976) philosophical view asserts a logic of soul, distinct from science and philosophy:

We are faced with the task of coming to terms with the fact impressing itself on us with growing urgency, that the soul has a logic of its own, an experience of its own not to be seized by languages appropriate to physical phenomena on the one hand, and to mental processes on the other. (p. 7)

1.1.2.2.6 The Language of Soul

Soul-Medicine's one-on-one and group sessions with people facing their own mortality through cancer include an archaeological endeavour into the interior realms of the psyche to retrieve and ancient memory, felt in our bones (Woodman, 2001), that suffering has dimensions of soul suffering that nothing less than a soul-medicine will assuage. In our cancer centre, what constitutes soul-medicine has been the focus of inquiry, person by person, in their daily life and in our sessions, as well as in the groups. While Western culture has deeply bound and conditioned medieval religious meanings to the word 'soul,' (De Pablo & Evans, 1994b; Yoshikawa, 2009b), with the meaning that Hacking ascribes, it is that aspect of our human interiority that lies beyond the reaches of the cognitive sciences. For Bachelard (1969), an early twentieth century philosopher of science, soul is that dimension of human life where, as the saying goes, pictures speak a thousand words and can cut through as well as express existential-spiritual pain with a remarkable precision. Deep in our psyche, suggests Bachelard (1969) in his phenomenology on imagination, dwells the language of soul, communicating in images, feeling, intuition, metaphor, dreams, wisdom from the ages, and through contemplative reverie comes the penetrating insight of the poet, artist, sage, and shaman. Poets and sages are part of every organisation and institution, often silently writing poems, creating art, and offering salient wisdom and heart-healing stories to patients and colleagues yet their work is hidden from documentation or professional discourses.

1.1.2.2.7 *Soulful Spaces*

Todres (2007) describes a “soulful-space” in the relational dimension of psychotherapy – “a spaciousness in which vulnerability is embraced” (p. 162). This type of interaction is difficult for practitioners dealing with brief, problem-focused assessments, algorithms to screen for psycho-social distress, and countless people to be seen and treated every day. Yet despite these constraints many try to carve out time for more in-depth, person-centred conversations with their clients/patients. However, all too often such efforts seem futile with economic drivers and benchmarking determining how clinicians deliver their care. A particular kind of healthcare despair can creep into the heart and soul of the most caring clinician, eroding hope in change. Is it possible that a “poetic resistance” is called for globally to preserve the care in the delivery of ‘health-care’?

1.1.2.2.8 *Soul-Medicine as “Poetic Resistance”*

Poetic resistance is certainly Soul-Medicine’s discreet aim in the medical context. Kinsella’s (2006a) article was perhaps prophetic towards how the arts, humanities, and health sciences, through visionary individuals, are “trying to find their way back into an interdisciplinary relationship” (personal conversation with Dr Carla Garcia, psychiatrist in the London Regional Cancer Program and faculty member, Western University, Schulich School of Medicine and Dentistry). She has voiced a quest, emerging in many health-science disciplines and training programs, for a poetics of wholeness and soul-filled human experience to find

their way into the discourses of science. Kinsella's work on rediscovering and reintegrating phronesis (practical wisdom), which arose from her own clinical practice, proposes a fluid movement between clinical practice wisdom, health education, and research domains (Kinsella, 2006b, 2007; 2010a, 2010b, 2012; Kinsella & Vanstone, 2010).

The central question at the heart of Soul-Medicine group inquiry is articulated by Freeman (1998a):

Insofar as the modern historicised self has effectively become severed from the mythical domain, the narrative fabric of the self has become frayed ... an important task for thinking in modernity is to begin to imagine how the narrative fabric of the self may be *knit back together*. (emphasis mine. (p. 48)

The biomedical discourses, even when clinicians deliver them with deep compassion, offer little to 'knit the self back together.' Something far broader and more poetic, with distilled living wisdom is often needed. Despite all the gains of biomedical technology, the struggling pass through my office door. They are responding, I believe, to a "mytho-poieic desire" (Freeman, 1998a, p. 45) that thirsts for poiesis (creating) the poieic and mythical-archetypal, to overcome a feeling of fragmentation by the cognitive-rational knowledge(s) of cancer including the repetitive screenings for depression and anxiety reinforcing the "psy" (Rimke, 2010) sciences overwriting of soul language for distress (Hacking, 1995). The 'dark night of the soul' (May, 2005; Starr, 2003) – St John-of-the-Cross's powerful term – requires nothing short of Freeman's call to meet the mytho-poieic self poetically and meaningfully.

1.1.2.2.9 *Poetics of Experience*

Mair (1989) describes “the poetics of experience” in psychotherapy and worries about its disappearance:

If we destroy the whole world of experiencing, destroy the infrastructure on which they can grow and achieve recognition, then they will not exist. Needs can disappear. We can come not to need or to recognise what could otherwise have been. We could become devoid of poetic passion. We could become carefully groomed constructions of factory-made components, not voice in pain. (p.247)

The clinical interventions of Soul-Medicine are essentially such a poetics of experience. They take place within a therapeutic clinical relationship, grounded in psychotherapy and spiritual care training, as well as within a clinical service that makes soul-care visible in health care. The poetics arise through Mair’s (1989) “conversation of our lives” (p. 258). The medicines are multi-dimensional and encompass a double-meaning of Western notions and indigenous meaning(s), learned from First Nations friends and elders. They have taught me that all living relations, the whole earth we belong to, are ‘medicines’ for the whole person, without dualism of ‘body’ and ‘spirit.’ Soul-medicine is a linguistic reintegration of this wisdom of the first peoples, which colonialists tore asunder and then repressed.

1.1.2.2.10 *Soul “Medicines”*

Medicines of Soul-Medicine include therapeutic presence (Chochinov et al., 2013), compassion, poetry, art, collaging, dreams, music, and giving space to explore personal expressions of the soul’s symbolic language of suffering and

hope. Soul-Medicine supports, guides, and offers ingredients of soul from diverse wisdom traditions and their practices, as well as the images, dreams, and narrative inherent in the living conversation. This cornucopia assists people living with cancer in seeking a sense of integration and wholeness. It renders an invisible realm visible, as Mair (1989) suggests:

Our places of human habitation are mostly invisible. We will have to conjure out of invisibility the worlds that we inhabit. To do this we need a poetic imagination to speak of our experiencing within the ongoing conversation of our lives. To speak of what we know and do not know takes artistry, the startling uncertainty of new ways. The familiar narrative forms of 'behavioural science' will not do. (p. 258)

Soul-Medicine is such a conjuring of a world out of invisibility. It is made visible by asserting clinical space, discourse in medical charts, rounds and consultations, and professional conferences. Such "soul treatment" strives to give voice to the personal, the interconnected, the relational, the feeling, the intuitive, the story, and the poetic that feed poiesis, creative living, and strength in suffering. Such a *poiesis* cannot be reduced to its parts to be studied or treated without losing something deeply important for the assuaging of grief and lament (Freeman, 1998a, p. 45, 1998b, p. 461). Soul-language conserves explorations of despair and hope as part of the human experience of struggle-in-life. Poetry, story, meditation, art, music, silence, laughter, exploring metaphors and images used to describe interior experiences are all potential medicines for the soul. This clinical domain of soul-medicine and its discourses are my own version of poetic resistance to the fragmenting, dignity-eroding (Chochinov, 2007) aspect of our medical context. To be clear, I do not suggest that soul language should *replace*

other clinical discourses. I propose merely for the *release* of such a discourse and its potential, illuminated by patients' narratives, from a Berlin Wall type annexing in medicine with its own iron curtain separating the soulful realm from integration with medical treatment. There is no clinic to treat the soul.

Soul-Medicine is thus the co-creation of many individuals in a daily, dyadic inquiry into the existential wilderness of cancer for both patients and clinicians. Many of my colleagues and other clinicians have engaged in soul-full practice, engendering living wisdom and healing interventions. Soul-Medicine, through its poetic, resistive actions, seeks to offer "treatment" for the "soul that is lesioned" (Hacking, 1995, p. 5).

1.1.2.2.11 '*Comunitas*' and '*Conspiratio*'

In Ellis's (2002) words:

Good autoethnography works towards a *communitas*, where we might speak together of our experiences, and commonality of spirit, companionship in our sorrow, balm for our wounds, and solace in reaching out to those in need as well. (p. 41)

May this story, my story, provide some soul-food to you for sustaining your own poetic-self in poetic-resistive acts, interventions, and discourses in your own life.

May it also be an invitation to trust the pathless-path and foster in your own work-life Ivan Illich's notion of *conspiratio* -- the conspiracy of friendship (Taggart, 2011), which Dr. Kinsella told me about in an e-mail as we reflected on the connections between Soul-Medicine and her call for poetic resistance. It is *conspiratio* in hallway and coffee line conversations incepting creative alliances that have evolved Soul-Medicine, one relationship at a time. *Conspiratio* speaks

to the power of such intangible relational forces that can perhaps offer some hope for the soulful and soul-seeking practitioners in healthcare.

1.1.2.2.12 Afterword...

*soul-medicine's story comes to rest
for now
we are but movement and story... story-ing our lives
within nature's story-ing us
stories... lives
endlessly birthing
dying
in a world where spring follows winter.*

For John Graham Butlin, 1930–2014

1.2 STUDY POPULATION

1.2.1 Ovarian Cancer: Searching for Wisdom?

In oncology care, I've worked with many women living with ovarian cancer, and became interested in focusing on the 'wisdom' expressed by this population in my research. This is a unique population for many reasons, not the least of which includes the existential crisis many women with this diagnosis face in light of challenging mortality rates. Most women present with advanced stage (III or IV) at diagnosis and overall mortality rates are high: 63%-75% (Holschneider & Berek, 2000). Prognosis of a woman diagnosed with stage III or IV ovarian cancer is likewise guarded with median survivals in the range of 3 – 5 years (CCS, 2014; NCI, 2014). For those women diagnosed in earlier stages it can still

be difficult to live with the fear of recurrence (Lebel et al., 2014). Studies over recent decades have highlighted the particularly unique and acute challenges faced by women with ovarian cancer (Burles & Holtslander, 2013; Grzankowski & Carney, 2011; Guenther, Stiles, & Champion, 2012; Schaefer, Ladd, Lammers, & Echenberg, 1999). Once first line surgery and chemotherapy for ovarian cancer is completed, the most acute need is related to the distress and uncertainty (Beesley et al., 2013; Ekwall, Ternestedt, & Sorbe, 2007; Schulman-Green, Ercolano, Dowd, Schwartz, & McCorkle, 2008).

Ahlberg and Nordner (2006) stress the importance that a support group experience plays in providing women with connection to others living a similar experience. Landsbergen et. al. (2010) contend from their study that a psycho-education group can meet informational needs but does not alleviate the psychosocial distress ovarian cancer triggers for the women living with it. Recent studies show that structured psycho-educational and cognitive-existential support-groups are potentially a helpful intervention assisting women to cope with these challenges (Ahlberg & Nordner, 2006; Lebel et al., 2014). Given that many women with ovarian cancer find their way to my office for supportive counseling, psychotherapy and the support groups (Butlin, 2010, 2011) and in light of the potential benefits for this population, I proposed to examine the wisdom that women express as they face stage II to IV ovarian cancer. Within the groups run from 2009 – 2012, one pilot group was specifically offered for with women with ovarian cancer. This group voiced a need for ongoing support groups specific to ovarian cancer as they described feeling alienated in groups where other

cancers, with less life threatening implications, were shared in other participant's narratives.

Malterud's (2008) words speak to the importance of recognizing the wisdom generated through insider – in this case patient - experiences:

Expert knowledge runs the risk of becoming self-affirmative, maintaining stereotyped positions and attitudes. Furthermore expert knowledge cannot be expected to cover insider experience, and may therefore be insufficient for understanding complex human and social phenomenon. Research drawing on the wisdom of lay people, striving for a high level of pragmatic validity while maintaining the basic standards of scientific studies, can make a difference. (p. 1140)

Women living with ovarian cancer need not be framed only as recipients of 'expertise' in care for 'their' challenges and suffering. Their very closeness to a most real and difficult suffering, facing a radical confrontation with their mortality for an extended period of time framed by a relentless uncertainty about their future, positions them as potential sources and generators of wisdom due to nature of the suffering often provoked by this diagnosis (Arriba, Fader, Frasure, & von Gruenigen, 2010; Ferrell, Smith, Juarez, & Melancon, 2003). It also positions them as 'expert researchers' into the phenomenon of wisdom and what supports its formation in such circumstances.

1.2.1.1 Patient's Wisdom: What Is It? Why Is It Important?

Ovarian cancer presents one of the most acutely difficult psychological experiences of knowing one will likely experience a recurrence in the next 2-5 years but not knowing when or how it will return (CCS, 2014). In this way it is a life context where the fundamentally salient characteristics of 'wisdom' as (1) a

capacity to tolerate ambiguity, (2) manage uncertainty and (3) self-regulate emotion (Ardelt, 2003; Baltes & Smith, 1990; Glück & Bluck, 2013; Webster, Taylor, & Bates, 2011) may be needed if any quality of life is to be experienced in the day to day. It is possible that the compressed time frame of prognosis which necessitates a deliberate and time sensitive contemplation of these issues may mean that this population can offer insights to a broader community of people for navigating these existential challenges beyond this specific diagnosis as they are common to being human, even beyond living with cancer. This reverses the more paternalistic notion of patients as only 'recipients of care' and reframes the women as 'insiders' to a specific type of knowledge, in this case wisdom, as it is embodied in their lives, that is valuable for the clinicians and administrators of the systems to learn from in providing their oncology care.

Post-traumatic studies focusing on cancer indicate that it can be a psychological and spiritual trauma leaving a significant wake in the inner life of the individual suggest that cancer leaves its effects long after the tumour is removed (Boyer & Cantor, 2005; Kangas, Henry, & Bryant, 2002; Schulman-Green et al., 2008). Post-traumatic growth studies (Austin, 2001; Cordova, Cunningham, Carlson, & Andrykowski, 2001; Janoff-Bulman, 2004) also indicate that not all these effects are negative and that 'benefit-finding' can be a significant aspect of the experience for some (Costa & Pakenham, 2012). One clinician has formed a 'wisdom-therapy' intervention that aims to facilitate this post-traumatic growth momentum in severely embittered individuals, but not in the oncology context (Lieberei & Linden, 2011; Linden, 2008).

The evolution of wisdom may be seen not only as an individual cognitive process, but also as embodied and relational. Wisdom researchers report that “social interaction plays a significant role in wisdom-related performance” (Küpers, 2007, p. 173; Staudinger & Baltes, 1996). Both Yang (2008) and Küpers (2007; Küpers & Statler, 2008) argue that wisdom evolves as an “emergent event” arising from the “space in-between” (Küpers, 2007, p. 181) rather than simply being a form of static knowledge one ‘possesses’. Küpers (2007) specifically calls for developing and fostering embodied wisdom through “post-dualistic relational forms of wisdom” (p. 181) and also in-group situations that foster a “wisdom supportive environment” (p.185). This notion of ‘space-in-between’ as wisdom formative, echoes Galvin and Todres (2008) notion of “embodied interpretation” (p. 313) arguing that experience dwells somewhere between the “first or third person position” (p. 314). As such, embodied, post-dualistic and relational spaces that open towards fostering wisdom can examine and illuminate the ‘space-in-between’ researcher and participant. They state,

As researchers engaged in offering embodied interpretations we wish to reflect themes that communicate something of the uniqueness of individuals’ experiences, as well as the shared intersubjective horizons within which any unique experience occurs. This frees us to a form of poetic re-presentation that does not merely stick to the same words as our interviewees, because the experience that we wish to understand and portray is neither fully another’s alone, nor is it fully our own. Rather it reflects a meaningful-world-with-others. Embodied interpretation addresses itself most to the relevance of an existential level of understanding; that is a level of understanding that wishes to honour the places where commonality (community) and uniqueness (individual) meet. Such sensed understanding is an event where meaning can ‘come home’ to persons. (p. 314)

Furthermore, Hauser-Meyer (2006) conducted a retrospective phenomenological study with 7 women living with advanced breast cancer, who practiced Transcendental Meditation focusing on their existential experiences. Her study illuminates the possibility that meditation may foster a sense of 'inner wisdom'. She writes:

Initially, these women came to meditation looking for freedom from fear, and what they discovered was an inner wisdom that gave peace, hope and meaning in their lives, with improved physical health for some. (p.2)

Yet the term 'inner' falls once again into the dualistic split incepted with the mind/body Cartesian dichotomy. Wisdom is possibly more fundamentally an embodied concept than solely a cognitive one, while cognition and intelligence can certainly play a significant role (Jeste, 2010; Sternberg, 2001). Wisdom is, as well, differentiated from spirituality and religion while both can be implicated in experiences of personal wisdom (Wink and Dillon, 2013).

Women with ovarian cancer grapple with "the fundamental pragmatics of life" (Baltes & Staudinger, 2000, p. 125) which is identified as a characteristic of wisdom. Every day these pragmatics must be addressed and creatively problem solved to respond to the existential question, "How do I live with this?", meaning how does one live with a life-threatening diagnosis as I drop my kids off to school, get sick from chemotherapy, lose my hair and embarrass my children in public (or myself perhaps?), fear I won't see them graduate, tell my mother who is very elderly and this might just cause her to give up and die, all concerns described in counseling sessions in my office. The varieties of 'how' that arrive

reflect the multidimensional psychological, existential-spiritual challenges of life with cancer.

This study acknowledges a turn that is taking place in recent decades towards more embodied understandings of knowledge (Ferrari & Weststrate, 2013; Kinsella, 2015; Küpers, 2005; Sternberg & Jordan, 2005) and seeks to attend to the embodied dimensions of wisdom in addition to cognitive aspects from the experiences of the women living with this diagnosis.

1.2.1.2 *Clinical Interventions Targeting Wisdom*

Bangen and colleagues (2013) recent review on wisdom research suggest that studies on wisdom in *clinical* contexts has been scarce (p. 1264). In their discussion they state, “Despite increasing research focus, wisdom has received little clinical attention... To our knowledge, only one psychotherapy technique has explicitly targeted increased wisdom as a therapy goal” (p. 1264). Further to this point, they recommend a focus on research on developmental processes of wisdom rather than “wisdom as an outcome” (p. 1264).

Bangen et al.’s (2013) literature review highlights the variety of areas wisdom has been researched. The only psychotherapeutic intervention with wisdom as a therapeutic goal has been in the area of trauma and post-traumatic growth (Abernathy, 2006; Linley & Joseph, 2004, 2004; Linley, 2003). They highlight wisdom’s relation to ethics; for example LeBon (2001) discusses how wisdom is tacitly involved in the ethics, interventions and relationships interwoven into therapy that inherently strives to be ‘wise’. They discuss wisdom as an

emergent concept described as a capacity for “benefit finding” from adversity as an aspect of wisdom (Low, Bower, Kwan, & Seldon, 2008) and this is grounded in focusing on the positive strengths in human experience rather than simply psychological pathologies (Robbins, 2008; Schneider, Pierson, & Bugental, 2014; Seligman & Csikszentmihalyi, 2000).

In the scoping review conducted for this study, one article focused on a study of ‘benefit-finding’ in people with thyroid cancer, this was the only study with any relation to findings related to wisdom that was taken up explicitly in oncology care (Costa & Pakenham, 2012; Pakenham & Cox, 2009).

1.2.1.3 *Wisdom and Post-Traumatic Growth Investigations*

Cancer leaves its effects long after the tumour is removed (Boyer & Cantor, 2005; Kangas, Henry, & Bryant, 2002; Schulman-Green, Ercolano, Dowd, Schwartz, & McCorkle, 2008). Post-traumatic growth studies (Austin, 2001; Cordova, Cunningham, Carlson, & Andrykowski, 2001; Janoff-Bulman, 2004) also indicate that not all these effects are negative and that ‘benefit-finding’ can be a significant aspect of the experience for some (Costa & Pakenham, 2012). One clinician has formed a ‘wisdom-therapy’ intervention that aims to facilitate this post-traumatic growth momentum in severely embittered individuals, but not in the oncology context (Lieberei & Linden, 2011; Linden, 2008). Wisdom might be a differentiated outcome of living with a terminal cancer diagnosis than ‘benefit-finding’ and worthy of further study.

Bangen et al. (2013) recommend further investigation in relation to wisdom in their discussion of interventions identified in their literature review such as mindfulness and acceptance based psychotherapies that emphasize cultivation of aspects identified as components of wisdom, such as non-judgmental awareness and emotional regulation. They suggest that these types of interventions might assist with fostering wisdom and that wisdom could be studied from this perspective. They also suggest that additional research on the development process of wisdom (versus as an outcome) may offer understanding on how best to cultivate wisdom in clinical practice. This fits with the content of the supportive care group forming the context for studying wisdom in this study as these psychotherapeutic elements are integrated in the sessions.

Bangen et al.'s literature review in 2013, calling for more investigation of wisdom in clinical therapeutic interventions, invites us to consider that research into wisdom in oncology care, and specifically, one that investigates wisdom phenomenologically and as part of process of group sharing about a shared experience of a life-threatening illness, are as yet, underused in wisdom research (Glück, Bluck, Baron, & McAdams, 2005; Küpers, 2005, 2007). This potentially (Breitbart, 2005) offers a unique contribution not only to oncology but also to research literature on wisdom.

1.2.1.4 *Wisdom and Spirituality*

The appeal for renewed interest on *sophian* (intuitive) forms of wisdom intersects with discussions amongst researchers on whether wisdom and

spirituality are correlated or inter-related at all. According to a Delphi consensus survey with leading wisdom experts wisdom and spirituality are connected by *exception* rather than as a rule (Jeste, 2010). A Delphi process conducted by Jeste (2010) found that definitions and operationalization of wisdom are best explicated in secular rather than spiritual terms. McLaughlin and McMinn (2015) position their commitment for investigating the means to further integrate of faith (from within a Christian paradigm) and psychology in the context of contemporary developments in a science of wisdom and more ancient, long standing religious traditions' views on wisdom.

Wink and Dillon's (2013) study specifically aims to distinguish wisdom's implicated role with spirituality and religion building on an earlier study of the differences between practical and transcendent wisdom (Wink & Helson, 1997). Their 2013 study includes spiritual seekers who do not describe themselves as religious, and religiously oriented individuals ascribing to religious beliefs/communities and specifically explored the relationship of religion, spirituality and wisdom. They report that their major findings show that personal wisdom is correlated positively with *both* religiousness and spirituality. They report that the latter might have different features in terms of loci of control, personality characteristics and characteristics of wisdom might be differently valued and weighted, but, despite these differences, they suggest that there is a correlation despite an expectation that they would find spirituality more correlated than religiousness. Based on their study, however, they declare that wisdom is not reducible or interchangeable with religiousness or spirituality and that

personal wisdom should be understood in its own terms. Further, Wink's (2013) study concludes, "its developmental trajectory, substance, and implications for psychosocial functioning clearly deserve further study" (p. 186).

In the supportive care group process forming the pre-study phase for study recruitment, each person's spiritual values, beliefs and insights and as well the wisdom they draw from their own paradigm is welcomed as contributive to the shared inquiry for 'what helps me live' in the day to day. The groups thus offer an open space for this dimension of their daily life to influence insights about wisdom in their lived experiences of ovarian cancer. At the same time, wisdom conceptually creates a conceptual commonality for discussions between varying belief systems and spiritual/religious paradigms in how wisdom is actually experienced, rather than what 'ought' to be experienced, based on particular beliefs.

Investigations of wisdom appear to dwell in the 'hyphenated gap' between existential-spiritual dimensions of interiority in the cancer experience, and hold potential to inform debates about whether spirituality or existential categories best suit investigations of psychosocial needs of cancer patients (Brennan, 2006; Butlin, 2015c; Salander, 2006, 2015). The concept of 'wisdom' offers a discursive space for intangible dimensions of inner and lived experiences, without needing to open up debates about belief paradigms. Wisdom is a 'humanist' concept and accessible for most. As such, wisdom is held out as a conceptual space for exploration offering a means for participants to explore their own "wisdom-praxis"

(Küpers, 2007, p. 184) personal theory and enactment in daily life of what they construct as the meaning of 'wisdom'

1.2.1.5 *Wisdom and Gender*

This study focuses specifically on women's experiences of wisdom. It thus has potential to contribute to a current trend with researchers on wisdom who have turned attention towards gender in lived experience and conceptualizations of wisdom (Aldwin, 2009; Glück, Strasser, & Bluck, 2009). Indications from wisdom research focusing on gender suggest that men are more inclined to see philosophy, achievement or work situations as influencing development of wisdom whereas women see confrontations with mortality, experiencing difficult life events and religio-spiritual experiences as more influential (Aldwin, 2009; Glück et al., 2009). They suggest one reason is that "decontextualized representations of wisdom as a word" (Glück et al., 2009, p. 42) draws different findings, more genderless, than when actual recollections of wisdom related experiences are drawn upon. This study proposes to take up this focus to deepen insights into the embodied experiences of wisdom in women living with ovarian cancer. This focus on gender has in turn has led to discussions on an embodied dimension to wisdom.

This study situates itself as a feminist project aiming to reclaiming women's excluded 'wisdom-labour' (Morini, 2007) in the context of oncology care. It identifies with the philosophical aims of projects such as reclaiming women's creative work in quilting (Brown, 1989) or women's oral history in the

essays collected by Gluck and Patai (1991) or more pertinently, women's wisdom as important lay voices in health care (Malterud, 2008; Rosato, 2006; Rosato, 2008).

1.2.2 A 'Wisdom Primer' Supportive Care Group For Women With Ovarian Cancer

1.2.2.1 Supportive Care Group Clinical Intervention Prior to Study Participation

The supportive care group design (Appendix II) was established and unchanged from the previous ten groups prior to the groups from which participants were third-party recruited. The study was not aiming to examine *whether* the group was successful in fostering 'wisdom' in the participants. It was selected as a pre-study recruitment pool because it afforded the possibility for recruited participants to have experienced a "wisdom-supportive environment" (Küpers 2007, p. 185) with specific wisdom-enhancing interventions taught and practiced in daily life between the weekly sessions. The group process, therefore, functioned as a type of 'wisdom-primer' for the study's focus of eliciting personal perspectives on wisdom's phenomenological dimensions.

The six-week long, supportive care group, 'Soul-Medicine' was run with eight groups of women living with various cancers, and one as a pilot group for ovarian cancer only, between 2009-2012 (Table 1.1). Participants were provided with experiential exercises, group discussions, individual journaling exercises, readings, poetry, art collaging using self-selected photos/pictures, and 'at home

practices' to explore accessing their own 'wise-ways' of sourcing hope, meaning, purpose in daily life, while living with a horizon of radical uncertainty. Themes of discussions have included, fear, stress reduction, hope, mortality, relationships, spiritual themes such as inner peace, spiritual distress, existential themes such as loneliness, angst, hope, mortality, and what provides medicine for the soulful dimensions of daily life. These groups have allowed for the elucidation of what might be seen as forms of wisdom in the lives of individuals living with cancer. The groups integrate learning empirically based practices that include: mindful, non-judgmental awareness (Chiesa & Serretti, 2009; Kabat-Zinn, 1991; Kabat-Zinn, 2006; Ott, Norris, & Bauer-Wu, 2006; Smith, Richardson, Hoffman, & Pilkington, 2005); 'felt-sense' and focusing (Gendlin, 1981; Levine, 1997; Todres, 2008); 'self-compassion' (Neff, 2003, 2011; Neff & Lamb, 2009; Neff, 2009, 2011a; Neff, 2004); engaging with 'dual-awareness', one eye on the present, one eye on the horizon, for coping with uncertainty (Cohen, 1993; Hales, Zimmerman, & Rodin, 2008; Lo et al., 2014; Rodin & Zimmerman, 2008); and wisdom formation from imagining a 'wise person' to talk to (Glück & Baltes, 2006; Solomon, 2008) during meditations imagining meeting them in a comforting place in nature. Content includes a variety of meditation practices using visual imagery, art pictures, breathe exercises, mindful awareness, self-compassion exercises, felt-sense awareness, kinesthetic meditation using objects from nature (Appendix II).

Individual spirituality was explored and welcomed as contributive to the shared inquiry for 'what helps me live' in the day to day (groups) and

perspectives on phenomenon of wisdom (study). Spirituality and religious beliefs are potentially implicated as a possible dimension of wisdom but not in themselves, 'wisdom' *per se* (Wink & Dillon, 2013; Wink & Helson, 1997). The groups and study interviews thus offered an open space for this dimension of their daily life to influence insights about wisdom in their lived experiences of ovarian cancer. At the same time, wisdom conceptually created a commonality for discussions between varying belief systems and spiritual/religious paradigms in how wisdom is actually experienced, rather than based on particular spiritual or religious beliefs.

Through these processes, practices and skills, the supportive care group experientially taught *wisdom-enhancing skills* and aimed to facilitate participants' personal connection with their "wisdom-resources" (Glück & Bluck, 2013, p. 79). Sternberg (1998) asserts that teaching skills and ways of thinking is one means for cultivating wisdom-enhancement. The notion of wisdom was offered at the outset as a human potential that holds the possibility of being claimed as part of 'being human' drawn from suffering experiences and could be passed on to others as a form of eldership in the world to others in their own struggles. Group content and process aimed at fostering personal capacity for reflecting on personal wisdom and strengthening an ability to discover and claim personal wisdom reflectively and apply with deeper intention into daily life.

Personal wisdom was explored as a *possibility* for being gleaned from their explorations and learning(s) as a contribution to pass on to others in their lives, when relevant and meaningful, both as legacy (Gessert, Baines, Kuross,

Clark, & Haller, 2004) and as affording a dignity conserving process (Chochinov, 2006, 2012; Chochinov et al., 2011) to live with continued sense of meaning and purpose in living with a terminal illness.

The group process is theoretically underpinned by the principles of (a) phenomenology whereby the women become their own investigators into their lived experiences of 'wisdom' in everyday life and bring their insights into the group discussion around the weekly themes (Appendix II); (b) poetic inquiry whereby poetry is read for sources of insight relating to the themes and poetry is created in week 5 by participants about their lived strengths, discovered in a time of duress; (c) embodiment whereby they are invited to reflect upon the ways that their body 'speaks' with (i) intuition that can discern choices without a rational or cognitive explication, (ii) with feelings that provide information about what the person values or does not value in order to guide them to understand what types of experiences feel life-affirming and hope filling versus experiences that create feelings of wasting time, irritation, draining of emotional and/or physical energy for living life (iii) with wisdom as something their 'body' acts and knows and generates rather than as a knowledge simply acquired through only cognitive processes. The theories of imagination inform the uses of exercises that engage imagination explicitly, that cultivate a capacity for 'reverie' that Bachelard argued generates a sense of well-being, particularly when engaged in nature upon the living world of the cosmos, that allow for the exploration of creating 'horizons of hope' that diminish the impact of fear and its capacity to generate horizons of terror and despair.

1.2.2.2 Wisdom Resources as Explored in the Supportive Care Group

Empirical research has identified specific *inner resources* pertaining to wisdom. Glück and Bluck's (2013) MORE model of "wisdom-resources" (Glück & Bluck, 2013, p. 79) include: (a) a sense of mastery as "a belief that they are able to deal with life's challenges" (p. 79); (b) openness, as an awareness "that there are multiple perspectives on every phenomenon" and an interest "in learning from new perspectives and from other people" (p. 80); (c) reflectivity as "the willingness to look at life issues in a complex way, rather than to simplify them" and an ability to "reflect deeply on experiences as they strive to see the 'big picture', identify larger themes, developmental links over time, and relations between issues" (p. 82); (d) emotion regulation and empathy in two aspects involving "perceiving and regulation one's own emotions" and the ability to reach out to others through empathic concern (p. 83). Their study also addresses wisdom as multidimensional.

Schmit et al.'s (2012) study adds three additional dimensions of wisdom-resources, particularly pertinent to the lives of women living with ovarian cancer. In addition to openness, reflectivity and interactional aptitude (emotional regulation and understanding of other's emotions), they add: (a) practical, "the ability to screen information and to be able to select or focus on the aspect that is most critical" (p. 40); (b) paradoxical, "an ability to tolerate uncertainty and ambiguity" (p. 41); and (c) ethical sensibility, "which centres on values" (p. 42) and "focuses more on the dynamic interrelationship of wisdom's dimensions rather than measures of certain characteristics" (p. 42). The group content and

discussions held a focus on meaning-centered exploration and skill building for tolerating distress associated with uncertainty, ambiguity, ultimacy of the paradox of mortality pressing on one's daily life (e.g. How do I live when I know I am dying?).

Empirical research has also identified specific *wisdom-enhancing interventions* that can foster and/or elicit personal, contextualized wisdom in individuals. The following were embedded in the pre-study supportive care group process and in the subsequent research interviews with volunteer participants. The wisdom-enhancing interventions are: (1) *social interaction* identified as a central ingredient for *transmission* of wisdom (Baltes & Staudinger, 2000; Küpers, 2007; Staudinger & Baltes, 1996); (2) *reflection across a lifespan* (Glück et al., 2005) shown to provide a contextual means for eliciting an articulation of personal wisdom (Glück et al., 2005) rather than inviting abstract reflection on wisdom devoid of personal experience or application in life. The latter having been shown in Glück et. al's (2005) study to tend towards eliciting conceptual and philosophical reflection on wisdom regardless of individual's lived experiences of 'being wise' in their own lives. (3) *exercises that engage imagination* (Glück et al., 2005) as a means for eliciting unreflective personal wisdom resources. While imagination has not formally been studied as a characteristic of wisdom in itself it is utilized in key studies targeting wisdom enhancement. An exercise developed by Staudinger and Baltes (1996) instructed research participants to discuss life problems with significant others and subsequently also to *imagined wise others* and both interventions had similar

benefits for enhancing personal wisdom. This intervention was taught in the supportive care group process through a meditative practice imagining meeting a wise person in a place in nature they've been in their lives to discuss a current difficulty they are having. Within the interviews themselves participants were asked what they would "pass on" for living with ovarian cancer reversing the imaginary consultation so they themselves become the person passing on their implicit wisdom to an imagined woman, newly diagnosed. The question was careful to not explicitly ask for their 'wisdom' to mitigate performance anxiety for claiming oneself as 'wise'.

A deep-seated belief in human capacity to form a personal, guiding and lived 'wise-way' through acute difficulties borne out over ten years as a psycho-oncology practitioner was certainly present for the researcher. How this might emerge, or if it would, was under investigation through this study.

1.2.2.3 *Why Wisdom?*

Implicit theories of wisdom (Baltes & Staudinger, 2000) do not focus on generalized, objective characteristics of 'wisdom' or a focus on objective measures of traits of wisdom in people. Rather, implicit theories of wisdom "allow individuals' subjective definition of wisdom ... to be their guide in nominating and describing a wise event from their own life." (p. 546). This study focused on participants' implicit wisdom as experienced in their own perspective from within their unique lifeworld. It was more concerned with whether a participant felt 'wisdom' was possible for them and if so, what ways does personal discoveries

of, and about, wisdom assist them to live the difficult diagnosis and its emotional, mental, existential, spiritual and practical impact in daily life.

1.3 SEARCHING FOR WISDOM IN ONCOLOGY CARE: A SCOPING REVIEW

1.3.1 Introduction

The concept of “wisdom” has been a compelling and emergent topic of interest informing debates and investigations within many disciplines, and it has had a prominent place in ancient philosophy, beginning with Socrates, Plato, and Aristotle (Ardelt, 2005; Bluck & Glück, 2005; Osbeck & Robinson, 2005). In recent times, wisdom has become a focus of attention in such fields as aging and human development (Ardelt, 2000; Baltes & Kunzmann, 2004; Gugerell & Riffert, 2011; Yang, 2014), psychology (Staudinger & Glück, 2011); trauma and therapy (Abernathy, 2006; Linden, 2008), professional practice (Carr, Bondi, Clark, & Clegg, 2011; Kinsella & Pitman, 2012), and business leadership (Küpers & Statler, 2008; Yang, 2011) among others. While the construct of wisdom is difficult to operationalize and control for randomized empirical research, investigations of clinicians' and patients' experiential wisdom may contribute to advancing oncology practices. The reasons for the need for wisdom-based epistemologies for practitioners and patients are manifold (Butlin, 2015) in light of the rising cancer rates (CCS, 2014; Government of Canada, 2017); the uncertainty inherent to cancer care (Holland & Lewis, 2000); patients' struggles to

make meaning of their illnesses (Breitbart, 2005; Breitbart et al., 2010; Chochinov, 2003; Vos, 2014); patients seeking quality of life while dying (Angiola & Bowen, 2013); physician-assisted suicide developing into a legally sanctioned option in some regions (Fine, 2015); and reports of healthcare practitioner burnout and grief in oncology care (Granek, Krzyzanowska, Tozer, & Mazzotta, 2012; Lyckholm, 2007). Being attentive to the urging of clinicians (MacLeod, 2003; Roy, 2012) to better understand the meaning of “wisdom” and “wise practice” may foster best practices in oncology care and inform organized efforts to attend to wisdom, such as those reflected in the Choosing Wisely initiatives in North America (see, e.g., www.choosingwisely.org).

Theories of wisdom (Bangen, Meeks, & Jeste, 2013; Schmit, Muldoon, & Pounders, 2012; Staudinger & Glück, 2011) generally acknowledge that difficult situations, challenges to personal or collective morals, and even tragic life situations are significant factors in the formation of wisdom (Glück, Strasser, & Bluck, 2009; Webster, 2003). Bluck and Glück's (2004) research highlights wisdom as implicated in meaning-making, which has been identified as a valuable therapeutic intervention for those living with cancer (Breitbart et al., 2012, 2015; Greenstein, 2000; Lee, Cohen, Edgar, Laizner, & Gagnon, 2006). Bluck and Glück (2004) define wisdom as follows:

Wisdom is an adaptive form of life judgment that involves not what but how one thinks. It is a combination of experiential knowledge, cognition, affect, and action that sometimes occurs in a social context. Wisdom is defined as a personal resource that is used to negotiate fundamental life changes and challenges and is often directed toward the goals of living a good life or striving for the common good. (p. 545)

Applying wisdom in cancer care seems relevant, given that cancer inevitably brings “fundamental life change and challenges”, and that the “goals of living a good life” are central aims of clinicians and patients in treatment decision making. As such, oncology care may be a prime context in which to elucidate the wisdom developed through clinician and patient experiences.

1.3.2 Objectives and Research Questions

To investigate the potential significance of the phenomenon of wisdom, a scoping review (Arksey & O'Malley, 2005; Rumrill, Fitzgerald, & Merchant, 2010) was undertaken, in the context of oncology healthcare, to examine: (1) how the concept of wisdom has been used; (2) the ways in which wisdom has been a focus of inquiry; and (3) how wisdom has been characterized, when the term is used.

The following research questions guided the review:

- What genres of articles in oncology healthcare use the term “wisdom”?
- In what ways is the concept of “wisdom” a focus of inquiry in the context of oncology healthcare?
- How is “wisdom” characterized in the oncology healthcare literature?

1.3.3 Scoping Review Methodology

Rumrill and colleagues (2010) state that a scoping review is useful when seeking to know “who is using specific terms and for what purpose” (p. 402). It offers a topography of a topic as a means of understanding and interpreting the

existing state of knowledge (Rumrill, Fitzgerald, & Merchant, 2010). This approach is typically chosen as a means to map key concepts underpinning a research area, identify what the main sources and types of evidence are, and highlight where there may not have been a previous comprehensive review (Catty, Kinsella, & Doyle, 2014). Arksey and O'Malley (2005) contend that a scoping review is “guided by a requirement to identify all relevant literature regardless of study design” (p. 22). A scoping review aims to give “a narrative account of existing literature” (p. 27), rather than synthesizing the findings of different kinds of study designs and methodologies. The process is iterative rather than linear, “requiring researchers to engage with each stage in a reflexive way” (p. 22). Arksey and O'Malley (2005) highlight four main reasons to employ a scoping review in a particular area:

- To examine the extent, range, and nature of research activity
- To determine the value of undertaking a full systematic review
- To summarize and disseminate research findings
- To identify gaps in the existing literature

The authors state that the scoping review methodology is appropriate when “it is difficult to visualize the range of material that might be available,” for helping to identify “the overall state of research activity,” and to highlight gaps in the literature, “particularly where no research has been conducted” (p. 21). The topic of wisdom in oncology care fits these criteria well given that no reviews in this domain were found during a preliminary search of the literature.

A scoping review thus provides a useful means to map current scholarly conversations on the place of “wisdom” in oncology care. The five steps include: (1) identifying the research question, (2) identifying relevant studies, (3) selecting studies, (4) charting the data, and (5) collating, summarizing, and reporting the results.

1.3.4 Methods

In consultation between the first author and oncology reference librarians, the search terms Wisdom AND Cancer AND Oncology OR Palliative OR End-of-life OR Spirituality OR Existential were selected for a preliminary MEDLINE search covering the period from 1980 to March of 2015. This produced 963 records. Four electronic databases — CINAHL, SocINDEX, PubMed, and PsychINFO — were then selected to search for records addressing the uses of “wisdom” in the oncology care literature. It was reasoned that if the word “wisdom” did not appear in either the title or abstract, then the likelihood of it being a major concept in the study was decreased; therefore, the key search terms were used to search titles and abstracts, resulting in 118 records. Duplicates were removed ($n = 8$) and the inclusion and exclusion criteria were applied (Table 1.2), resulting in 58 records (Figure 1.1 and Table 1.2).

Given the amount of published literature available, literature deriving from networks, conferences, books, and book reviews were excluded. A secondary search of reference lists was then conducted manually to identify articles where “wisdom” appeared in the title, and one additional reference was found.

Table 1.2 Inclusion/exclusion criteria.

Inclusion Criteria	Exclusion Criteria
“Wisdom” in title or abstract	Does not use term “wisdom” in title or abstract
English Language	Language other than English
Time frame: no time limits set	
Type of literature included:	Type of literature excluded:
<ul style="list-style-type: none"> • Peer-reviewed research articles • Peer-reviewed literature reviews • Commentary/Opinion pieces in peer-reviewed journals • Quality improvement reports in peer-reviewed journals • Peer-reviewed articles/essays • Unpublished academic theses 	<ul style="list-style-type: none"> • Duplicates • Books • Book chapters • Book reviews • Newsletters • Professional magazines • Obituaries • Interviews • Author’s name is “Wisdom” • Articles that were not specific to the oncology context (e.g. “wisdom teeth”)

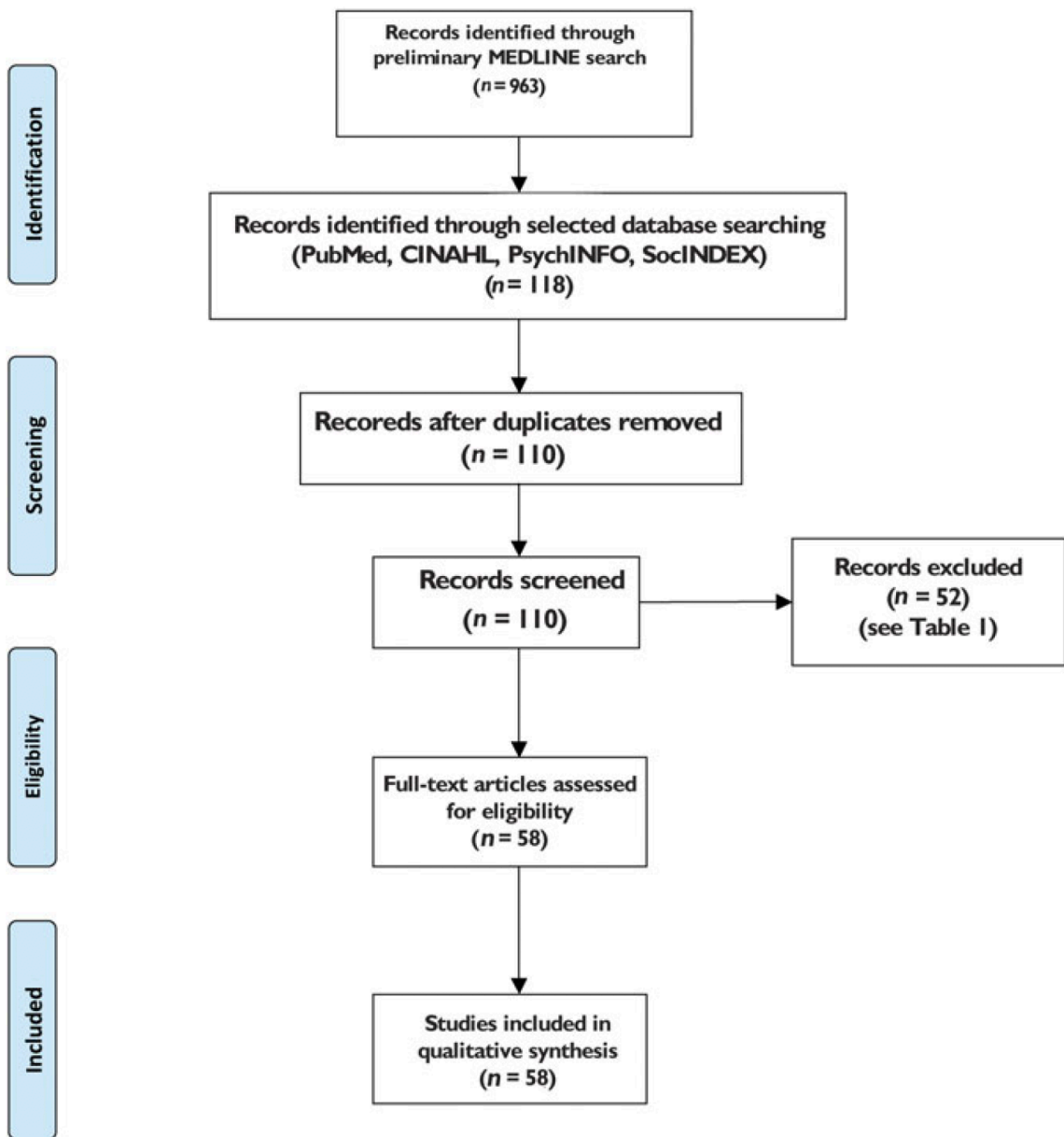


Figure 1.1 Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) Flow Diagram.

This study was excluded, however, as it did not fit all of the keyword search criteria (see above) because it had no reference to “oncology” or “cancer” in the title or abstract.

1.3.5 Data Analysis

The first author (HB) conducted the initial analysis and the subsidiary thematic analyses. The second author (EAK) was intimately involved in each step of the study, providing quality control of the process, guidance on methodology, review of the analyses, checking of accuracy, and representation of the data. The third (CG) and fourth (GB) authors have each engaged extensively in dialogical inquiry into the concept of wisdom in oncology healthcare, which informed the concept, design, and methodology for our scoping review. They reviewed the findings for relevance, coherence, and broader application in specifically different clinical contexts (psychiatric oncology care, radiation oncology), and contributed to assessment of the analysis, representation of the findings, and quality checking for relevance, resonance, worthiness of topic, coherence, and richness of description (Tracy, 2010).

Data from all 58 records were initially analyzed and extracted from the records by the first author according to the research questions (see above). This highlighted that almost no empirical studies had taken place that foregrounded, at the outset, the concept of wisdom for a topic of study.

As a result, in consultation with the second author, the first author developed the first question and applied it to all 58 included articles/studies:

“What genres of articles in oncology healthcare use the term ‘wisdom’?” This approach enabled a distinction between wisdom as a formal construct, wisdom as a focus of empirical inquiry, and more informal discussions in commentary pieces or case examples. This brought to light that many of the articles had used the word “wisdom” without explicating it conceptually or making it a primary focus. This analytical step iteratively provoked refinement of the second research question—“In what ways is the concept of ‘wisdom’ a focus of inquiry in the context of oncology healthcare?”—which allowed for identification of the rubric of genres for all 58 articles/studies and finalizing the ones reported in the Results section.

From this analysis, we noted that one of the genres identified included articles that discussed wisdom as a *finding* but where wisdom was not foregrounded in the study design – that is, it was not highlighted in the Objectives or Method section of the article. These research studies reporting wisdom as a finding seemed pertinent to the aim of this study with potentially rich data since wisdom emerged as a topic of interest without the researchers looking for it explicitly. It was decided that a thematic analysis would be conducted on those 16 articles to investigate what was being discovered about wisdom in their findings.

Broadly speaking, “Thematic analysis is a method for identifying, analyzing, and reporting patterns [themes] within data” (Braun & Clarke, 2006, p. 79). Thematic analysis is viewed as a skill and methodology that, as Vaismoradi et al. (2013) argue,

... provide core skills to researchers for conducting many other forms of qualitative analysis” and “that qualitative researchers should become more familiar with thematic analysis as an independent and reliable qualitative approach to analysis. (p. 400)

For example, in the case of our study, it proved useful as a means to analyze a portion of the data that indicated depth and breadth to the concept of wisdom in an otherwise generally impoverished dataset where wisdom was used anecdotally with little critical or reflective examination. Vaismoradi et al. (2013) state that “thematic analysis involves the search for and identification of common threads that extend across an entire interview or set of interviews” (p. 400) or, in the case of this scoping review, across a set of studies. Fereday and Muir-Chochrane (2006) differentiate inductive data-driven categorization of themes developed using words and phrases from the data itself from a deductive analysis using theory-driven codes predetermined by a template created from the field's literature on the topic of inquiry into which the data is thematized. For the purposes of our study, an inductive data-driven analysis was selected, and the themes were developed and categorized using words and/or phrases appearing in the studies.

Braun & Clarke's (2006) method for thematic analysis was employed. In line with their characterizations of different epistemological perspectives, a constructionist epistemology rather than an essentialist/realist one was to be adopted, as the aim was to gain insight into how meanings pertaining to the concept of wisdom were taken up in the texts without aiming to empirically prove its existence or verify research from other fields on its characterizations. As well,

Braun and Clarke's work highlights the importance of a rich description of themes that characterize wisdom and its meanings or uses rather than a detailed account of one aspect in detail. Finally, their "phases of thematic analysis" (p. 87) were followed in our study, including: (1) familiarizing yourself with the data, (2) generating initial codes, (3) searching for themes, (4) reviewing themes, and (5) producing the report. Outcomes of this analysis were reviewed by the second author and iteratively reworked in dialogue and a second analysis. The third and fourth authors were asked to review the representation of findings of the scoping review overall and the thematic analysis specifically in the interests of veracity and trustworthiness, with contributions focusing the analysis on the worthiness of the topic, richness of rigor, resonance, contribution to the oncology field, and meaningful coherence (Tracy, 2010). The relevance of key themes was foregrounded as a result.

For question three – "How is 'wisdom' characterized in the oncology healthcare literature?" – all 58 records were analyzed for characterizations of the term "wisdom." This involved examining the adjectives used, the interpretations offered, and the contexts of its use. The aim was to examine the ways in which the concept of "wisdom" is tacitly, formally, and informally adopted in the published oncology literature. Originally, this section only included the 26 articles where wisdom's use did not fit into any of the other genres assigned. However, given the number of adjectives characterizing wisdom in all of the articles and, as well, the number of articles where wisdom was simply used without it tying into

any theme or focus of the study whatsoever, it was decided to include all 58 articles in the analysis of wisdom's characterizations.

1.3.6 Results

1.3.6.1 *Part I: What Genres of Articles in Oncology Care Use the Term “Wisdom”?*

Asking the question “What genres of articles in oncology healthcare use the term ‘wisdom’?” allowed for a clearer distinction to be made between wisdom as a formal construct, wisdom as a focus of empirical inquiry, and more informal discussions in commentary pieces or case examples. This brought to light that many of the articles had employed the word “wisdom” without explicating it conceptually or making it a primary focus. The analysis of the 58 records, organized according to the genres identified, represents a summary of current scholarship on wisdom in oncology care.

1.3.6.2 *Part II: In What Ways Is the Concept of “Wisdom” a Focus of Inquiry in the Context of Oncology Care?*

1.3.6.2.1 *Empirical Research with Wisdom Incorporated into the Study Design*

Of the 58 articles, only 2 research articles explicating wisdom as a central concept integrated into the methodology and design of the study. Both were by Cueva and colleagues (2014; 2005), who employed arts and theater-based methodology in their cancer education initiatives with Alaska's indigenous peoples as a means to integrate “dynamic wisdom” and to “share cancer

information in a culturally respectful way” (2014, p. 529). The authors argue that arts- and theater-based approaches can allow for culturally sensitive knowledge and wisdom, specifically, to be revealed.

1.3.6.2.2 Empirical Research Articles Where “Wisdom” Appeared in the Findings

A total of 16 articles reported “wisdom” as a finding in their results, even if they did not specifically articulate wisdom conceptually in their study at the outset. These findings were of particular interest; therefore, a thematic analysis was undertaken. Wisdom was depicted around four common themes as: (1) acquired and/or passed on, (2) an inner resource, (3) “practice wisdom” as derived from practitioners' lived experience(s), and (4) informing a culture of conventional wisdom.

1.3.6.2.3 Wisdom as “Acquired” and/or “Passed On”

Six articles depicted wisdom as something acquired and/or passed on—even as a legacy—from the illness experience with cancer (Austin, 2001; Costa & Pakenham, 2012; Gessert, Baines, Kuross, Clark, & Haller, 2004; Greszta & Siemińska, 2011; McTaggart, 2001; Williams, 1995). Costa and Pakenham's (2012) study focused on “benefit finding” (BF) as a capacity some individuals mobilize in adversity. Their study was the only one to use a scale specifically designed to measure wisdom—the Self-Assessed Wisdom Scale (Webster, 2003). They state, “most prior research on BF has relied on positive affect as the main indicator of positive adjustment. Hence, findings in this study showing that

BF is strongly associated with wisdom and spiritual well-being are noteworthy” (p. 742). They suggest that the wisdom and spiritual well-being measures tap into more existentially oriented growth emerging from adversity, which the purpose-in-life and self-acceptance scales do not.

Greszta and Siemiński (2011) undertook a cross-sectional study of 50 patients that investigated wisdom related to changes in patients' value systems following a cancer diagnosis. They identified an increase in a cluster of values that included “delayed gratification (wisdom, inner harmony)” (p. 55). Austin's (2001) grounded theory study reported on posttraumatic growth in 20 women with breast cancer, with the women's processes of “distilling insights” and “creating wisdom” implying an active role in wisdom's formation.

Wisdom was also associated with a theme of legacy or something that can be passed on. McTaggart's (2001) interpretive descriptive study of mother/daughter relationships in the face of cancer highlights a process of “acquiring wisdom” passed on by mothers with breast cancer to their daughters. Gessert and colleagues' (2004) intervention study of “ethical wills” used Likert-type scales to measure a variety of existential themes emerging through patients' experiences. They describe an ethical will as “a statement, usually written, capturing one's values, wisdom, hopes, and advice. Their findings indicate wisdom as being reflected in “reduced suffering” in the categories “concern for loved ones,” “unfinished business,” and “fear of the future” (p. 517).

Williams (1995) used “narrative analysis” in her dissertation on the phenomenon of transcendence in the experience of parents of children with

cancer. Drawing on the accounts of three participants, she identified wisdom as something of value that can be passed on, as a means for coping within a supportive group environment.

1.3.6.2.4 Wisdom as an “Inner Resource”

Five articles point to wisdom as an “inner resource” within people's illness experience of cancer (Back, Trinidad, Hopley, & Edwards, 2014; Baerg, 2007; Hauser-Meyers, 2006; Kenford et al., 2005; Wilensky, 1988). Back and colleagues (2014) used previously audiotaped conversations between standardized patients and oncology fellows who were giving patients the news that the goals of care needed to be reframed because a cure was no longer a possibility. They played the recordings of the interviews to current patients and family members of patients who had recently died and then interviewed the participants, asking them to identify the statements they found most useful in these conversations. Their study aimed to draw on patient and family perspectives to elicit guidance for practitioners. The researchers employed the constant comparative method to identify three kinds of statements that were perceived as most helpful: “we're in a different place,” “here's what we can do now,” and “use your inner wisdom” (pp. 3–4). They did not discuss how using inner wisdom might occur.

Hauser-Meyer (2006) conducted a retrospective phenomenological study with seven women living with advanced breast cancer who practiced transcendental meditation focusing on their existential experiences. Her study

suggests that meditation may foster a sense of “inner wisdom.” She writes, “Initially, these women came to meditation looking for freedom from fear, and what they discovered was an inner wisdom that gave peace, hope, and meaning in their lives, with improved physical health for some” (p. 2).

Similarly, in her dissertation, Smith (2005) discusses analysis of dreams in groups as an inner resource for tapping wisdom and inner guidance. This echoes a theme of other studies that depict wisdom as an “untapped resource” within the individual, but also adds the notion that this resource can function as a form of guidance. Wilensky (1988) used six case studies to explore the use of hypnosis to “tap into a person's own body wisdom to provide information about physical problems,” thereby challenging the mind–body split and pointing to the body's wisdom. Baerg's (2007) case study of counseling adolescents with cancer found that through the use of art and poetry “the teens find valuable hints to healing, and gain wisdom and insight that begins to soothe their souls” (p. 65).

1.3.6.2.5 *“Practice Wisdom” as Derived from Practitioners' Lived Experience(s)*

Four articles suggested that wisdom emerges within practitioners' practice experience as cancer care providers (Cueva, 2011; Johansen, Holtedahl, Davidsen, & Rudebeck, 2012; Jordens & Little, 2004; O'Callaghan, 2005). Wisdom is often termed in this context as “practical wisdom” or “practice wisdom.” Jordens and Little (2004) utilized narrative inquiry and genre theory to study ethical reasoning from interviews with clinicians treating colorectal cancer. They concluded that “policy genre is both the unfolding of practical wisdom in

speech, and the appropriate choice of genre where a display of ethical identity is called for” (p. 1635). Music therapist O’Callaghan (2005) explored her own reflexivity through reflexive journaling during her music therapy practice, which she suggests was implicated in “extending practice wisdom” (p. 55). Cueva (2011) conducted a narrative inquiry study with 11 researchers on their experiences as principal investigators in oncology care research. She states, “I was privileged to move beyond people’s academic profiles to learn from their gems of insight and wisdom” (p. 194). She presents the results as a means to share their “collective wisdom” (p. 199), suggesting a legacy dimension to wisdom in the field of oncology care.

Johansen and colleagues (2012) offer some perspective on “practical wisdom” and its tensions in the clinical practices of general practitioners (GPs) in oncology care. They used a thematic narrative approach in a study with 14 GPs in Norway. The interviews explored in depth experiences of being a GP for people with cancer at different crucial points in the course of their illness, and the findings reveal themes of loyalty, honesty, and shared humanness. Practical wisdom was identified as a knowledge that tended to become subordinated to the judgment of specialists in the biomedical model of care. This tension was noted specifically between primary care physicians who have access to the day-to-day lived experience of their patients versus the larger institutionalized healthcare delivery model (e.g., hospitals) and the specialists who only work within these contexts, with fewer opportunities to know their patients’ experiences over time.

1.3.6.2.6 Wisdom as Informing a Culture of “Conventional Wisdom”

One study discussed wisdom as informing a culture of “conventional wisdom.” Raffa's (1997) grounded theory study of breast cancer prevention organizations identified conventional wisdom as a constraining and dominant culture in such organizations, which can create conflict with new and emergent views.

1.3.6.2.7 Quality Improvement

One article reported a quality-improvement project where the aim was to integrate “spiritual wisdom as a component of care” (English & Picchi, 2014, p. 50). The program was in the context of a Catholic healthcare pilot project, focused on outcomes related to spiritual wisdom. The aim was to increase the competence of “palliative care teams” in recognizing and addressing spiritual suffering and integrating the patient's beliefs and values into advanced health planning” (p. 51). This was a result of a strategic initiative to “bring spiritual wisdom to the care of the seriously ill, with an interdisciplinary approach to meeting spiritual needs and relieving spiritual suffering.” The program focused on spiritual wisdom by “listening intently to the soul in conversations with seriously ill patients and their loved ones” with a view to “embed spiritual assessment and healing presence into the structure and design of the goals-of-care and patient and family conversation” (p. 51).

1.3.6.2.8 *Essay Articles*

Five essay-style articles were identified where wisdom was explicitly used. Three incorporated wisdom as a concept in their discussions. The topics included: how nurses can enable courage and wisdom in cancer patients to assist with feelings of helplessness (Richardson, MacLeod, & Kent, 2012); how “soul-wisdom” (p. S48), as a source of inner guidance, comfort, healing, including a “gut feeling” (p. S48) is experienced by cancer patients and caregivers (Vachon, 2008) and how the “wisdom of the body” (Solodow, 1988, p. 2) can be harnessed for its natural healing abilities from a Japanese health psychology approach. Ho (2005) wrote about dance movement therapy for Chinese cancer patients. She suggests that the movement therapy allowed participants to “regain and embody the traditional wisdom of balance” and the “wisdom of mind–body interconnectedness,” (p. 87) important concepts in Chinese culture. Cunningham (1993), in his essay “Does Cancer Have Meaning,” details three methods of therapy that he employed with support groups to yield an understanding of the meanings of cancer. These included: (1) to engage in reflection through writing an autobiographical account of the cancer experience; (2) to get in touch with “inner sources of unconscious wisdom” through dreams, mental imagery, hypnosis, or an imagined dialogue with a wise person; and (3) to search the spirit by drawing on transcendental practices (such as meditation) in order to discern and use higher levels of meaning for healing (p. 69).

1.3.6.2.9 *Comment or Opinion Articles*

Six commentaries or opinion pieces discussed wisdom. Two journal editorials by physicians reflect explicitly on “practical wisdom” as a means to enhance care and clinical practice in palliation, and as a critical element in palliative care. They note that practical wisdom has received little attention and is perhaps even endangered (MacLeod, 2003; Roy, 2012). Roy (2012) paints a bleak picture of palliative care devoid of wisdom as “subservient to the dictates of technology, regulations, rigidly espoused principles, or blindly followed routine” (p. 67). He notes that it is difficult to demonstrate knowledge of wisdom. Yet, he also contends that he is able to recognize its presence or “glaring absence” in his observations over the course of caring for the dying for some 30 years (p. 68). MacLeod (2003) foregrounds the practical wisdom (*phronesis*) gleaned from clinical experience and argues for attention to wisdom as a means to improve physicians' caring practices. Further, Solomon (2008), in his editorial commentary on a special edition focusing on family in palliative care, asserts that clinical wisdom involves the “necessity of focusing on family” (p. 408).

Another commentary piece is offered in Yancey's (2004) editorial on studies covering the WISEWOMAN (Well-Integrated Screening and Evaluation of Woman Across the Nation) chronic disease screening and health promotion initiatives in underserved populations. In addition, Mehta (2013) demonstrates how an ancient Hindu story from the *Bhagavata Purana* offers insights on wisdom for grieving and preparing a person for dying in contemporary palliative

care. Liao and Arnold (2006) further highlight the significance of wisdom in their editorial commentary on a paper that reviewed the literature on cancer pain.

1.3.6.2.10 Personal Stories

Two peer-reviewed articles focusing on wisdom gleaned from personal stories of cancer were identified. A nurse discussed how spiritual scripture offered a means to source hope, meaning, and courage during her experience of breast cancer, and a physician presented stories of the wisdom gained by four individuals who integrated psychotherapy into their healing from a life-threatening illness (Sealy, 2013; Zucker, 2002).

1.3.6.2.11 Anecdotal Uses

The genre “anecdotal uses” was categorized to cover articles that employed the term “wisdom” in a self-evident, everyday sense or in a taken-for-granted manner, without an analysis of the term from a conceptual, theoretical, or methodological perspective. This genre was the largest and most varied category with the 26 selected articles. These anecdotal uses reflected a multitude of meanings while also suggesting that wisdom is a tacit, submerged phenomenon in oncology discourses. Three prevalent anecdotal uses identified in the data included: conventional wisdom, wisdom as supportive of professional practice, and wisdom as contributive to society.

1.3.6.2.12 *Conventional Wisdom*

“Conventional” wisdom was variously depicted as beneficial for improving “accuracy of prediction and reducing conflict at the end of the life” (Ridley & Fisher, 2013, p. 642) as associated with “capturing and optimizing collective knowledge and insight” (Robson & Rew, 2010, p. 230); as a cumulative process acquired by a profession (Zebrack, Burg, & Vaitones, 2012); and as erroneous where popular wisdom is shown to circulate tenacious medical myths (Whorton, 2000). Reyna and Farley (2006) argue that, “despite conventional wisdom, adolescents do not perceive themselves to be invulnerable” in their behaviors, such as in relation to smoking and its cancer risks (p. 1). Bull (2004) bluntly states, “Conventional wisdom for surviving this disease is just plain wrong” (p. 5). Lippman and colleagues (2007) encourage alternative viewpoints, “even ones that question supposedly “established wisdom” (p. 484). McKenna and colleagues (1999) challenge the “conventional wisdom that stress and personality influence the development of breast cancer” (p. 520). Barber (1980) argues against the “traditional wisdom” of certain individuals being “unhypnotizable,” using the case of a patient with chronic cancer pain, to show responsiveness to treatment (p. 4). Bobo and colleagues (1986) point out that “conventional wisdom has long shielded alcohol-treatment clients from pressures to quit smoking” (p. 21) despite the link between smoking and cancer.

However, Foley's (2001) editorial argues that “conventional wisdom” is something to be challenged in order to further best practices beyond the current status quo, while acknowledging that this is never easy. Elliott and colleagues

(2008) indicate that complementary and alternative medicine users believe that they are perceived as “challenging medical wisdom” (p. 52). Others use the term “wisdom” to imply a tacit guiding principle by which practices can be debated or questioned (Balon, 2004; Newell, Girgis, Sanson-Fisher, & Savolainen, 1999).

“Common wisdom” was also depicted as a source of knowledge, often overlooked, such as the “common wisdom” that healthcare is “dominated by costs in the last year of life” and that such knowledge is deemed important for “future planning in healthcare” (Polder, Barendregt, & van Oers, 2006, p. 1720). Like conventional wisdom, common wisdom infers a more limited scope or validity compared to other examples of wisdom discussed in this review.

1.3.6.2.13 Wisdom as Supportive of Professional Practice

Wisdom was also associated with ways to support colleagues in dealing with challenges in clinical practice. For instance, “words of wisdom” (Demierre, Kim, & Zackheim, 2003, p. 1485) were noted as a means to advise fellow oncologists on how to avoid burnout in cancer care (Lyckholm, 2007, p. 269). Other uses included suggestions that “nurses need wisdom” in discussing issues of sexuality in palliative care (Woodhouse & Baldwin, 2008, p. 20) and that “optimal cancer care balances the need for scientific knowledge, statistical analysis, and rational thought with the need for wisdom, kindness, compassion, and love” (Geffen, 2004, p. 93). Wisdom was also used to speak of “practical,” “clinical,” “cumulative,” or “experiential” wisdom in practice and education (Mullan & Boston, 2006; O’Donnell, 2007; Sigband, 2001).

1.3.6.2.14 *Wisdom as Contributive to Society*

Wisdom was also depicted as contributive to society. Aucoin and Wassersug (2006) draw on the traditional historical role of eunuchs as offering positive contributions to society, including wisdom, in order to reflect upon the implications for modern-day men with prostate cancer. Lampert (2004) implicates wisdom in being “humane” (p. 97) as she reflects on attitudes toward death in her psychotherapy practice with cancer patients.

1.3.6.3 ***Part III: How Is “Wisdom” Characterized in the Oncology Care Literature?***

All 58 records were analyzed, and 21 different characterizations were identified (Table 1.3). Wisdom was often combined with an adjective giving it a variety of characterizations. It was characterized as *dynamic*, as something *found*, *gained*, or *acquired* through lived experiences, *created* through distilling insights, that can be *ancient*, *shared*, and *passed on*. Wisdom was characterized as something that could be *harnessed* for *healing* and *soothing* of the soul, or tempering feelings of helplessness in others. It was depicted as often being mediated by *words* yet culled from *experience*, transmitted through *storytelling*, and as a constituent of clinicians' *practice* and *care*. As well, wisdom was suggested to be *critical* and *humane*. Wisdom was referred to as *soul wisdom* or *spiritual wisdom* or *practical wisdom* or *body wisdom* or *unconscious wisdom*, thereby considering additional dimensions of human life, which can be lost in clinical oncology treatment discourses.

Table 1.3. Genres of records with “wisdom” in title or abstract. Fifty-eight records were found and analysed.

Genres	Number (N=58)
Empirical research with wisdom incorporated into study design	2
Empirical research articles where “wisdom” appeared in the findings	16
Quality improvement article	1
Essay	5
Commentary/opinion articles	6
Personal story articles	2
Anecdotal uses	26

The most frequent characterization (11) was encapsulated with adjectives such as “conventional/established/traditional/collective wisdom.” These depict a social character to conceptions of wisdom beyond the individual. This type of wisdom was depicted as something that guides and sometimes as an approach that is constraining with respect to possibilities for new actions and insights. Foley (2001) challenges “conventional wisdom,” suggesting a “culture” of tacit, collective knowledge, which may or may not serve the cancer population. The second most common use was “practical wisdom” or “practice wisdom” (7), which located wisdom as arising from lived experience of practitioners.

1.3.7 Limitations

One limitation of this review is that only four databases were searched. These databases were the ones deemed by expert oncology librarians as the most likely to fulfill the purpose of our review; nonetheless, some articles may have been missed. Furthermore, texts such as published books and social media were not included, though they also may offer insights. It is important to note that a “scoping review” cannot be read as an appraisal of evidence (Grant & Booth, 2009); it does not evaluate the quality of research studies or findings (Arksey & O’Malley, 2005). Rather, our scoping review maps the ways that “wisdom” is depicted in the published literature, as a concept, a focus, and/or a finding. Thus, this review offers a snapshot of genres of peer-reviewed articles, the ways in which wisdom is a focus of inquiry, and how wisdom is characterized in the literature reviewed.

Furthermore, wisdom is alluded to in the Discussion sections of research articles on interventions such as meaning-making therapy (Breitbart et al., 2012, 2010, 2015; Greenstein, 2000; Vos, 2014); dignity therapy (Chochinov, 2006; Chochinov et al., 2011; Hack et al., 2010; McClement et al., 2007) and Managing Cancer and Living Meaningfully (Lo et al., 2014; Rodin et al., 2007). Yet, due to the absence of “wisdom” in the title, abstracts, and explicit designs of these intervention studies (and perhaps others), they were not included in our scoping review, despite the potentially meaningful findings they may have offered. Finally, variations on the term “wisdom” – such synonyms or variations as “wise” or “wisely” – were not included in our search. It is thus possible that other literature that examines or references the concept of wisdom may have been missed (such as the Choosing Wisely articles referenced below). However, it is likely that the core search on wisdom will have surfaced a largely representative cross-section of the types of available literature.

1.3.8 Significance of Results

This study highlights that tacitly circulating through oncology literature is reference to the resource of wisdom as dwelling in human experiences and practices within oncology care. Our findings suggest that the concept of “wisdom” is used in the oncology literature with a breadth of meanings and a taken-for-granted presence suggesting the importance of the concept for the field. Nonetheless, the terminology is unclear and varied, and a scholarly focus on wisdom has not been applied in cancer care to the degree it has in other fields.

As such, it behooves us to examine this concept as it is depicted in the sociomaterial, messy, complex, and technologically sophisticated environments (Fenwick, 2014) that aim to alleviate the suffering of those living with cancer.

Critical questions for oncology care are thus raised. “What is wisdom in healthcare specifically?” “How can the wisdom of patients and the clinical wisdom of frontline care providers be best elucidated?” “How might wisdom inform cultures of care, interventions offered, and best practices in the midst of busy and often fragmented healthcare systems?” (Breitbart, 2004; Chochinov, 2013). Our findings suggest that more rigorous studies focused on the concept and elements of wisdom in oncology care are required if deepened understandings and insights are to be gleaned and passed on to oncology patients and practitioners with ever more sophisticated medical technologies at their disposal. Better understanding of wisdom's formation and preservation in clinical life is perhaps more pressing than ever in countries like Canada, which have now decriminalized assisted dying (Attaran, 2015; Chochinov, 2016; Fine, 2015), where “wise” protocols for best practices will be needed to guide assisted dying in healthcare and clinical practice.

It can be noted that there are wide variations in approaches to wisdom depicted in the oncology literature. For example, Webster's (2003) scale using quantitative measures developed for an individual's self-assessment of their perceptions of personal wisdom was utilized in Costa and Pakenham's (2012) study of benefit finding for patients with thyroid cancer. Glück and Bluck (2005)

prefer to use a qualitative methodology to study wisdom, integrating autobiographical stories to identify the ways in which individuals across age groups use and experience “wisdom to transform negative...life situations” into positive ones (p. 543). These differing approaches highlight the question as to what type of research methodologies are most appropriate for studying the intangibles in lived experiences – such as wisdom. Indeed, whether wisdom is best measured with a scale is a subject of debate in the current literature focusing on wisdom. For example, Küpers (2007; Küpers & Statler, 2008) studies wisdom extensively in the complex and changing context of business leadership and argues for wisdom as simultaneously being individually embodied and also embedded within social matrices that foster or constrain “wisdom-supportive-environments” (Küpers, 2007, p. 185). As a result of this awareness, Küpers (2007) has called for phenomenological approaches rather than the experimental/quantitative approaches characterizing earlier decades of wisdom research in the fields of psychology and adult development. Yang (2013; 2008) also challenges quantitative approaches to wisdom research, arguing for a process view of wisdom that uses qualitative methodologies. These point to potential directions for taking up research on wisdom in oncology care, a field with a burgeoning focus on qualitative methodologies, as a means to examine the nuances of the lived experiences of those living with cancer.

Beyond the approaches to research, the focus of the research is also of importance. Our findings suggest that more research focusing specifically on wisdom is required. Such research might assist in clarifying the meaning(s) of

statements such as “use your inner wisdom” by physicians—for instance, when the goals of care need reframing, as identified in the study conducted by Back et al. (2014). Such research may also help solidify wisdom as a unique construct and personal resource within oncology practice, distinct from the conventional wisdom of traditional practices and guidelines.

Findings of particular interest were empirical studies where wisdom emerged as a finding. Wisdom was identified as “acquired and passed on” and as an “inner resource,” emerging from participants’ experiences with cancer. Back et al.’s study (2014) was a key example of research that did not have wisdom as a focus in its study design. The aim was to identify patient preferences for types of communication with their oncologists, yet emerging from the findings was a clear preference from patients and bereaved family members for the concept of “inner wisdom” at the point where treatment becomes focused on quality of life versus a curative approach. Due to the fact that wisdom was not identified at the outset as a concept of inquiry, the findings of Back and colleagues (2014) suggest that the notion of “inner wisdom” exists tacitly enough for patients to identify that they prefer this statement over the others that were employed. Findings such as this offer some potential direction for the field of psycho-oncology, as it aims to offer empirically based interventions for enhancing quality of life when living with cancer. Further investigations of harnessing those potential benefits for patients and providing such resources as “inner wisdom” are promising. This finding also highlights a potential direction for existing research on meaning-making and other existential–spiritual therapies to

foreground wisdom in the study design, and to identify appropriate methodologies for investigating patients' inner lives, as well as garnering patients' own voices in the research on wisdom.

Attending to the ways in which wisdom may emerge through living with cancer and become an inner resource may have untapped therapeutic value for patients as well as clinicians. Incorporating a focus on wisdom in patients' experiences of living with cancer and their encounter with the systems providing treatment could inform broader perspectives on clinical treatment programming. This may strengthen patients' agency and autonomy (Sherwin, 1992) through recognition that they have wisdom to contribute to their own care.

Wisdom was also identified in this review as “practice wisdom,” deriving from clinicians' experiences. This finding is interesting in light of recent calls for attention to practical or practice wisdom in professional practice, in health professional education, and for integration into such contexts as oncology and palliative care (Kinsella & Pitman, 2012; MacLeod, 2003; Roy, 2012; Zucker, 2002). Such “practical wisdom” arising from lived clinical experience may temper the limitations of “conventional wisdom” as promoted by evidence-based guidelines like the Choosing Wisely initiative (ASTRO, 2015; Levinson et al., 2014). In that program, “wise choices” are grounded in evidence-based care and on one level may represent a form of “conventional wisdom” that may not always serve patients well considering the uncertainties and nuances of individual patient care (Bauman, 2015). Our scoping review did not include the literature related to the Choosing Wisely initiatives because only the concept “wisdom”

was used as a search term, and not its variant forms of “wisely” or “wise.” The Choosing Wisely campaign, launched in 2012 in the United States by the American Board of Internal Medicine (Levinson et al., 2014), holds that “the goal is to provide high-quality care, prevent harm, and decrease the use of unnecessary care” (Levinson et al., 2014, p. 2). Since then, it has been launched in many other countries and has grown exponentially (Cassel & Guest, 2012; Levinson et al., 2014). The literature associated with the uptake of this campaign in a variety of countries and medical contexts might benefit from a separate review because of its growth (Cassel & Guest, 2012; Levinson et al., 2014). The Choosing Wisely guidelines aggregate the published evidence, as identified by medical experts, to identify practices that are either associated with harm or an absence of benefit. Thus, these guidelines are best viewed as a subset of evidence-based practice organized through the lens of harm avoidance and system optimization. While it is stated that the guidelines are intended to serve as a starting point for discussions with patients, it is unclear how patients’ perspectives on the meaning and application of wisdom are garnered. For example, while Levinson and colleagues (2014) mention that such key terms as “avoiding harm” and “wise choice” were evaluated for their resonance by key stakeholders in the campaign (including physicians and patients and in a variety of countries), perhaps further conceptual, philosophical, and theoretical investigations of wisdom have potentially significant application and educative value in such movements. Adoption of the Choosing Wisely moniker also illustrates the need for a better understanding of the nature of wisdom in medical

practice to reduce the cooption of a potentially powerful concept to serve more pedestrian needs. Further unpacking of wisdom's meaning(s), which our scoping review points toward as a valuable endeavor for oncology, could support more rigorous investigation among oncology patients as to how this body of evidence in the Choosing Wisely campaign has been established as “wise,” which stakeholders have contributed to this understanding of wisdom, what criteria were being used to identify wise choices, and finally, by what criteria the wisdom of a choice was assessed.

Characterizations of wisdom in our scoping review reflect it as multidimensional and integrating practical, spiritual, transcendental, embodied, emotional, and psychological aspects that are reflected in studies focusing on wisdom in other fields (Ferrari & Weststrate, 2013; Glück & Bluck, 2013; Sternberg & Jordan, 2005; Trowbridge & Ferrari, 2011). Due to wisdom's ineffability (Aldwin, 2009), it may offer a concept that might circulate between and around such dualities as clinician/patient perspectives, psychological/spiritual concepts (Brennan, 2006; Salander, 2015; Wein, 2014), and transcendent/practical dimensions (Wink & Helson, 1997) in the search for a more integrative bio-psycho-spiritual paradigm (Breitbart & Alici, 2009; Chochinov, 2003; Holland, 2009; Sulmasy, 2002).

Of note is that the two empirical studies focused directly on wisdom were conducted among Alaskan indigenous communities, suggesting the possibility of a cultural valuing of wisdom. One might ask whether there are distinct cultures of

wisdom in oncology care contexts that can be intentionally elucidated and in what direction they might point the field of psycho-oncology.

Diffuse concepts regarding wisdom – such as “wisdom of the body,” “unconscious wisdom,” and “soul-wisdom” – appear in essays rather than empirical research studies. An evidence-based-medicine paradigm, for example, has little epistemological flexibility for studying such intangibles (Fenwick, 2014; Greenhalgh, Howick, & Maskrey, 2014; Kinsella, 2012). For instance, “embodied soul” was a central concept in medical practice from Greco-Roman times up to the 18th and 19th centuries, when it was all but erased from Western medical practice as a philosophical conceptualization of human beings, their illnesses, and how they might best be treated (Bates, 2009; De Pablo & Evans, 1994; Wright, 1991). Such discourse is reentering the medical oncology literature through editorial and narrative pieces and is also mirrored in an increased focus on patient-centered practices and patient communication (Bauman, 2015; Butlin, 2015). One wonders if such discourses reflect a hunger or longing for different kinds of conversations in oncology care. For example, MacLeod (2003), a palliative care physician, appeals for a revival of interest in how medical practices can integrate *wisdom* into medicine.

The prevalent anecdotal uses identified in our scoping review further reflect a potential tension in oncology discourses between a form of “conventional wisdom” that may constrain new approaches, knowledge, or innovations (Bull, 2004; Foley, 2001; Raffa, 1997) and a “collective wisdom” that may improve knowledge and practice (Ridley & Fisher, 2013; Robson & Rew,

2010). Wisdom in oncology discourses thus seems to have a dual nature that can be renewing, enlightening, and revolutionizing to clinical practice and commonly held knowledge, but which when unquestioned can become ossified into restrictive and perhaps even harmful beliefs and practices that run contrary to new evidence. The tension between the wisdom that renews and conventional wisdom that constrains suggests that there may be a place for epistemic reflexivity (Kinsella & Whiteford, 2009) – a form of critical interrogation into how such conventional wisdom comes to hold sway in the development of knowledge relevant for practice in oncology care.

The findings of our review further depict wisdom in a range of people – including patients, clinicians, family members, groups, and researchers – in the context of cancer care. Nonetheless, the absence of representations of the wisdom of those living with cancer was particularly noteworthy and may in part be explained by the exclusion of numerous books and articles that may have offered further insights into the wisdom of those living with cancer. This absence reflects how the wisdom of patients can be significantly muted beneath the voices of clinicians and researchers.

Questions are raised as to why patients' voices are absent. Perhaps it is reflective of “who” drives research agendas (usually not the patients) and what gets funded by national research bodies (e.g., the quest for a cure). Further, the culture of oncology may be focused on hope to a greater degree than wisdom in light of a tradition of interventionist focus rather than the more emergent focus on quality of life. Or, perhaps wisdom is an overly retrospective concept—one looks

back for wisdom—at the same time that cancer care is a prospective culture of survivorship. If wisdom is identified as a valuable construct in clinical oncology care, how then to integrate and harness its contribution effectively? There is a disturbing gap between the absence of contributions from patients in the literature reviewed and the growing expert discourses focusing on clinical *phronesis* (practice wisdom) in the medical humanities, medical education, professional practice discourses, and in the editorials, commentary, and opinion pieces by physicians speaking to the concept of wisdom. This gap suggests that researchers in oncology, editors of expert journals, clinicians, managers, and senior administrators may need to be more proactive in promoting publication about care-improvement initiatives based on patient experience (Back, Trinidad, Hopley, & Edwards, 2014; Barnes & Cotterell, 2011; Robert et al., 2015; Rogers, Pickles, Hide, & Maher, 2008; Tsianakas et al., 2012) and research that reflects patients' voices about their cancer, their care, and their well-being.

A fruitful task for scholars and practitioners may well be to learn more about the phenomenon of wisdom—to find effective means to document and harness wisdom; to discover ways to embody wisdom, individually and collectively; to engage in critical reflexivity about what has come to be accepted as conventional wisdom; and to encourage and support the emergent wisdom of those living with cancer and optimize ways of sharing this wisdom with patients and providers. This may help to close some of the gaps between practice and conventional wisdom, patients' and clinicians' wisdom, and academic and grassroots frontline wisdom.

1.4 REFLEXIVE POEM: FROM THE HEART OF HEALTH CARE

This poem was written during the process of conducting the literature view from my immersion into thirty years of literature studying wisdom in the fields of psychology, adult development and aging. Researchers on wisdom in recent decades were turning towards questions of how wisdom might be studied to include embodiment, intuitive and phenomenological forms of wisdom and from the finding of the literature review that while wisdom seemed to be used in oncology literature in taken-for-granted ways, it had not been formally included in constructs of medical practices or what 'wise care' might look like in contemporary forms of medicine.

Breathing Space

From the Heart of Health Care

*how to source values of care
from invisible currencies?*

*we hold onto our selves, yes
we hold onto each other, yes
but that which we seek
hunger
long for
eludes
evades our sorry grasp*

*the seeking
the grasping
all emptying
pouring us into hollow spaces
between the cracks
of smiles
toasts
and handshakes
where other things
like values
like care
become
invisible*

*how to value the empty?
the hollow?
the fallen mind?*

*how to value wisdom
when it will not
form itself
into something
graspable*

*how to trust the
wise way
when it insists
on being*

*no way
in the way
way-less
leaving us
waylaid
on the side
of the straight road
where masses
march towards
a destination
no one has actually seen*

(only heard tell)

*and no-one can remember
its exact location*

(if it ever had one)

*and what is even there
is long forgotten*

*but...the march continues
nonetheless
towards awards
rewards
filled pockets
endlessly
emptying*

while quietly

invisibly

*the wise ones
hold out their
begging bowl*

begging for lost coins...

*love
(is it real?)*

*solidarity
(who dares?)*

*a tiny coin of care
(have you seen one?)*

*the wise ones
are silent*

(do we hear?)



CHAPTER 2

**INTRODUCTION TO HERMENEUTIC-POETIC-PHENOMENOLOGY
METHODOLOGY AND THEORETICAL LENSES**

**CHAPTER 2: INTRODUCTION TO HERMENEUTIC-POETIC-
PHENOMENOLOGY METHODOLOGY AND THEORETICAL LENSES**

2.1 GENERAL CONSIDERATIONS

In this section I offer (a) the problem statement, purpose statement and research questions that guided development of this study; (b) the philosophical and theoretical underpinnings for the novel methodology of hermeneutic-poetic-phenomenology; and (c) the methods for conducting the research. Additionally transparent are the research ethics that undergirded ethical conduct and processes of the researcher conducting the study.

2.1.1 Problem Statement

The wisdom, and opportunities to cultivate such wisdom, that women with stage II to IV ovarian cancer may have access to, is frequently invisible in current oncology practices and discourses. The opportunities for women to gain insights about their existential experiences of ovarian cancer in order to make a contribution to their own care, the care of other women and their relationships and everyday life are few and far between. Further, recognition of such dimensions in clinical discussions with their own care providers, remains challenging and is rendered relatively invisible in the clinical context in which they come for supportive care and treatment.

2.1.2 Purpose Statement

This inquiry seeks to illuminate, within the lived experiences of women living with stage II to IV ovarian cancer, who have participated in a “*Soul-Medicine*” – *For Living With Ovarian Cancer* supportive care group: (a) what meaning(s) participants give to the notion of ‘wisdom’; (b) what might constitute ‘wisdom’ in their lived experiences; and (c) the ways ‘wisdom’ might be experienced through the existential challenges of ovarian cancer.

2.1.3 Research Questions

The following questions formed the basis of research within this thesis:

1) In what ways do women living with ovarian cancer experience the phenomenon of “wisdom” for living daily life, following participation in a facilitated supportive care group?

2) What meaning(s) and lived experiences are revealed about wisdom through the images symbols/images/metaphors generated in their group participation through poetry, art-collages and conversation that participants identify as meaningful?

3) In what ways do women describe the phenomenon of wisdom as it relates to their existential concerns (i.e. fear of recurrence, hope, hopelessness, meaning, meaninglessness, purpose, purposelessness, mortality, well-being, spiritual questions/struggle, spiritual meaning)?

4) In what ways do women describe the phenomenon of wisdom as it relates to the provision of their health care?

5) In what ways do women describe the phenomenon of wisdom as it relates to family members and community supports?

6) Are there emergent findings that could inform structured approaches to fostering wisdom in oncology care, such as: developing wisdom generating practices in women, educating providers about recognizing wisdom in their patients and cultivating wisdom in their own practices, fostering wise practices in family members and community supports?

This chapter begins by situating hermeneutic-poetic-phenomenology within the philosophical tradition of phenomenology. It follows with a conceptual examination of the poetic-phenomenological philosophical work of Bachelard and argues for its relevance to hermeneutic-poetic-phenomenological methodology. This is followed by an examination of the methodological affordances of four key concepts in Bachelard's philosophy (a) imagination and horizons of hope; (b) imagination and reverie; (c) image-centered knowledge; and (d) material imagination. These concepts are examined and illustrated with study findings to assist with exemplifying Bachelard's rather unique and complex philosophy of imagination and poetic-phenomenology and integrated into hermeneutic-poetic-phenomenology.

2.2 HERMENETIC-POETIC-PHENOMENOLOGY: A NOVEL

METHODOLOGY

*Suddenly an image situates itself in the centre of our imagining being.
It retains us; it engages us. It infuses us with being.*
(Bachelard, 1969, p. 153).

How can we enter the poetisphere of our time? (Ibid, p. 25)

Phenomenology is both a philosophical perspective and a methodology that inquires into phenomena experienced in everyday human life (Park Lala & Kinsella, 2011; Wright-St Clair, Kerse, & Smythe, 2011). Hermeneutic-poetic-phenomenology is proposed as an approach to qualitative inquiry that responds to calls in the field to discuss the role of poetics and “poeticizing” in phenomenologically informed research (Todres, 2007; Van Manen, 1997). Van Manen (1997) writes that researching lived experience is “not unlike poetry, it is a poetizing project”; a “poeticizing activity” (p. 13). He notes that in phenomenology “results cannot be severed from the means of attaining them” and that a phenomenological approach aims toward “poetizing” through “evocative speaking” and “a primal telling” (p. 13). The notion of *poiesis*, from which “poeticizing” is drawn in English, is defined in the Oxford dictionary (2012) as “creative production” and connotes “to make” and links to the meaning of “poetic” which is defined as, “creative, formative, productive, active”. Yet these English words, impoverish an ineffability to the creatively transforming dimension of *poiesis* held within its meaning. *Poiesis* is used in this discussion of methodology to include van Manen’s (1997) notion of “poeticizing” to connote a catalytic

dynamism within phenomenon. '*Poiesis*' and '*poeticizing*' are both used here to point us towards a creative, spontaneous emergence of phenomenon in their 'becoming'. As well, they infer a transforming agency to bring phenomenon, dwelling invisibly, taken for granted, into 'being', embodied into visibility, not in a static way but in an endless movement, spiralling between 'being' and 'becoming' as *poiesis*.

To orient the reader for the following detailed presentation of the philosophical underpinnings, Hermeneutic-Poetic-Phenomenology the following summary is provided.

Hermeneutic-poetic-phenomenology is a novel methodology drawing on Gaston Bachelard's (1960/1969) philosophy of poetic-phenomenology and places it within an interpretive lens by linking it with hermeneutics. It uses poetics throughout, as a method of inquiry, to conduct analysis that is *hermeneutic* (meaning, language, words, context, culture, lifeworlds) and *phenomenological* (invisible, taken-for-granted, phenomenon – operating out of awareness but moving our ways of 'seeing' and 'acting' in the world actions). Poetic inquiry is joined with the philosophical underpinnings of Gaston Bachelard's poetic-phenomenology as a means for 'poeticizing' the analysis process, opening the researcher up to intuitive, non-verbal, feeling, felt-sense dimensions of the phenomenon and to open an interior space for *poiesis* to emerge about and from within the researcher in an encounter with the phenomenon under investigation through the 'poeticizing' process. Findings are represented in a phenomenological-poem – a poem that evokes and reveals, invokes and points

the reader towards their own encounter and potential *poiesis* of meaning(s) and experience(s) of the phenomenon.

Presented now are the philosophical underpinnings for the differentiated aspects of hermeneutic-poetic-phenomenology as a methodology developed specifically for this investigation on wisdom.

2.2.1 Interpretivist Research Paradigm

An interpretive turn took place in philosophy of science and social science around the 1960s and 1970s (Kuhn, 1967; Taylor, 1987). Interpretivism is a school of thought that stresses the importance of *both* interpretation and observation (Snape & Spencer, 2003) and suggests that humans are continuously interpreting their world, and engaging in acts of interpretation related to knowledge construction (Kuhn, 1967). In our interpretations of the world, Goodman (1978) suggests that humans are involved in “world-making” (p.6); he asserts that arts need to be considered, in addition to science, as legitimate contributors to knowledge generation (p. 102).

This research, is grounded in the assertion of an interpretivist understanding that (Snape & Spencer, 2003):

- knowledge is generated by and intertwined with situated experience (Haraway, 2004; Harding, 1991);
- interpretation is influenced by the social, historical and personal contexts of the ‘knower’;

- the interpretive role of the researcher is integrated as contributive to knowledge generation.

2.2.2 Phenomenology

Phenomenological philosophy, and the research traditions grounded in it, aim to “evoke pre-reflective, or primordial stories, of particular moments or events ... the storied textual accounts of in-the-moment experiences that hold potential to throw new light” (Wright-St. Clair, 2015, p. 58). Van Manen (1997) highlights that phenomenological methodology “requires an ability to be reflective, insightful, sensitive to language, and constantly open to experience” (p. xi).

After decades of research predominantly investigating wisdom’s characteristics within behavioural science and a post-positivist methodology (Ardelt, 2004; Glück & Bluck, 2013), researchers have recently suggested the need for a turn toward phenomenological methodology for studies of wisdom (Küpers, 2007; Yang, 2008). Interestingly, whilst forerunners in wisdom research frequently referred to wisdom as a phenomenon (Baltes & Baltes, 1990; Baltes & Smith, 1990; Staudinger & Baltes, 1996), they did not specifically engage in phenomenological inquiry to elucidate it. Ardel (2004) points to this tension in her critical review of wisdom research and specifically critiques the limitations of definitions, operationalization and measurements of wisdom in light of objectivist and positivist epistemological approaches shaping research methodologies. In response, leading wisdom researchers themselves have contended “wisdom may be beyond” what traditional methodological approaches “can achieve”

(Baltes & Staudinger, 2000, p. 123). Ardelt's critique suggests that turning to other more appropriate methodologies might be useful.

Glück's (2017) recent review article, offering a summation of new developments in the field of wisdom research, suggests that qualitative research methodologies hold promise for the field of wisdom research. A recent study used Grounded Theory for investigating wisdom at end-of-life (Montross-Thomas et al., 2018), while Saraga, Boudreau and Fuks (2018) used Interpretive Phenomenological Analysis (IPA) to investigate the phenomenon of practical wisdom in physicians' clinical practice. Küpers (2007), from studying wisdom in the context of leadership, recommends phenomenology as a generative methodology for investigating wisdom, given its capacity to attend to its "inter-relating", "intersubjective", and "interdependent" aspects (p. 173). He notes some common threads that connect phenomenology with investigations of wisdom:

As phenomenology aims to describe and understand how phenomena present themselves in the lived experience of "being in the world", so practices of wisdom relate to experiential dimensions of human existence. With this, phenomenology and wisdom value mindfulness for keeping consciousness alive to the *present life-worldly reality*, that is for helping make sense of phenomena and for aiding the ability to understand, interpret and transform. (p. 174)

This study takes Ardelt's (2004) critique, and Küper's (2007) call, to investigate wisdom from a phenomenological perspective.

2.2.3 The Philosophical Phenomenological Tradition

Husserl (1859-1938) is considered a foundational influence in the phenomenological tradition (Crotty, 2003). He vigorously challenged abstracting

tendencies in objectivist sciences applying scientific method to the study of human life and thereby increasingly abstracting generalized theories about human life from the actual lived experiences of people (Crotty, 2003; Dowling, 2007). Husserl became known for his “battle cry of ‘back to the things themselves!’” meaning the phenomenon that are taken-for-granted where, if inquired into with fresher eyes, with more focused intention, may be mined for new, deeper and renewed insights and meaning(s) (Park Lala & Kinsella, 2011). Husserl’s express aim in developing phenomenology as *both* a science and philosophy aimed at “elucidating lived experience” (Van Manen, 1997, p. 25) that offers “plausible insights that brings you in more direct contact with the world” (p. 9). As such, phenomenology aims to illuminate and revivify phenomenon that are familiar to us, such as ‘aging’ (Wright-St Clair et al., 2011) where the “common meanings” (Taylor, 1987), such as ‘wisdom’ have lost their aliveness and the lived experiences in their specificity are erased to us. Husserlian informed phenomenology focuses on “*description* of the lifeworld and lived experiences rather than *interpretation*” (Finlay, 2011, p. 93) and aims to bring an “essence” (Van Manen, 1997, p. xii). This approach rests on an underlying ontology asserting the possibility that there are such essences before any conscious act of inquiry and that these can be revealed by “human inquirers on lifeworlds and phenomenon in lived experience” (Van Manen, 1997, p. 25).

A phenomenological approach in research methodology can take a phenomenon circulating with “common meaning” and taken-for-granted in its anecdotal use, such as was found with ‘wisdom’ in oncology literature and

investigate its lived meaning(s) with specific participants to illuminate the phenomenon (Kinsella, 2007; Wright-St. Clair, 2015).

Phenomenology is thus a methodology that integrates a strong philosophical foundation with a method of inquiry into taken-for-granted phenomena experienced in human life (Park Lala & Kinsella, 2011).

2.2.4 *Hermeneutic Phenomenology*

Martin Heidegger (1889-1976) is considered the father of existential-philosophy and interpretive phenomenology and his work has been used as a primary philosophical underpinning for many social and health science research inquiries using hermeneutic phenomenology (Smythe, Ironside, Sims, Swenson, & Spence, 2008) which in turn has informed contemporary developments of phenomenology (Smith, Flowers, & Larkin, 2009).

Hermeneutics is frequently defined as the art of interpretation (Kinsella, 2006). Indeed, the terms hermeneutic and interpretive are frequently used interchangeably, and are closely related in phenomenological research approaches. Wright St. Clair (2015) suggests, "Interpretive [or hermeneutic] phenomenology is a suitable mode of inquiry when little is known about the 'hidden' phenomenon of interest" (p. 6). Interpretive phenomenology draws on the philosophical underpinnings provided by Heidegger (1927) who was a student of Husserl's but then took his work into a new direction that catalyzed the interpretive tradition in philosophy and research inquiry (Crotty, 2003).

Heidegger argued that humans are always interpreting as an aspect of human consciousness (Park Lala & Kinsella, 2011). Heideggerian informed phenomenologists contend that a *hermeneutic*-phenomenological approach grounds academic discussions in a focus on lived *experience* that “resists being pinned down, refuses to be a set of steps, is enacted differently by each one of us, and yet shares a common quest” (Smythe et al., 2008, p. 1390).

Later in his life, Heidegger (1971) discussed the poetic dynamism of *poiesis* within human interiority as something that urges existential experience into language. Poetic language can both *reveal* and, over time and with common use, *conceal* the existential phenomenon within words, idioms, metaphors and symbolic language that are formed and used in everyday speech. While Heidegger’s later work investigated *poiesis* and the poetic dimension of language, it was Gaston Bachelard (1969) who investigated the poetic image and its genesis within a phenomenology of imagination as means for restoring it to significance in human ‘being’ and ‘knowing’.

Studying with Heidegger, it was Ricoeur (1970, 1977) who contributed to a more fully theorized ‘hermeneutic turn’ in phenomenology (Schwandt, 2000). He furthered Heidegger’s work arguing that any employment of language, such as in phenomenology, is infused with the interpretive dimensions of the language being employed (Kearney, 1991). The one using language for description is already inheriting interpretations and offering interpretations through their choices of words. In other words, the world around humans is already interpreted to some degree by the very language passed on, and always mediating socially

influenced perspectives and the always-already-interpreting consciousness of the human being.

Taking up the focus that hermeneutic-phenomenology focuses on the interpretation of *meanings(s)* of the phenomenon under investigation rather than *descriptions* (Smythe, Ironside, Sims, Swenson, & Spence, 2008). This study brings a lens to the types of ideographic *meanings* ascribed to 'wisdom' by the participants. Kearney (1998) suggests that hermeneutics put simply is "the art of deciphering hidden meanings" (p. 147). Such interpretation involves negotiating what has been described as a hermeneutic circle: "moving between the part (individual, life context, culture, time, place, personal meanings, social meanings, cultural meanings) and the whole" (Crotty, 2003, pp. 98–99). It pays attention to *contextual* meanings and "goes beyond rich descriptions of things, towards understanding" and "is not a thematic analysis of the content ...it is a way of thinking, the gaze is always directed toward the phenomenon within the text" (Wright-St. Clair, 2015, p. 62). These contextual meanings can be those arising from within the individual's own life situation, experiences, cultural, socialization, innovation as well as the collective meanings within a particular lifeworld for a group or society at large. An eye to contextual meanings can, and must in the interpretivist tradition, include the researcher's influence upon those meanings so there necessarily can be an "... 'interpretive leap', when suddenly something otherwise concealed shows itself in some way" (Wright-St Clair et al., 2011, p. 62). Thus, hermeneutical-phenomenological inquiry can engage a process where "inter-subjectivity is embraced" in the research process (Finlay, 2011, p. 109). I

propose that a hermeneutic-phenomenological methodological perspective, may help to illuminate ‘taken-for-granted’ understandings of wisdom and offer new, (or renewed), deepened and expanded interpretations (Park Lala & Kinsella, 2011).

2.2.5 Hermeneutic-Poetic-Phenomenology

2.2.5.1 Gaston Bachelard’s Poetic-Phenomenology

Gaston Bachelard (1938/1964, 1939, 1942/1983, 1943/1988, 1946, 1948/2002, 1958/1994, 1960/1969, 1988) was an early twentieth century philosopher and phenomenologist, and was the inaugural Chair of the History and Philosophy of Sciences at Sorbonne University, Paris from 1939 to his death in 1961 (Chimisso, 2001). Bachelard was a contemporary of Martin Heidegger whose work he read and took up with an interest in phenomenology as a method of inquiry. Towards the end of his career as a philosopher of science and an avid supporter and teacher of the value of scientific reason for researching the material world, Bachelard turned to studying the phenomenology of imagination (Bachelard, 1958/1994, 1960/1969) to advocate for the crucial role of human imagination in sustaining ‘well-being’ and ‘flourishing’ in human life (Bachelard, 1960/1969; Kearney, 1998).

Bachelard is posited as an underutilized philosophical resource with the potential to contribute important epistemological insights to qualitative research (Scheurich & McKenzie, 2005). Like Heidegger he saw language as a “living force” that can elicit from us a poeticizing effect; he writes, “....poetic reveries are also born from the living forces of language” (Bachelard, 1969, p. 46).

Bachelard (1969) writes, we must “recognize a power of poetization which can well be designated as a psychological poetics” (p. 16). He developed his unique poetic-phenomenology to investigate the poetic image as revealing the dynamic of *poesis* in human imagination with implications for well-being, preserving the humane and humanizing dimensions of life, and for ameliorating existential angst and alienation. He argued for a reclamation of imagination from its philosophical exile (Kearney, 1988). For Bachelard (1969) “a poetic image can be the seed of a world, the seed of a universe imagined out of a poet’s reverie” (p.1). Bachelard was very influential for a number of European philosophers and academics who are more widely used in North American scholarship today; thinkers such as Foucault, Derrida, Althusser, Sartre and Merleau-Ponty (Kearney, 1998, p. 96). As many great contributors to philosophy are, he was a multi-faceted person and original thinker, drawing together multiple sources and genres to originate his unique philosophy (Chimisso, 2001).

2.2.5.2 Philosophical Underpinnings

In articulating a hermeneutic-poetic-phenomenological methodology Bachelard’s (1960/1969; 1942/1983) poetic-phenomenology is drawn on to provide philosophical underpinnings for this novel methodology.

Drawing on Bachelard, this study contends that poetic approaches to phenomenology attend to the unique power of the poetic image as a means of communication that extends beyond that of the representational ‘concept’. As Bachelard (1969) asserts:

Between the concept and the image, there is no synthesis... Whoever gives himself over to the concept with all his mind, over to the image with all his soul knows perfectly well that concepts and images develop on two divergent planes... By giving stability to the image, the concept would stifle its life. (p. 51-52)

Building on an in-depth study of Bachelard's (1938/1964, 1939, 1942/1983, 1943/1988, 1946, 1948, 1958/1994, 1960/1969, 1964, 1983, 1986, 1988) philosophical inquiry, hermeneutic-poetic-phenomenology is proposed as a research approach that has the potential to engage with poetic, embodied, contemplative, and existential dimensions of phenomena. It engages with Bachelard's (1969) notion of "poetico-analysis" (p. 123) applied to the phenomenon of wisdom for attending to the poetic, embodied, contemplative, existential, spiritual dimensions of wisdom, and its formation, within the lived experience of the women (Finlay, 2011; Romanyshyn, 2007; Todres & Galvin, 2008). By integrating a hermeneutic approach to Bachelard's "poetic-phenomenology" the interpretive role of the researcher is acknowledged and highlighted as an integral dimension of the inquiry.

Hermeneutic-poetic-phenomenology offers a means to attend closely to images, metaphors, and symbolic language for their meaning-laden immediacy; or what Bachelard (1969) refers to as "image-centered knowledge" (p. 7). Furthermore, as Bachelard writes, "...it is through reverie one must learn phenomenology" (p. 14) this methodology also seeks to exemplify that the necessary approach to reading poetry requires an attitude fundamental to phenomenology as a form of inquiry. This has been named by early phenomenologists as the "phenomenological attitude" (Park Lala & Kinsella,

2011; Wright-St. Clair, 2015; Wright-St Clair et al., 2011) Bachelard links this stance of the phenomenologist with the notion of “reverie” and states, “...the I which dreams the reverie reveals itself not as poet but as poetizing I (p. 22). Thus, the experience of reverie, in itself, is an encounter with phenomenon in life versus conceptualizing knowledge about lived experience. It may hold forth a greater potentiality for evoking the phenomenological aim of an ‘aha’ moment in the reader about taken-for-granted phenomenon.

Poetics as findings and their representation might lend a reader the possibility of expediently entering into and engaging with the phenomenon under study. Reverie allows for approaching a poem, not in an attitude of speed reading, but rather in a slower, more contemplative stance inviting musing, reflection, insight and awakening to new experiences of a phenomenon, familiar, yet revived from the encounter. Reading the poetics of findings in a poetic phenomenology study might give a reader, unfamiliar with phenomenology per se, personal and experiential insight into the purpose and potential of phenomenology as a method of inquiry. An attitude of reverie, dwelling with the poem, its images, turns of phrases, opening oneself to an encounter with something not yet known in oneself is all that is required. The reader might then encounter poetic phenomenology’s potential potency for awakening insight and perhaps to be moved towards making changes in oneself, one’s professional practice and personal life.

Bachelard’s poetic-phenomenology highlights the significance of the imagination as an embodied dimension of poetics giving rise to the poetic image.

Bachelard contends that “a universe is born from a single image” (Bachelard, 1969, p. 175) articulating the condensed mediation of meaning and lived experience that images convey. His work illuminates the immediacy of the poetic image, and suggests poetics as able to mediate an originating *poesis* of the phenomenon that the image brings to the attention of the hearer or reader. This *poesis* is sparked through evocation and resonance, as readers imaginatively enter the poetic image and encounter their own lived experience of a phenomenon. *Poesis* is thus different in process and effect than knowledge translation; research that can convey *poesis* may be an effective means for revealing and mediating the less conceptually graspable layers of existential, spiritual and emotional dimensions of human experience. A poetic image can evoke a ‘knowing’ rather than an intellectualized form of ‘understanding’. On Bachelard’s phenomenological investigations into imagination, Étienne Gilson (Bachelard, 1958/1994) writes, “I feel quite certain that their ultimate import has not yet been fully realized. Perhaps it will never be, for what Bachelard calls imagination is a most secret power that is as much of a cosmic force as of a psychological faculty” (p. xiii). The term *poesis*, perhaps best captures for the contemporary mind this deeply intangible dimension of the human psyche.

Bachelard’s body of work was his effort to study this dimension of *poesis* in the human mind through a focus on its expression through the poetic image for studying imagination at the ontological level, within ‘being’, would be impossible. The poetic image was his means to explore the phenomenon of imagination operating with human being and becoming, the poetic image as the ‘becoming’ of

imagination at the level of our unknowable, ineffability of human 'being'. Therefore, Bachelard (1958/1994) studies the potency of phenomenon encased within *poetic images* as a means for a "communion" with "great ontological significance" (p. xvii). He states, "The poet does not confer the past of his image upon me, and yet his image immediately takes root in me" (p. xvii). This happens in such a way that Bachelard's phenomenology of the poetic image proposes,

"The poetic image is not subject to an inner thrust. It is not an echo of the past. On the contrary: through the brilliance of an image, the distant past resounds with echoes, and it is hard to know at what depth these echoes will reverberate and die away. Because of its novelty and its action, the poetic image has an entity and a dynamism of its own... (p. xvi)

For example, Bachelard (1994) offers the image, "a lamp in the window is the house's eye" (p. 34). He shows us, "With the example of the hut and the light that keeps vigil on the far horizon, we have shown the concentration of intimacy in the refuge, in its most simplified form" (p. 37). The image of a dwelling with a single lamp burning in the window can invoke from within the reader a sense of home, hearth, warmth, intimacy, safety, longing, belonging, of times of being an outsider looking in and times of being an insider looking out on the world. This singular image elicits 'intangibles' of resonances with the image of a lamp in the window in our imaginal life without lengthy description. In Bachelard's (1969) words, "There, we are touching on one of the paradoxes of the imagination: while thinkers who reconstruct a world retrace a long path of reflections, the cosmic image is immediate" (p. 175). He notes the paradox and power of the poetic image:

The crisis on the simple level of a new image, contains the entire paradox of a phenomenology of the imagination, which is: how can the image, at times very unusual, appear to be a concentration of the entire psyche? How – with no preparation – can this singular, short-lived event constituted by the appearance of an unusual poetic image, react on the other minds and in other hearts, despite all the barriers of common sense, all the disciplined schools of thought, content in their immobility? (Bachelard, 1969, p. xiv)

Bachelard (1960/1969) argues, in the last book of his career, that the poetic image is the most direct source to a resonance with the original experience of the poet and as such, through the poetic image the ontology and value of imagination, poetics and 'reverie', the attitudinal state of contemplation on the cosmos, could be studied, through a phenomenological approach. As such, Bachelard (1969) finds he must create novel terms such as "existentialism of the poetic" (p. 119), poetic phenomenology (123), poetics as a "psychology of frontiers" (p. 123), the image as a "psychological fact", "poetico-analysis" (p. 123), meaning an analysis of the poetic image for its capacity to evoke reverie and an existential resonance in the reader of an original, mediated, experience of the writer to the reader. "Poetic-analysis" says Bachelard, "ought to return all the privileges of the imagination to us. Memory, without reverie, is a field full of psychological ruins, a whatnot full of memories...." (p. 100). On imagination, Bachelard writes (1958/1994):

And what is more, the imagination by virtue of its freshness and its own particular activity, can make what is familiar into what is strange. With a single poetic detail the imagination confronts us with a new world. From then on, the detail takes precedence over the panorama and a simple image, if it is new, will open up an entire world. (p. 134)

As well as opening up new worlds from within our inner life, Bachelard (1960/1969) also argues for the poeticizing imagination as playing a role in genesis, a creating activity in the human psyche:

...the phenomenological requirement with respect to poetic images is simple: it returns to putting the accent on their original quality, grasping the very essence of their originality and thus taking advantage of the remarkable psychic production of the imagination” (p. 3).

He further suggests, “...we must then recognize a power of poetization which can well be designated a psychological poetics” (p. 16).

This study is thus founded on Bachelard’s work as contributing to an epistemological shift focused on reclaiming the value of poetics and imagination in human well-being and inquiry, and as its own species of knowledge generation, differentiated from conceptual processes.

By integrating a hermeneutical approach with Bachelard’s poetic-phenomenology, this methodology provides space for an explicit focus on the interpretive dimensions of such inquiry, allowing for the interpretive role of the researcher to be engaged and images arising in their writing and imaginal life in response to the research data, to be attended to as part of the inquiry. Ricoeur argued for such a hermeneutical treatment of the image; he claims that

...what matters in imagination is less the *content* than the *function* of images...for new meanings to come into being they need to be spoken or uttered in the form of new verbal images. And this requires that the phenomenological account of imagining as *appearance* be supplemented by its hermeneutic account as *meaning*. (Kearney, 1998, p. 148)

Thus a hermeneutic-poetic-phenomenological methodology has the potential to bring into focus inter-subjective, relational and processual dimensions

of meaning formation (Küpers, 2005, 2007; Yang, 2008). The poetic image itself imbues the research process with rich and opened horizons of meaning. The poetic form allows for evocations, creative representations of the data, such that it invites readers or hearers into resonance with, or experience of poetic representations of phenomena.

2.2.5.3 *Embodiment and Poetics*

This study joins with others who link poetics and embodiment (Prendergast, Leggo, & Sameshima, 2009; Todres, 2007; Todres, 1998). A number of scholars have suggested that the poetic and the act of *poiesis* in poem-making has the potential to elicit embodied epistemological insights (Knowles & Cole, 2008; Tasker et al., 2014), change the face of traditional epistemological perspectives (Öhlen, 2003; Richardson, 1992a, 1992b), and ‘re-body’ approaches to knowledge-generation (Todres & Galvin, 2008).

Bachelard (1960/1969) declares his phenomenological project to be implicated in the generativity of a particular kind of *existential* and *embodied* knowledge. It is Bachelard’s (1960/1969) investigations of the poetic image and its capacity to not only bring insight to the reader but also to *mediate* a particular type of lived, embodied experience that foreshadowed contemporary researchers’ work, such as Galvin and Todres (2009). Galvin and Todres (2009) argue that an integration of poetic inquiry with phenomenological research inform an inquiry process they term “embodied interpretation” (p. 305). They suggest

that embodiment and poetic inquiry are fundamentally inter-related with the aims of phenomenology.

It is also Bachelard's (1938/1964, 1942/1983, 1943/1988; 1946; 1958/1994, 1960/1969) work that suggests that particular poetic images reveal and mediate immediate, lived experience in a way that evoke and resonate with the readers, and which may even to transform the reader's experience of their lifeworld. Outlined are three dominant themes in his project: (1) the poetic image as having generative, transformative potential, (2) the poetic image as capable of *mediating* direct experience and not merely recounting it, (3) the "poetics of the perceptible" as a means for informing embodied dimensions of inquiry.

The philosophical roots for claims that link embodied inquiry with poetic inquiry through phenomenology are found in Bachelard's (1960/1969) phenomenology of the poetic image. Bachelard elucidates that poetics and phenomenology both integrate embodiment in ways that can be usefully foregrounded and explored in phenomenological methodology. His philosophical study of the phenomenology of poetic images and behind this, the ontological role of imagination may be useful for advancing fields such as poetic inquiry and embodied inquiry.

Prendergast (2009) highlights why evocation of a felt sense is not the only or end aim of poetic forms of inquiry and representation. Poetic inquiry, versus poem writing, aims to further insights into meaning and invite deepened understanding both in the inquirer and as well as the reader. She argues, "We stop short of claiming that we are writing poetry as a primary concern because

our evocative interests occur within the human scientific concern and a broadly hermeneutic tradition” (p. 313). Poetic inquiry thus interfaces between poetry and research as a genre that pushes beyond just evoking a feeling experience in the reader but invites them to deepened understanding, perhaps even questions and provoking their own curiosity into the phenomenon at hand thereby engaging head and heart, understanding *and* experience (p. 313). In sum, at the interface of embodiment and poetic inquiry:

“Embodied interpretation emphasizes its *holding* before its *sharing* in order to permit the phenomenon to touch us so that it can touch another. The aesthetics of embodied interpretation involves play, embodied resonance, care for the phenomenon, and its aliveness...care for the audience, a contemplative gesture of dwelling, an interest in a kind of human understanding of where things have come from and where they are going (narrative coherence), a hermeneutic scientific concern with how parts and wholes fit together, and an existential concern for our uniqueness and commonality” (p. 315).

Prendergast thus lays out an argument for the interweaving of theories of embodiment, poetics and the aims of phenomenology with these three dimensions as a potent combination for inquiry.

2.2.5.4 Ethics and Critical Insight

Bachelard’s (1960/1969) focus on imagination within poetic phenomenology reveals an ethical imperative and critical standpoint. Bachelard (1969) turned to poetic-phenomenology within a context of the rise of fascism in Europe during and after the years of World War II. He argued for redemption of the poetic imagination as critical for human life to flourish. As Chair of Philosophy of Science at Sorbonne University in Paris, Bachelard had witnessed the

implications of fascism's radical use of instrumental reason for its ends (Kearney, 1998). Bachelard (Bachelard, 1960/1969; Bachelard, 1958/1994; Bachelard, 1983) worked on a subtle remedy by arguing for imagination's restoration to its rightful place in philosophy given its significance to the understanding of human flourishing and its generative force in human betterment and well-being. Bachelard (1960/1969) resolutely sounded a call in his final publication offering the sum of his work on a phenomenology of imagination that a return to reverie, and attention to the potent, transformative potential of the poetic image might help to heal the human sense of alienation and serve as a critical anti-dote, sustaining human agency, creativity and connectivity, in face of the rise of instrumental reason's sway over human life and creativity.

Kearney (1998) ascribes to Bachelard, an illumination of imagination and its ethical role in human life. He quotes Bachelard "the world in its entirety needs to be renovated" (Kearney, 1998, p. 7) which Kearney refers to as the "ethical imagination" (p. 6). For Kearney, the ethical orientation of imagination arises from its capacity to envision a different future from one that invokes despair and helplessness, to one that inspires hope and meaning in the present, and action towards its future becoming (Kearney, 1998).

Whereas the paradigm of scientific reason focuses on human progression through rationality and logic; Bachelard proposed that imagination nourished and balanced such progression with deepened connection to what it means to be human. Kearney (1988) further links poetic imagination to ethics with his theory

of the 'ethical imagination' arguing that it demands of us the capacity to "imagine otherwise" (p. 364). He argues that:

[an] imagination responsive to the ethical dimension of things would be *critical*. But it would also be *poetical*. ...inventive making and creating carried by the word *poiesis*. If the ethical Imagination is not to degenerate into censorious puritanism or nostalgic lamentation it must also give full expression to its *poetical* potential. (p. 366)

Kearney (1998) suggests that at the end of the day imagination "cannot take leave of the other" (p. 218); imagination and its inner life and production of new ideas, new visions of future changes, cannot exclude the 'Other' in its focus. Imagination must involve dialogue with the 'Other' and envision the 'common good' if it is to prevent solipsism (Kearney, 1988, 1998). For Kearney, "Here and now I face an *other* who demands of me an ethical response" (Kearney, 1988, p. 261). Indeed, it has been stated that "phenomenological traditions incorporate and acknowledge that life cannot be truly compartmentalized and human beings cannot be objective" (Tasker et al., 2014, p. 5). Bachelard's call and his turn to studying the role of human imagination in well-being and its enrichment of human life, has, half a century later, borne out to be a call that we cannot ignore (Kearney, 1998).

As research institutes and researchers find themselves in increasing challenges to meet bottom lines and provide outcomes based findings that serve industry, for-profit interests (Fenwick, 2014; Greenhalgh, Howick, & Maskrey, 2014), a turn towards hermeneutic-poetic-phenomenology may well be a politically significant and humanizing. Such an approach may be seen to offer a "zone of resistance" (Birardi, 2009) or "poetic resistance" (Kinsella, 2006) to

reductionist views of the lifeworlds of persons who are ill. As Smythe et. al. (2008) suggest, “the finding is a calling, an invitation to others to come and look and think along with us, rather than extracting a generalizable ‘this is true for everyone’ series of statements. To ‘find’ is to point towards that which already withdraws” (Smythe et al., 2008, p. 1393). A hermeneutic-poetic-phenomenology invites such a call. Tasker, Loftus and Higgs (Tasker et al., 2014) highlight the value of poetics in phenomenology suggesting, “People make meaning of their experiences in conversations with other people and poetic phrases within such talk offer a means of coming to deeper understanding of those experiences” (p. 5). Poetic inquiry, through a phenomenological approach is thus a way into deepened insights and revealing of existential states in human interiority that can be otherwise difficult to reveal in ways that move, evoke and expand empathic insights from readers of the research.

2.2.5.5 *‘Reverie’ and the Phenomenological Attitude*

Bachelard (1960/1969) discusses ‘reverie’ as a means of fostering a poetic-phenomenological attitude and suggests spaces for ‘reverie’ foster a sense of well-being. Reverie in phenomenological methodology involves ‘dwelling’ with the material in the ‘phenomenological attitude’ (Park Lala & Kinsella, 2011; Wright-St. Clair, 2015; Wright-St Clair et al., 2011). For Bachelard (1960/1969) dwelling on the phenomena within a poetic image is best experienced in a state of ‘reverie’: “ the images of the poet’s reverie dig life deeper, enlarge the depths of life” (p. 155). He writes, “From one reverie to the

next, the object is no longer the same; it renews itself and this renewing is a renewal of the dreamer” (p.156).

Bachelard (1960/1969) calls for “slow reading” (p. 161) as a means for reverie, in which a *poesis* of a phenomenon may be evoked from within a world of meaning and experience. Reverie attends to the cosmos as a source of inspiration and belonging. For Bachelard “the imagining consciousness holds its object (such images as it imagines) in an absolute immediacy...the shortest route of all is between the imagining subject and imagined image” (p. 151). In reverie the imagination is allowed to flow from one image to another, mining meaning and comfort from the process as “the simplest hearth encloses a universe” (Bachelard, 1969, p. 193). Hermeneutic-poetic-phenomenology allows for reverie by bringing the researcher into a posture of dwelling with the images that emerge in the data, with the aim of foregrounding the images through poetic representation. The poetic representation of images can thus invoke reverie in the reader as they too are invited into ‘slow reading’ and dwelling with the poem’s images, thus evoking their own experience of the phenomenon under investigation and potentially yielding personal insight.

2.2.5.6 Reclaiming Story in Health Care Research

Frank (2000; 1997, 2013) has devoted much of his career as a medical sociologist attending to the poeticizing dimensions of human being and knowing, particularly in experiences of illness. He calls for means to “counter-story” the biomedical narratives that people who are ill find themselves in. A hermeneutic-

poetic-phenomenology holds potential to foreground aspects of people's illness experiences and to mediate these in creative, agency mobilizing, catalytic ways. A hermeneutic-poetic-phenomenology invites the audience who encounters representations of the findings into their own encounter allowing for new horizons to open up in their imaginal worlds. In this way, a hermeneutic-poetic-phenomenology holds implications for a trajectory beyond the research study, pointing the audience towards the "surplus of meaning" dwelling in the poetic experience of the images, potentially catalyzing the individuals receiving the poetic findings to be drawn towards a new, not yet visible, future of possibility (Bachelard, 1960/1969).

2.2.5.7 Conclusion

The above section presents philosophical underpinnings for the productive potential of hermeneutic-poetic-phenomenology. Although his work has largely been overlooked it is argued that Bachelard has much to offer contemporary conceptions of phenomenological research, particularly through his articulation of a poetic phenomenology, and his attention to: the power of the poetic image, the phenomenological attitude of reverie, and the use of the poetic imagination. Using these philosophical underpinnings afforded by Bachelard, it is argued that a hermeneutic-poetic-phenomenological approach to inquiry brings into view the poeticizing capacity of human consciousness, and the power of embodied lived stories of illness experience to speak to existential concerns. We have argued for hermeneutic-poetic-phenomenology as a worthy research methodology with an

important and timely approach to research in health and social care contexts. It has the potential to offer a humanizing, creative, poetically evocative approach to the study of taken-for-granted phenomenon in lived experiences of illness, health and social care. Furthermore, we propose that it offers a way for researchers and readers to experience a potentially transformative approach to gaining insight and renewal within their research experiences. Poetic findings from this study are used to illustrate the power of the poetic image for qualitative research. Key concepts from Bachelard's philosophy are illuminated including: (a) imagination and horizons of hope; (b) reverie; (c) image-centered knowledge; and (d) the material imagination (section 2.3, Theoretical Lenses). As such, this methodology offers a starting point for further integration of Bachelard's philosophy into contemporary phenomenological research. Reinvigorating Bachelard's poetic phenomenology in research practices and methodologies can guide us to deepen attention to a philosophy of imagination in research. It has particular relevance for researchers exploring poetic inquiry (Butler-Kisber, Guiney Yallop, Stewart, & Wiebe, 2017; Galvin & Todres, 2009; Prendergast et al., 2009; Wiebe, 2015) and embodiment (Brown, Cromby, Harper, Johnson, & Reavey, 2011; de Jager, Tewson, Ludlow, & Boydell, 2016; Park Lala & Kinsella, 2011; Todres, 2007; Todres & Galvin, 2008) in qualitative methodology offering philosophical rigor to a focus on evocation, aesthetic, embodiment in both conduct and representation of the research. As Bachelard (1969) states, "Thus the images of the poet's reverie dig life deeper, enlarge the depths of life" (p. 155) and as such it makes this type of phenomenological research, with its

emphasis on a more contemplative and poetic approach to the process, part of “enlarging the depths of life” for researcher, participants and the social world in which it is shared.

A hermeneutic-poetic-phenomenology thus holds potential to foreground silenced voices or aspects of people’s illness experiences and to mediate these in creative, agency mobilizing, catalytic ways. It invites the audience who encounters representations of the findings into their own encounter allowing for new horizons to open up in their imaginal worlds. In this way, such an approach points readers towards the broader horizons of meaning dwelling in the poetic experience, potentially catalyzing individuals to be drawn towards ethical creating of a new, not yet visible, future of possibility (Bachelard, 1960/1969).

With an increasing focus on managerial discourses such as benchmarking, numbers of patients seen, wait lists and bottom lines, a turn to poetics may be seen as having the tenor of a fool’s errand. Yet, perhaps precisely because of its apparent tension with a prevailing normative knowledge paradigm in health care (Kinsella, 2012) it is perhaps a time ripe for a return to poetics and its capacity for generating transformative images, story, poetry, and art into health sciences research.

A hermeneutic-poetic-phenomenology is proposed as a suitable methodological approach for bringing into view concealed and perhaps taken-for-granted experiences of wisdom and experiences of ‘wise care’ and the ‘wise clinician’ in the lives of women living with late stage ovarian cancer.

2.3 THEORETICAL LENSES

This research is informed by social theory, and philosophies of embodiment and imagination. As such, three theoretical lenses inform this study. The first draws on theories of embodiment, the second draws on theories of imagination, and the third draws of feminist theories of relational bioethics.

2.3.1 Theoretical Lens #1: Theories of Embodiment

A number of scholars have noted what has been characterized as an ‘embodied turn’ in the study of human experience (Brown et al., 2011; Green & Hopwood, 2015; Park Lala & Kinsella, 2011). Park Lala and Kinsella (2011) note that a major thinker in this domain is Merleau-Ponty (2006), who studied the phenomenological inter-relatedness between embodied experience and perception. Park Lala and Kinsella (2011) draw attention to Merleau-Ponty’s central tenet, “We do not have bodies, we are our bodies” (p. 78) as salient for phenomenological research with ill and dying persons. Moreover, they suggest that the “intercorporeality” (p. 82) of the researcher in relationship with participants is an area for attention in the research process. Finally, they call for attention to Merleau-Ponty’s suggestion that the body can be viewed as a “skillful embodied intelligence” and note that embodied knowledge “is often overlooked in research practices” (p. 84).

The idea of embodiment has been elaborated by a number of thinkers in different ways. Foucault, for instance, wanted to use various research methods, “to expose” that bodies are “totally imprinted by history” (Scheurich & McKenzie,

2005, p. 851). He argued that bodies are not ahistorical and carry inscriptions from personal and collective history that should be acknowledge. A number of scholars have drawn on his work to argue that even our subjective experiences of our bodies are influenced by social, cultural, historical and political factors that 'inscribe' our experience of 'body' (Grosz, 1994; Koggel, 2009; Lorentzen, 2008; Pauly Morgan, 1998; Sherwin, 1998; Shildrick & Mykitiuk, 2005). Given the centrality of the body in the experience of living with ovarian cancer, theories of embodiment are proposed as informing a theoretical framework for the current research.

2.3.1.1 *Feminist Theories of Embodiment*

Scholars focusing on feminist perspectives have argued that women's experiences have long been excluded from the knowledge generated by fields such as science (Harding, 1991), philosophy (Weedon, 1987), and theology (McFague, 1993; Radford-Ruether, 1993). From the perspective of feminist science, Haraway (2004) argued for attention to embodied situated knowledges. She stated, "I am arguing for the view from a body, always a complex, contradictory, structuring and structured body, versus the view from above, from nowhere" (p. 34).

Sherwin (1998), argues that women possess valuable knowledge from their health experiences yet she contends that this is regularly discounted or not readily made accessible by the professional health 'experts' who attend to women's health (p. 4). Sherwin underlines a fundamental premise of feminist

bioethics as starting from women's experiences and concerns in regards to health matters (p. 10). Shildrick and Mykitiuk (2005) argue that women's embodied experience have typically not been viewed as a source of expertise. They suggest it has often been ignored, even subjugated, and that that the body is typically viewed and treated as a material (and problematic/diseased) site for medical intervention. A number of feminist scholars have continued to argue for recognition of women's first hand accounts of their bodily lived experience, and pointed to the lack of validation of such knowledge in contemporary health care is problematic (Grosz, 1995; Shildrick, 2000; Shildrick & Mykitiuk, 2005).

2.3.1.2 *Embodiment in Health Care Research on Illness*

Frank (2013) suggests that an exclusive focus on the material view of illness as merely disease process in 'cells' and organs is insufficient in health care research. Attention to embodiment on the other hand allows for inclusion of forms of knowledge and insight that have typically been excluded from research methodology (Park Lala & Kinsella, 2011). For example, Gendlin's (1981) study of "felt sense" (Todres, 2007) draws attention to embodied knowledge for instance when there is a 'gut feeling' that cannot be adequately explained, or an 'inner knowing' that might be connected to intuitive knowledge (Billay, Myrick, Luhanga, & Yonge, 2007). Embodied knowledge has been articulated by some women with ovarian cancer, as part of their impetus for seeking diagnostic testing or follow-up screening so that further treatment can be given to try to slow down the recurrence of the cancer (Jasen, 2012). Attending to such forms of

knowledge in the research process might assist researchers, and ultimately clinicians and patients, to learn from this form of “skillful embodied intelligence” (Park Lala & Kinsella, 2011, p. 84).

2.3.1.3 *The ‘Colonized’ Body*

Feminist thinkers, Shildrick and Mytikiuk (2005), suggest that “rather than a traditional model in which the transcendent mind is unconstrained by the immanent flesh... the subject’s very being - or more accurately – their becoming – is dependent on the body...embodiment is the condition of being a self at all” (p. 6). They contend, “the self is always intricately interwoven with the fabric of the body” (p. 2). Shildrick and Mytikiuk (2005) suggest that embodiment is a crucial perspective to consider, given that fields such as bioethics have continued to perpetuate a split to what they refer to as “a secure transcendent self as moral agent, and a more or less unruly body that must be subjected to its dictates” (p. 3). Taking this line of argument further, Grosz (1994) claims that “the body has thus far remained colonized through the discursive practices of the natural sciences, particularly the discourses of biology and medicine” (p. x). She argues that a feminist refiguring of the body has potential to reveal some kind of understanding of embodied subjectivities, which refuses reductionism and resists dualism.

2.3.1.4 *Embodiment In Gynecological-Oncology*

A number of studies have drawn on theories of embodiment to consider: how women's gynecological examination experiences are 'performed' (Hall, 2012); experiences of 'self' are co-constructed by both physician and the woman during the examination process and where 'self' has a fluidity and changeability to meaning(s) (Galasinski & Ziolkowska, 2007); and also, how discourses about ovarian cancer influence the process of differential diagnostics on the part of the physician (Jasen, 2012). Jasen's (2012) study shows how medical and societal discourses have shifted from ovarian cancer as the "silent killer" to, "the whispering disease" (p. 489). She writes, "...some patients recalled that they were not aware that ovarian cancer was called the 'silent killer' until after their disease was recognized" (p. 507). She argues that the metaphor 'silent killer' perpetuated a tacit assumption that early detection was close to impossible so that symptoms such as unusual menstrual bleeding, nausea and bowel issues were not recognized. A growing movement led by women argued for women to listen to the whispers of their bodies:

...ovarian cancer is not 'silent' but that women must 'listen' to their bodies in order to recognize the signs of 'the disease that whispers'. They urged others to put aside their fears of disapproval, trust their own perceptions and intuitions, and – shifting their use of the word 'listen' to its more literal sense – demand their doctor's attention. (p. 508)

Changing the metaphor, was seen to change the type of discussions taking place in clinician's consulting rooms and in ovarian cancer educational literature for women. Jasen (2012) highlights how women's embodied knowledge

of symptoms can occur long before detection is likely in clinical assessments, and that such knowledge can be life-saving in the early stages of ovarian cancer.

2.3.1.5 *Embodiment in Contemporary Research on Wisdom*

An ‘embodied turn’ has also recently been noted in wisdom research (Küpers, 2005). Küpers (2005, 2007, 2013) and Yang (2013; 2008) argue for a turn to embodiment in both the characterization and processes of development of wisdom. Küpers (2005) critiques some theories of wisdom for the lack of attention to the dynamic and relational aspects:

This balance theory [of wisdom] does not adequately express the interrelated dynamism that is inherent in the balances. Thus, it will be necessary to extend this rather person-centered conceptualization of individual-level balances of creative, analytical and practical skills towards more inclusive, interrelated and responsive practices. These practices can then be related to such issues as embodied well-be(com)ing of organizations. (p. 184).

He points to the need for more investigation on embodiment as integral to wisdom and its theoretical and practical developments (Küpers, (2005, 2007; Küpers & Statler, 2008).

2.3.1.6 *Embodied Inquiry*

Embodiment has also become a focus of significant attention in cognitive science. Johnson (1999) states that “we can only reason by means of our embodied, imaginative rationality” (p. 81). A growing number of researchers have been appealing for a ‘re-bodying’ of interpretive acts. Todres (2007) for instance has developed a phenomenological research approach he calls

“embodied inquiry”. He states that his aim is to offer “...a remedy to a Cartesian tradition that may have overemphasized the ‘cognitive’ and the abstract dimensions of understanding” (p. 14). Todres’ (2007) discussion of “embodied inquiry” focuses on intersubjectivity between researcher and participant, therapist and client, in an embodied-relational matrix that he refers to as a “soulful space” (p. 17). He suggests that embodied inquiry allows for this soulful space to become part of the subject matter and genesis of the research process itself. Todres (2007) draws on Gendlen’s philosophy about ‘felt sense’ “...to show how we use much more than our thoughts when we think and how the lived body is full of fertile excess, intimate with crossings and bridges, textures and relationships that are the ‘stuff’ of understanding” (p. 14).

2.3.1.7 Conclusion

In summary, a variety of theories of embodiment inform the current research and comprise a theoretical lens that attends to wisdom as an embodied phenomenon in lives of women living with ovarian cancer.

2.3.2 Theoretical Lens #2: Theories of Imagination

The proposed research is also informed by theories of imagination. Philosophers such as Bachelard (1958/1994, 1938/1964, 1960/1969; 1942/1983; 1997/2008), Heidegger (1971) and contemporary philosophers Kearney (1988, 1998) and Biradi (2009) have argued that imagination is an essential dimension of ‘being human’ and is inextricably implicated in human innovation, language,

and endeavour. Psychiatrists such as Jung (1963) and those who took up his theories in psychiatry (Jung, von Franz, Henderson, Jacobi, & Jaffé, 1964; 1933; Von Franz, 1997) and psychology (Jager, 1996; Martinez, Thiboutot, & Jager, 1999) have also argued for the fundamental significance of imagination for its power to create images that effect change in potent ways within the human psyche and in our social worlds. This study will attend to imagination's place in the phenomenon of wisdom when living with difficult existential states. The theories of imagination that underpin this study are drawn most particularly from the philosophical work of Kearney (1988, 1998) and Bachelard (1938/1964, 1939, 1942/1983, 1943/1988, 1946, 1948/2002, 1958/1994, 1960/1969).

2.3.2.1 Bachelard's Phenomenology of Imagination

Aspects of Bachelard's philosophy that are particularly salient for the current research are his attention to imagination as it relates to: (a) horizons of hope for the future, (b) his unique concept of 'material imagination'; (c) his study of the attitudinal state of 'reverie'.

For Bachelard, "Imagination...faces the future (Bachelard, 1958/1994, p. xxxiv). Of Bachelard's phenomenology of imagination Kearney writes:

"In other words, the imaginary for Bachelard is not so much a world of *un-reality* as of *sur-reality*. It does not deny reality *per se*, but only the ossified and habitualized crust of reality. It does not annihilate the real world; it mobilizes its potencies of transformation. "The imagination is not...a faculty which fabricates images of reality; it is a power which forms images which surpass reality in order to change reality." (translating and quoting Bachelard, 1960).

From this surplus encompassed within the poetic image, new possible futures are born. Bachelard (1942/1983) writes, “The imagination invents more than objects and dramas – it invents new life, a new spirit; it opens eyes which hold new types of visions” (p. 16). In this way there is a “mobility of images” (Bachelard, 1943, p. 2) and images both act upon us as we deposit our intentionality into them when they are conjured into our speech. For Bachelard (1960/1969) reverie upon nature, engaging with poetic images in poetry or creating them each open up new worlds that potentially source a sense of ‘well-being’ in the midst of life’s vagaries.

Bachelard’s (1942/1983) unique theory of the “material imagination” (p. 134) offers insight into the potent effect of embodied experiences and word-images drawn from nature. He notes their power to express existential tensions such as death-birth, loss-hope, alienation-home. Bachelard (1942/1983) speaks of the importance of the material imagination in reclaiming ‘reverie’ and the link to transformation:

Thought form and concepts harden rapidly, material imagination still remains an active power. It alone can revitalize traditional images endlessly; it is one that constantly breathes new life into certain old mythological forms. It gives life back to forms by transforming them, for a form cannot transform itself....If we encounter a transformation, we may be sure that material imagination is at work behind the metamorphosis. Culture transmits forms to us too often in mere words. If we knew how to rediscover, in spite of culture, a little natural reverie, a little reverie about nature, we could understand that symbolism is a material power. Our personal reverie would very naturally reform atavistic symbols because they are natural symbols. (p. 134)

Bachelard (1942/1983) argued for the pre-verbal role of imagination as “dynamic” in its nature (p. 85). In his study of images of nature in literature he

distinguishes two types of knowledge, one, “objective knowledge” and the other “image centered knowledge” (p. 7). He offers the example of the poetic image of ‘swan song’ as an elemental image for the last dying opus of an individual that mediates this existential experience. He explores the “heavy waters of Edgar Allan Poe” whose images of water are inter-related with death and dying. This materializing imagination, “is the transcendent aspect of *natura naturans*. It is the graft which can truly provide the material imagination with an exuberance of forms, which can transmit the richness and density of matter to formal imagination” (p. 10). For example, “water, quickly becomes a contributor of images, a founding contributor for images” (p. 11). Bachelard argues:

...the voices of water are hardly metaphoric at all; that the language of the waters is a direct poetic reality...that streams and rivers provide the soul for mute country landscape...that waters teach birds and men to sing, speak, recount...that human language has a liquid quality, a flow in its overall effect, water in its consonants. (p. 15)

He suggests that the process of the elements of nature providing a substance, a “muscular imagination...serves as one more proof of the direct nature of symbols formed by material imagination” (p. 15). It is through imagination that “the endless exchange of the visible for vision itself takes place” (p. 30).

Bachelard (1960/1969) offers a phenomenology of reverie as a means for fostering a poetic-phenomenological attitude in life. Daniel Russel, who translated this last book of Bachelard, writes in his introduction, “Reverie has traditionally been understood, especially in the United States to be unproductive, impractical and so completely unempirical as to be considered almost immoral in

a society orientated toward pure and sometimes mindless action” (Bachelard, 1969, p. v). Yet in phenomenology, Bachelard (1960/1969) argues that reverie is a critical mode of reflection taking on the contemplative modes of thinking and reflecting from which originating ideas, images, poetry are born. Reverie is not the mode of rational logic, it does not need to serve laws of method or linearity of argument. Instead, “reverie, slow reverie discovers the depths in the immobility of a word. We believe that, through reverie, we can discover within a word the act which names” (p. 48). According to Bachelard, through reverie the poetic can pierce the existential dimensions of the ‘Other’, as it distills something that evokes resonance. In other words, “In the poet’s reverie, the world is imagined, directly imagined. There we are touching on one of the paradoxes of the imagination... it gives us the whole before the parts...a single image invades a whole universe.” (p. 175).

A crucial and salient aspect of Bachelard’s poetic phenomenology is that it integrates the embodied world rather than abstracting from it. For Bachelard, it is a “poetic force” that during reverie animates all the senses, whether to engage in the poetic image being evoked in reading or in contemplation of the world around us (p. 162).

2.3.2.2 *Kearney’s Ethical Imagination*

Kearney (1988, 1998) traces the slow historical ‘redemption’ of imagination from its treatment as a threat, by classical philosophers, to an

integrated productive, formative, projective aspect of ontology (being) and epistemology (knowing). In his study of modern philosophers' he writes:

The adoption of hermeneutics – as the ‘art of deciphering indirect meanings – acknowledges the *symbolizing* power of imagination. This power, to transform given meanings into new ones, enables one to construe the future as the ‘possible theatre of my liberty’ as a horizon of hope. The implications of this approach are crucial....Ricoeur observes, ‘We have thought too much, in terms of a will which submits and not enough in terms of an imagination which opens up’. (Kearney, 1998, p. 147)

Kearney (1998) writes, “The function of imagination in poetry or myth....is defined as the ‘disclosure of unprecedented worlds, an opening onto possible worlds which transcend the limits of our actual world” (p. 149). Kearney draws on Ricoeur to argue, “The poetic image thus points to the very ‘depths of existence’ where ‘ a new being in language’ is synonymous with a ‘growth in being’ itself. It is because there is a poetical imagination that words dream being” (p. 160).

Kearney (1988) anchors imagination to ethics with his theory of the ‘ethical imagination’ arguing that it demands of us the capacity to “imagine otherwise” (p. 364). He too turns to the word *poiesis* to call our attention to imagination’s capacity for inventing and creating as a critical dimension of imagination’s dynamism to move us to respond ethically in the world. In *poiesis*, the ethical imagination must envision for the ‘common good’ if it is to prevent solipsism. Kearney therefore contends, “Here and now I face an *other* who demands of me an ethical response” (Kearney, 1988, p. 261).

Kearney (1998, p. 255) outlines three ways that imagination is ‘indispensable’ for ethics. First he points out the “*utopian potentiality*” (p. 255) of

imagination for future and historical relationships, in light of its capacity to challenge official stories with unofficial or dissenting narratives, which open up alternative ways of thinking and being. Second, he highlights the “*testimonial capacity*” (p. 255) of imagination as moral witness of exemplary lives in history, and the capacity to bear witness to a forgotten past. Third, he draws attention to the “*empathic powers*” (p. 255) of imagination to be receptive to others, to identify with those different to us (victims and exemplars), and to fuel compassion. He argues, “The poetic commitment to *storytelling* may well prove indispensable to the ethical commitment to *history making*. Ethics without poetics leads to the censoring of Imagination; poetics without ethics leads to dangerous play” (p. 236). It is in our imagination that we first imagine a world ‘other’ than the one that oppresses. New stories reveal new worlds.

Kearney (1998) calls for ethics and imagination to remain in relation. He highlights Lyotard’s description of ‘grand narratives’, as circulating in the ‘social imaginary’, and as imprinted upon the individual’s being, reducing imaginal agency with a potentially colonizing effect. If we do not address ethical challenges and complexities, then any ‘theory’ of imagination falls into a realm of ineffectual, private “world-making” (Goodman, 1978) orbiting around one’s ‘self’ without any relation to ‘other’ (Kearney, 1998, p. 218). For Kearney, rehabilitating imagination in contexts where traditionally, it has been excluded is an ethical imperative.

2.3.2.3 *Martinez and Jager: Theories of Imagination in Existential Psychotherapy*

Martinez et al. (1999) and Jager (1996) discuss Bachelard's work as relevant in existential psychotherapy. They point to the role of imagination in exploring the thresholds faced in life: mortality, living and dying, connection and alienation, hope and dread, and the potent nature of imagination to transform the lived experience of the present:

We could say that the imagination is characterized precisely by the fact that it creates a psychic "elsewhere" and a place of human habitation beyond the space and time opened by natural science and technology. It is for this reason that Bachelard thinks of the poet as "speaking on the threshold of being" and why he describes the image as perpetually celebrating the birth of the imagination. With the birth of the image, a liberating breach is made with the world of material necessity and natural causality. Our imaginary life revives at each instance of its manifestation the original and miraculous leap of the spirit that releases us from the slumber of natural life and opens our eyes and ears to a truly human world. The poetic image is itself this inaugurating instance of a true encounter between self and other, self and world. (Martinez et al., 1999, p. 6)

They also highlight how, in Bachelard's poetics, his own phenomenological study of imagination's capacities, "mediates for us between the exile of loneliness and solitude of intersubjectivity" (p.13). This has the capacity, they argue, to renew us to a sense of being alive: "a creative image arouses us to new life, it renews our thinking, our feeling and sensing, it restores to us our memory and awakens us to the inexhaustible variety and richness of our world" (p. 8). Martinez et al. (1999) posit creative images as "original manifestations of the human imagination" (p. 6).

2.3.2.4 Conclusion

In summary this theoretical lens on imagination will examine ways that imagination fosters 'horizons of hope', creates meaning in existential struggle, relates with nature for well-being, fosters a 'poetic-phenomenological' attitude in life, and plays a role in ethics by fostering empathy and deepened understanding of 'other'.

2.3.3 Theoretical Lens #3: Feminist Bioethics

Choosing 'wisdom' as a phenomenon under investigation with women living with ovarian cancer invites an ethical lens that attunes specifically to women's experiences in health care. As such, a feminist bioethics lens is proposed for this study. Feminist bioethics, however, cannot be considered a uniform perspective, as there is tremendous diversity and multiple standpoints in the field, which at times even conflict. Nonetheless, there are still common themes which draw feminist researchers into proximity that, according to Chunn and Menzies (2014) offer "distinctive contributions to the production of knowledge, not least through the deconstruction of gender-blindness that has historically characterized most of the extant mainstream... research" (p. 104). Feminist researchers have made significant contributions to generating or revivifying methodological approaches to inquiry of human experience and "particularly the assumption that the social world can be studied 'scientifically' in the same way as the physical world" (p. 104). One common aim in feminist

research is that it typically places emphasis on “voices from below”, and on embracing “research methods” that “break the silence” (p. 104).

2.3.3.1 Bioethics: Agency and Autonomy

Sherwin (1998) articulates how informed consent and its agential ingredients of autonomy and agency rest upon particular assumptions: (a) that humans are individual subjects, with a subjectivity that is accessible to the person, free from social, situated contexts, scripts, and power structures in which they live; (b) that as an individual subject, with the right information presented and the possible options laid out by a non-coercive physician or health care provider, they are able to make an informed decision about accepting or rejecting the expert’s recommendation; (c) that rationality is the basis upon which such a decision is made and non-rational modes of decision making are excluded from influencing the informed consent (intuitive, gut-feeling, emotion-affect based, embodied and empathic knowledges etc) and that such non-rational modes can even be pathologized into rendering a person as incapable of making their own decisions. Sherwin contends that women and other marginal groups have particularly come to be associated with such non-rational, illegitimate modes of knowledge bases such that these populations “are often seen as simply incapable of rationality” (p. 26); (d) the individual is deemed as an autonomous decision maker as long as the conditions of information, freedom from coercion, rationality are met without needing any attention paid to the social conditions of potential oppression, both external-societal and internal-psychic, which mould

her options and freedom for choosing, even prior to her conversation with a physician soliciting “informed consent” (Sherwin, 1998, pp. 19–47).

2.3.3.2 *Feminist Bioethics*

Feminist bioethics perspectives seek to further analyze how decision making is enacted in medical contexts (Shildrick, 2000; Shildrick & Mykitiuk, 2005). Tulloch (2015) highlights that feminist ethics emerged in the 1970’s to problematize constructions of ‘self’ in contemporary society with arguments for feminist ethics “as a reaction to and critique of the Cartesian model of the self....[as] a rational, disembodied, separate, unified self, a rational being essentially similar to all other moral selves and implicitly male” (p. 115). Tulloch (2015) further underlines the contribution of feminist ethics towards reintegrating a holistic lens on human personhood stating, “Feminist ethics rejected the privileging of mind over body characteristic of traditional ethics and provided an important paradigm in normative ethics and epistemology by insisting that one cannot be simply human, and that our social forms are gendered” (p. 115).

For this study, I draw specifically on a group of feminist bioethicists who aim to develop relational bioethics that as far as possible will pay attention to: (a) the dynamics of power and paternalism (Sherwin, 1992); medicalization which highlights the power of medical discourses as a means of social control (Pauly Morgan, 1998); and social constructions of identity, body, gender as they are enacted in medical contexts (Shildrick, 2000; Shildrick & Mykitiuk, 2005). Further, I aim to maintain awareness of the socio-political and globalized contexts of

health care and interests such as capitalism and government policy agendas circulating in health care agendas (Koggel, 2009; Nagel, 2005).

Sherwin (1998) proposes four features of a feminist relational ethic and its reconceptualization of agency and autonomy (p. 37) which inform this study. In her view, a feminist relational ethic should:

(1) Attend to the impact of social and political structures, especially sexism and other forms of oppression on individual's lives and aspiration.

(2) Acknowledge that the presence or absence of a degree of autonomy is not merely a matter of being offered a choice.

(3) Attend to the fact the person being offered a choice needs to have had opportunity to develop the skills necessary for the choice offered.

(4) Include society, not just the individual, in critical scrutiny.

McLeod and Sherwin (2000) argue that many factors can cause degrees of compromise to individual's abilities to exercise autonomy and agency and that these factors can affect "whole social groups" (p. 259) in ways that can be veiled and multi-faceted. In this regard, feminist relational ethics aims to be particularly attentive to imbalances of power, which can influence the 'individual' conversations of the doctor-patient dyad. Unequal distribution of power, money, resources, and social status contribute to health inequalities between the affluent and the impoverished classes in Western society (Crawshaw, Scott-Samuel, & Stanistreet, 2010). Feminist bioethicists emphasize and examine dynamics of power, patriarchy, and paternalism (Sherwin, 1992; Smith, 1990) as these manifest in and through social processes of "medicalization" (Pauly Morgan,

1998, p. 63) Medicalization is an important contemporary concept that highlights the power of medical agents, discourses, representations and practices as an influential source of social control over life processes such as fertility, birth, menopause, and even dying (Donchin, 2000; Pauly Morgan, 1998; Wolf, 1996).

2.3.3.3 *Feminist Ethics: Reclaiming Subjectivity, Agency and Epistemic Power*

Drawing on the work of Pauly-Morgan (1998), Lorentzen (2008) and Shildrick (2000), this study proposes a feminist project that aims to: (1) (Re)claim women's subjectivity and agency and (2) (Re)claim women's epistemic power through the design and implementation of the research.

Pauly-Morgan (1998) calls for women to reclaim subjectivity and agency with respect to their health but how to do this can be a difficult challenge. Lorentzen's (2008) offers suggestions on ways that reclaiming subjectivity and agency can be attended to in the clinical context. First, Lorentzen offers the concept of 'productive agency'. This involves fostering a form of agency that is relationally constructed in the dialogue between 'patient' and 'doctor' (or any clinician) through conversation that allows the 'patient' to offer meaningful and valued contributions into their medical decision-making and medical treatment. Productive agency allows for more than simply giving information about risks and benefits and assuming consent given is perceived as having autonomy and agency. Rather, a value of productive agency opens up a conversation that allows for contributions by the patient, including the women's own perspectives

on her body, her life circumstances and embodied knowledge of her illness and well-being so that she can offer her *voice* and *knowledge* in addition to her decision-making capacity into all stages of her clinical care.

Second, Lorentzen (2008) calls for integration of subjugated forms of knowledge. This means including, for instance, embodied knowledge as a type of knowing that one acquires through one's own bodily experiences of physical changes, both healthy and illness related, and empathic knowledge derived from an identification with another individual in some way be it a personal friend, social media story, and so on. Lorentzen highlights that embodied knowledge and empathic knowledge are not generally easily included as credible or valuable forms of knowledge in medical practices. Integration of embodied knowledge, such as the meaning of one's breasts, ovaries and womb to one's identity, embodied experience of one's self and one's lifeworld, may also guide patients to make a particular decision in their treatment. Empathic knowledge may also be important for women's decision making. This is reflected in potentially hopeful ways, as healthcare systems are evolving to include models of patient- and family-centered care, and operationalize concepts such as joint decision making and incorporations of patient values. Such a shift is still very much a work in progress.

A third possibility for revisioning a conceptualization of agency taken up in this study is offered by Shildrick (2000). Shildrick (2000) reframes the notion of 'vulnerability' to suggest that vulnerability itself can contribute to a form of agency when the clinician understands and acknowledges, albeit internally, their own

sense of vulnerability as they meet the patient in conversation. For instance, when human vulnerability is kept in the awareness of the clinician in the dialogue about the patient's treatment and well-being, then this sense of shared humanity, can provide an experiential encounter that might redress power imbalances between the 'medical expert' and the patient, thereby changing the tenor, power imbalance, tone and feeling to the conversation. Shildrick (2000) contends that this awareness of a shared humanity with vulnerability at the axis of this relational space, can form a common bond of 'being human' such that the "binary thinking which supports power relations" unsettles these dualities (p. 222).

The second aspect of this approach takes up Pauly-Morgan's (1998) call for women to reclaim epistemic power. Sherwin (1998) offers some insights on ways this can be done which include viewing autonomy as relational and as a "capacity and skill" (p. 37). This includes recognizing that "...transformative experiences are far more important to autonomy than access to alternative information" (p. 37). Women's bodies hold meaning(s) that have been erased by medical lenses and that can undergo transformational changes in perspectives. Grosz (1994) claims that "the body has thus far remained colonized through the discursive practices of the natural sciences, particularly the discourses of biology and medicine" (p. x). In *Volatile Bodies* Grosz (1994) affirms how sexual bodies, right down to our body fluids are experienced, whereby "Our pleasures and anxieties are always lived and experienced through models, images, representations and expectations" (p. 197). She notes an ongoing bias towards a greater emphasis on women's corporeality as bearing a burden of cultural

imprinting, particularly around our “fluids” and “viscosity” (p. 203). Given the site of ovarian cancer and the gynecological examinations that necessarily take place in the course of care, these cultural imprintings have salience for a study aiming to explore ways in which women (re)claim epistemic power in their oncology care.

2.4 CONCLUSION

This chapter has presented the philosophical underpinnings for the novel methodology of hermeneutic-poetic-phenomenology developed for this study of women’s perspectives on wisdom in their lived experience of ovarian cancer. It has shown that it draws on Gaston Bachelard’s philosophy of poetic-phenomenology developed in the early twentieth century and places it within an interpretive paradigm linking it with hermeneutics thus allowing it to attend to the phenomenological dimensions of meaning(s) in relation to the phenomenon of wisdom. Three theoretical lenses are integrated for the phenomenological analysis process to pay particular attention to (a) imagination and (b) embodiment; (c) additionally it brings a feminist bioethics lens to examine the dynamics of power relations, productive agency, empathic and embodied knowledge, autonomy, subjectivity and epistemic power. Together, the methodology and theory lenses examine participant perspectives of participants, individually. Findings integrate these perspectives, integrated with and through the researcher’s interpretive engagement to bring them together into

representation in portraits of findings for each participant, and a final phenomenological poem.

Breathing Space

Here

*Each of you
has been on a
long, long
journey
to Here*

*Here was not
where you wanted to be
here was where you were brought
by something
unexpected
unimagined
unbearable*

*yet, Here
is where you are
breathing
dreaming
hoping
loving
living*

*Here has rarely been
otherwise
if ever...
in all of human
history*

*Here is where
life meets us
in all her fierce
and tender forces
and only Here...
if we trust what
the sages
and the prophets
have told us...*

and only here

*is where love dwells
for us to know
to feel
and be lifted by
on currents
beyond our ken
to places
as yet unknown*

*Here is where
we can meet each other
and share what
lies deep in our
medicine bag
of fumbling wisdom
quickenning hopes
and Here
is where
even the sorrows
and despair
might be food
for one another
right Here
in this moment
together
because then
we might know
we are not alone
and meeting Sorrow
together
we stand in front
of Despair
shoulder to shoulder
and thus we
allow it
no more ground
and know
we are stronger
for meeting one another
Here*

*each of you
has been
on a long journey
to Here*

*Here is where
we meet
where we are breathing
hoping
dreaming
loving
living*

*Here is where
we meet life
in all her fierce
fullness
tenderness
and potency
and Here is
where we see
in another's eyes
that
Here
gives us just enough
perhaps,
for what you
and I may need
for that next step
in each
of our
journeys*

to

Here



CHAPTER 3

STUDY METHODS

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3.1 STUDY SUMMARY

This study responded to a call to study wisdom as a phenomenon with particular focus on relational, embodied and processual dimensions (Küpers, 2005, 2007; Küpers & Statler, 2008; Yang, 2013; Yang, 2008). It offers findings on the phenomenon of wisdom within the lived experience of women living with stage II to IV ovarian cancer, who had formerly participated in a supportive care group called “*Soul-Medicine*” – *For Living With Ovarian Cancer* (Butlin, 2010, 2011, 2015a, 2017) after their oncology treatment. The group content and processes included a focus on discovering personal “wisdom-resources” (Glück & Bluck, 2013, p. 79) through empirically identified wisdom-enhancing interventions (Baltes & Staudinger, 2000; Glück, Bluck, Baron, & McAdams, 2005; Staudinger & Baltes, 1996). This study inquiry focused on: (a) what meaning(s) participants give to the notion of ‘wisdom’; (b) what might constitute ‘wisdom’ in their lived experiences; (c) the ways ‘wisdom’ might be experienced through the existential challenges of ovarian cancer.

On the concept of wisdom specifically, Küpers (2007) calls for developing and fostering embodied wisdom through “post-dualistic relational forms of wisdom” (p. 181) and also in group situations that foster a “wisdom supportive environment” (p.185). The Soul Medicine group specifically aimed to provide this context with wisdom-enhancing interventions encompassing dialogical and relational space for personal wisdom to be claimed and discovered. It also aimed

for wisdom itself to be explored as a phenomenon in life, particularly in its potential for formation from and after difficult life situations, while it is generally agreed by wisdom research that it is not an inevitability wisdom will form through such experiences (Glück & Bluck, 2011; Schmit, Muldoon, & Pounders, 2012; Webster, 2003).

3.1.1 Inclusion and Exclusion Criteria

The study was not aiming to examine *whether* the group was successful in fostering 'wisdom' in the participants hence it was not included as part of the study other than for recruitment of study participants. The decision to not include the group process as part of the subject of study was to (a) mitigate potential triggering of performance anxiety for 'producing' wisdom for research within a care process that was an aspect of clinical care and (b) mitigate any compromise for psycho-spiritual benefit for participants joining the supportive care group. It functioned as the 'wisdom-primer' for participants to explore personal wisdom and wisdom-in-life.

The study also piloted a novel, qualitative methodology, hermeneutic-poetic-phenomenology, developed specifically for this research, to conduct analysis and provide a representation of findings through poetics.

This study, through engaging a feminist relational bioethics approach to the research aims to (re)claim these more textured, relational meanings of subjectivity, agency and autonomy, and to attend to ways in which participants

(re)claimed their epistemic power with respect to their experiences of ovarian cancer and medical treatment.

3.2 RESEARCH ETHICS

This section addresses the means by which attention has been paid to the ethical considerations of the research. From a practical and procedural ethical perspective, the research protocols were submitted for a full review (non-delegated) and approved by two review ethics boards: the University of Western Ontario Research Ethics Board (REB) and Lawson Health Research Institute (LHRI) (Appendix I).

The situatedness of the researcher is made as transparent as possible given the study's philosophical underpinning in interpretivism. It places the researcher's perspectives and insights into an interpersonal dialogue with participants. Section 1.1.2.2 of this thesis provides the published text of the autoethnography, and the Prologue contains the poetic-prose inquiry of my personal experience as the daughter of my father, who was diagnosed and died of stomach cancer within months of starting this doctoral journey (Butlin, 2017). Reflexive poems were written throughout the doctoral process and some are included in this thesis. Reflexive Notes on the interview phase are shown in Appendix VII. This study holds, at its core, the values of feminist bioethics that focus on research in health care that views knowledge and research as

relational, situated and partial. As such, researcher reflexivity and recognition of the insider role of the researcher are important considerations.

3.2.1 Researcher Reflexivity

The doctoral candidate researcher engaged in a reflexive process throughout the research design, by using reflexive journaling and dialogue with members of the doctoral advisory committee throughout the research as well as dialogue with experts in psycho-oncology (psychiatry, psychology and social work) and in poetic inquiry and phenomenology.

Reflexivity is useful for researchers to consider their conduct, interpretations, assumptions, and reflections at every possible turn. Methods for engaging in reflexivity can include “writing inquiry” (Richardson, 1994); poetry (Tasker et al., 2014); and journaling (O’Callaghan, 2005). These are forms of writing used in clinical practice by many therapists (Finlay, 2011; Morrow, 2005) as well as in qualitative research. This type of reflexivity comprised much of this doctoral researcher’s training in clinical spiritual care and psychotherapy and is therefore very familiar. Reflexivity was also used as a means of process ethics (Guillemin & Gillam, 2004), whereby the researcher will engage in the cycle of action – reflection – action to consider the ethical nature of moments and processes arising throughout the investigation. This type of reflexivity is a core competency for ethical conduct in the Safe and Effective Use of Self with the College of Registered Psychotherapy in Ontario (CRPO).

Collegial dialogical inquiry has also formed an enactment of reflexivity and speaks to the relational dimensions of wisdom foregrounded in this study. 'Expert' dialogue engages individuals within a code of confidentiality as prescribed by clinical or academic contexts and relies on relationships with there is high trust *and* high-level capacity for honesty and transparency whereby the researcher invites and accepts challenge or Socratic style questioning for deepened reflection, insight, self-awareness and knowledge development. For this study, expert, high-trust, respectful dialogue with a select number of individuals, including the doctoral committee as available, allowed for reflectivity, expert knowledge translation and joint inquiry through discussions on study design, ethics, philosophical coherence, methodological rigor and checking for resonance with findings chapter. Reflexivity in dialogue brings a transparency to the researcher's standpoint, influences, biases, blind spots and allows for deepened ethical sensibility, expanded viewpoint to consider multiple perspectives and attends to cultural, social and personal entrainment with and insight into the phenomenon.

Phenomenology offers a methodology that can integrate reflexivity because it guides the researcher into a philosophical way of thinking and being in the process of their research (Wright-St. Clair, 2015). Researchers taking up phenomenology are called to develop a 'phenomenological attitude' to undergird the research process (Park Lala & Kinsella, 2011; Wright-St. Clair, 2015; Wright-St Clair et al., 2011) whereby the interpretive process is not only acknowledged but also foregrounded as a dimension of the study and the researcher is "outed"

through reflexivity (Finlay, 2002, p. 531). Finlay describes reflexivity in the phenomenological research as a process that can then intentionally shift back and forth between the participants' and the researcher's experiences as a means to refresh one's gaze and to see with new eyes. She suggests that reflexivity is integral to the process and that the tension between self and other may be seen as a generative tension (pp. 11-14). As Bevan (2014) states, "To be clear, at the outset a researcher ... is attempting to add clarity to explicating experience" (p. 141). As such, it is important to underline that this study is a shared inquiry with participants regarding their lived experiences of the phenomenon of 'wisdom', one that seeks to illuminate their discoveries in a real time, iterative investigation.

3.2.2 Insider Research

Ethical conduct when the researcher is an insider requires a rigorous eye to the imperative of a robust reflexivity (Guillemin & Gillam, 2004). The papers forming this aspect of the research, as it was in development, are in Sections 1.1.1.2, 1.1.2.2 and Appendix III the thesis. Finlay (2011) argues that far from being a situation that biases the researcher and compromises the clinical role of therapist, the role of 'researcher-therapist' when engaged in phenomenology, provides an opportunity for rendering the interpretations of the researcher as visible and accountable. The roles of researcher and therapist become an inter-subjective confluence where the one informs the other and each provide checks and balances that require reflexivity within transparent, accountable relationships (Foley, 2002; Segal, 2010).

Finlay (2011) suggests that phenomenology is an effective methodology for researcher-therapists to research their client-patient experiences. She asserts that such research has the potential to 'bridge' the gap between research and practice. In speaking about the therapeutic potential of phenomenological research Finlay suggests:

"Phenomenological research is potentially transformative for both researcher and participant. It offers the individuals the opportunity to be **witnessed** in their experience and allows them to '**give voice**' to what they are going through. It also opens new possibilities for both researcher and researched to **make sense of** the experience in focus". (p. 10) (emphasis by author)

Thus, the insider perspective of group facilitator-researcher if navigated sensitively can be seen, as an opportunity to bridge theory and practice, to witness the lived experience of participants, and to interpret those experiences in productive ways.

Finlay (2011) highlights that practicing phenomenology is at the heart of good therapy which seeks to illuminate, give voice to and elicit the 'Other's' experience in the therapeutic encounter; similarly using phenomenology as methodology in researching clinical practice affords a 'giving voice' to the patient experience.

3.2.3 Process Consent

Process consent (Dewing, 2002) is one means to uphold the participants agency by reminding participants at regular intervals that they may at any time decide not to participate in the group, and that self-care - emotional and physical

- holds the greatest weight. The women were reminded that they could, at any time, join the non-research group, which will be running simultaneously. Pauses were taken with the Dictaphone turned off during their interviews if they needed time from a moment of grief and consent asked for continuing with choice not to stated.

It is also recognized that my own personhood as researcher and therapist was also being investigated, honed, illuminated, challenged and would be included tacitly as a 'subject' in the research. Contemporary phenomenological methodology provides a *process* that is, in itself, potentially voice-giving and transformative for those participating. This interpretive perspective is distinct from more traditionally post-positivist research designs which expect the researcher to 'bracket out' the researcher's assumptions, biases and interpretations (Finlay, 2002; Lincoln & Guba, 2003). Finlay (2011) states, "The aim of hermeneutic phenomenology is to evoke lived experiences through the explicit involvement of interpretation" (p. 110). The supportive care groups explicitly opened up a possibility for each individual, as well as for a group of women together, and for the researcher facilitator to create interpretations of what is involved in living wisely with ovarian cancer. As such, each group evolved its own unique discourse; the group process aimed for the unique, personal and specific rather than the generalizable. This study aimed to elicit such uniquely discovered personal meanings for 'practical wisdom' in order to hold out for other women the possibility for their own discoveries rather than to offer prescriptive advice.

3.3 SPECIFICS OF METHODS

The study investigated experiences of wisdom generated and reported by three women who had previously participated in an ovarian cancer supportive care group (*Soul-Medicine – For Living With Cancer*). Two volunteered from participation in the supportive care group run at a regional cancer centre in a tertiary care hospital and, one from the group that was run at an independent, non-for-profit cancer support centre. The study closed recruiting after three participants volunteered.

3.3.1 Participants

Inclusion criteria were for women who are English speaking, 18 years or over, diagnosed with stages II-IV ovarian cancer of any type. The participants were patients in active treatment or follow up at the London Regional Cancer Program (LRCP) or who were members of the non-for profit cancer support centre. Each had previously participated in the supportive group, *Soul-Medicine - For Living With Cancer* (Appendix II).

3.3.2 Ethical Conduct of Research

Study approval was obtained (Appendix I) from the University of Western Ontario REB and LHRI. REB-approved documents contained the following:

- a) Letter of Intent and Informed Consent
- b) Semi-structured interview guide
- c) Third-party recruiting script

3.3.3 Recruitment

Recruitment was carried out by the third party, from two REB-approved staff members of the Baines Research Unit at London Regional Cancer Program's team. They had no clinical practitioner related contact with potential participants in the groups. The third-party individuals gave the information about the study from an REB-approved script (Appendix IV) in the final 15 minutes of the last week's session of the supportive care group, "*Soul-Medicine*" for Living with Ovarian Cancer after Helen Butlin, the researcher-facilitator had left the room and the group and their interactions with Helen Butlin in her clinical role was formally complete. Each was in a clinical relationship for supportive care and counseling with a Supportive Care Social Worker for ongoing clinical support.

The third-party recruiter read the REB approved recruiting script and verbally explained the information about the study contained in the Letter of Information, and also gave them the Recruitment Package containing the Letter of Information and the Informed Consent form. Participants were informed that the study involved:

1. Two semi-structured interviews, recorded. First interview one week after the group ends. Second interview, within six weeks after.
2. The voluntary option to have any artwork or poetry generated in the group included in the study.

The third-party recruiter providing this information gave the contact number and name of the primary investigator if they wish to consider participation in this study, learn more about this study, and to call and make an appointment to

meet with the investigator-facilitator of the groups to answer any questions about the study.

If they wished to participate in the study, the investigator met with them to receive their signed letter of consent and set up the date and time of the first interview. Participants were informed of their options to withdraw from the study at any time by both the third-party recruiter during their invitation to volunteer, and as well, by the researcher-interviewer when they met to give their signed Informed Consent and set up the time of the first interview. Opt-out was also presented as an option at the outset of each interview. Process consent was clarified as the foundation of the participation. Process consent reiterates at regular intervals that any interview question, at any point in the process, can be left unanswered, without jeopardizing their participation in the group, or their oncology care. It was made clear that all data will be anonymized and any identifying features will be removed. Participants were given a choice to include their art collages and poems created in the supportive care group and with consent these were included as data for analysis.

3.3.4 Data Collection

Methods of data collection were: semi-structured interviews, photographs of participant generated art-collages from the group process, and photocopies of the poems generated in the groups.

a) Semi-structured interviews

Participation in two semi-structured interviews were carried out with each

participant after their supportive care group concluded, the first, one week after the group ends, the second, within six weeks following the first interview. The interviews were approximately 1.5 hours long, and conducted by the doctoral candidate researcher. Three individual participants were interviewed.

An REB approved semi-structured interview guide was used (Appendix V). Questions for the guide were generated to address the research questions and were informed by a review of the literature on wisdom in oncology care, and the practice-based insights of members of the research team and two external expert phenomenology researchers. The guide was developed in consultation with experts in phenomenology and pilot tested in interviews with two health care practitioners. Semi-structured interviews allow for diversion from the predetermined questions to follow in more depth the stories, insights and reflections of participants during the interviews. However, all the question topics were covered in each participant's interviews, with the exception of one participant's section of questions discussing motherhood, as she did not have her own children and, instead, discussed her relationships with nephews and nieces.

All interviews were audio-recorded and transcribed verbatim including pauses and incidental sounds. An HSREB protocol endorsed external transcription service, Transcription Heroes, transcribed the audiotapes of the semi-structured interviews.

b) Art-work

The art-work was created as an independent, voluntary project at home and brought in to show in the final 2 weeks of the group process if participants

wish to share them in the group. They were given the materials (Bristol board, glue sticks) and instructed to collect any pictures, photographs, images that they feel drawn to include on the art collage. The theme of the collage is to show their 'soul-medicines', things that create life affirming feelings, hope, peace, balance or anything that they are drawn to include in their collage. It is suggested that they trust their intuition and follow what feels right.

Photographs were taken of the works of art generated through the group process - including art-collages and other creative works that emerge. In addition photocopies of any poems generated by individuals or the group were made and included as part of the data set of the study. Each participant contributed their art collage to the study. Pictures are shown in the findings section in each participant's phenomenological portfolio.

c) Poetry

Poetry is created in week 5 of the supportive care group through a structured exercise guiding participants through the process. This process includes:

- i) In pairs, they each tell a story approximately for 5 minutes each of a time when they had to find strength beyond any previous experience before.
- ii) As the partner listens to the other's story, they write down phrases and characteristics of their partner's strengths from within the story.
- iii) When both partners have shared their story, and written the other's strengths down from what they heard. They then spend about 3

minutes circling the 'key' phrases, strengths, from what they wrote down. They are asked to circle the things that reflect the 'essence' of what they heard about their partner's strengths in the story.

- iv) They then spend about 3 – 4 minutes to arrange these phrases or words into 'stanzas', and create a poem using only these words or phrases, in any order they intuitively feel is right.
- v) They are invited to read the poem they have created to their partner, as a gift to them for their story, reflecting back to them the strengths they heard in the story.
- vi) They are invited, if they feel comfortable, to 'present' their partner's poem to the group by reading it to the whole group and the woman whose story is reflected in the poem, is invited to listen to their partner reading the poem and inwardly claim the gift of their strengths being mirrored back to them in the caring support and witnessing of the whole group.

After completing the group and volunteering for the study, each participant signed informed consent forms and was informed of process consent throughout the study process meaning they could withdraw any time without impact on their health care. Knowledge translation was made explicit to participants as part of informed consent and so they were fully cognizant that the explicit goal was to contribute personal wisdom to research and to oncologists who may read or hear presentations about the study, and also for other women living with ovarian cancer. Each completed the two semi-structured interviews. Interviewees were

offered breaks in the interviews or to reschedule if they were fatigued or emotionally distressed from discussing difficult topics. All were informed of having access to referrals for further support with a different Supportive Care practitioner external to the cancer program or to book an appointment with their Social Worker in Supportive Care if they wished to receive support and therapy for any distress stirred by the interview discussions on their experiences. Each were offered and accepted to receive a copy of the findings on completion of the study.

3.3.5 Data Analysis

This study engaged a novel methodology, hermeneutic-poetic-phenomenology adapted from the more frequently used hermeneutic-phenomenology for studying lived experiences in health care contexts. Philosophical and theoretical foundations along with the inquiry methods for analysis are laid out in Chapter 2. Being a novel methodology that functioned in this research as a pilot for potential viability, a method needed to be developed as part of this research study. The full method stages are described below and summarized in Table 3.1.

Table 3.1 Summary of Hermeneutic-Poetic-Phenomenology Analysis.

For a detailed full description of analysis, see Section 3.3.5.2.1.

Stage	Analysis Process	Findings generated
Phase 1: Poetic Inquiry	<p><u>Iterative process:</u></p> <p>(a) create two poetic inquiry documents each, using method of 'Found Poetry' - first iteration to capture each woman's two interviews in a poetic form (not yet a poem)</p> <p>(b) the poetic inquiry documents distilled through a rigorous poetic inquiry process through 4 – 8 iterations into one one-page poem</p> <p>(c) re-read all the interviews again, the poetic inquiry documents, the one page poem; write a haiku of found poetry for the most salient, succinct capturing</p>	<p>(a) two long poetic inquiry documents of found poetry for each interview per participant</p> <p>(b) distilled one-page poetic inquiry, prototype 'Found Poem' for each participant condensing both interview findings into one representing Poetic Inquiry findings</p> <p>(c) a single 'haiku' type of 3- to 4-line poem for each participant. Placed at beginning of phenomenological portrait in representation of findings</p>
Phase 2: Hermeneutic-phenomenological analysis	<p>Return to the original long version of the poetic inquiry findings; combine participant's two interviews.</p> <p>Long poetic inquiry and the interview transcripts are re-examined back and forth, producing phenomenological portrait.</p> <p>The participant's own poems and collage art from their</p>	<p>Phenomenological dimensions of poetic inquiry findings and original data discovered, written up in portrait drafts</p> <p>Each participant's individual Found Poem revised to include phenomenological findings.</p>

	<p>support group participation were included in this phase.</p> <p>Re-engaged the hermeneutic circle once again, moving from whole to parts, and parts back to whole, iteratively,</p> <p>Reflexive writing was engaged for the researcher.</p> <p>Findings are written using “thick description” drawn from both the interviews and the poetic inquiry documents.</p> <p>Each participant’s ‘prototype Found Poem’ recrafted to ensure rich integration of findings from Phase 1 – Poetic Inquiry and Phase 2 – Hermeneutic-Poetic-Phenomenology findings.</p>	
<p>Phase 3: Theoretical Lens Analysis</p>	<p><u>Theoretical lenses:</u> Applied to the portraits, interviews and the full single document poetic inquiry of both interviews.</p> <p>Conducted after phase 2, the phenomenological analysis, returning with ‘fresh eyes’ to the phenomenon now using each theoretical ‘lens’ as the focus to scope and deepen inquiry into the phenomenon.</p> <p>This stage ensured all aspects of the study underpinnings were attended to, and to add to each phenomenological poem where insights on these lenses may have been submerged or excluded.</p>	<p>Theory lens findings worked into individual poems from phase 1</p>

<p>Phase 4: Poetic- Phenomenology Analysis</p>	<p>Each single one-page poem reworked as a final Phenomenological Poem, to represent the phenomenological analysis, as well as the poetic inquiry findings.</p> <p>The individual poem still uses found poetry, but can include reworking these creatively, and adding some interpretive dimension.</p>	<p>Single poem for each participant still only using verbatim phrases, found in data, phenomenologically evocative of findings from Phases 1 - 4</p>
<p>Phase 5: Final Writing of Individual Phenomenological Portraits</p>	<p>Portraits are rewritten into their final representation, deepening the inquiry to bring to a final representation of findings</p> <p>Portraits include:</p> <ul style="list-style-type: none"> • An individual phenomenological poem of the participant's data • Detailed account of the findings for the individual participant • Participant's poem from the group (if contributed) • Picture of participant's art collage 	<p>Individual hermeneutic-phenomenological portraits</p>
<p>Phase 6: Final Hermeneutic- Poetic- Phenomenology Poem</p>	<p>A movement from poetic-inquiry to poetic-phenomenology in full: the researcher becomes poet.</p> <p>A final whole poem is crafted, integrating the three individual phenomenological poems, all findings from both analysis data sets (Poetic Inquiry + Phenomenological Portrait) into one phenomenological poem</p> <p>The poem needs to show</p>	<p>Final poem representing findings</p>

	findings without 'telling' to evoke felt-sense, affective, textured experience of the phenomenon using 'material imagination' and 'image-based knowledge' to invoke a 'knowing', an 'aha' about the phenomenon for the reader	
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3.3.5.1 *Hermeneutic-Poetic-Phenomenology Methods*

The novel method applying the methodology in analysis was developed in analysis, iteratively, from interview to interview, whereby additional processes that emerged on each iteration, were then applied further, on previously analyzed data and looped back to the earlier analysis process. Writing was an integral method of inquiry (Richardson, 1994). Reflections on this methodological development process are given in the Discussion (Chapter 5) section of this thesis.

Found poetics involves using interview transcripts, drawing from the verbatim words and phrases of participants and representing them, interpretively, in poems (Richardson, 1992; Tasker et al., 2014).

3.3.5.2 *Hermeneutic-Poetic-Phenomenology Analysis*

The next section depicts the analysis process used by the primary author to develop poetic interpretations of data.

There are six phases of analysis method in hermeneutic-poetic-phenomenology. 'Phases' is used rather than steps as the process evolved iteratively with each woman's data to develop the method applying this novel methodology. 'Steps' would imply a purely sequential process which might be used rigidly and is not the intent or process for hermeneutic-poetic-phenomenology as a creative-analytical art form. They function somewhat sequentially but in a spiraling fashion as in Heidegger's hermeneutic circle (Crotty, 2003).

The first phase conducted a poetic inquiry with the interview transcripts. The researcher created a poem using 'found poetry' (Gold, 2013; Tasker, Loftus, & Higgs, 2014) for each participant. Found poetry uses verbatim phrases from a textual document shaped into a poetic form. In its first iteration, every single phrase was included from every sentence to capture while distilling the interview in the most fulsome possible way, which is not yet a poem but a poetic representation of the text. Poetic inquiry allows the researcher to engage the participants' words, images, and perspectives and to represent them through their own intersubjective interpretation of findings. This involved using verbatim phrases of the interviews beginning with every phrase for each interview and turning them into a poetic format to create two lengthy poetic representations of the interview content. The poetic representation of the data (interviews, art-collage, and participant poems) is then further distilled engaging in poetic inquiry to a one-page poem per participant and then a type of 'haiku', a short 3 to 4 line poem.

The second phase conducts a hermeneutic-phenomenological analysis to draft individual phenomenological portraits of each participant's data focusing on the phenomenon of wisdom. This uses the methodology described in Chapter 2 that pays attention to interpretation of meaning, including awareness of language itself as already interpreting lived experience. Participant's choices of words, the researcher's interpretation and own subjective experiences connected to participant's word choices are included as part of the hermeneutic-phenomenological inquiry.

Their art was integrated by the researcher examining what participant's said about their meaning, writing associations of the images presented and their meaning(s) to the researcher and the ways the images spoke to findings emerging from the phenomenological analysis of the interviews.

Phenomenological, in-depth, portraits for each participant are produced that focus on the phenomenological dimensions of 'wisdom' as these are found from the analysis. This uses writing, reflective and reflexive writing as part of the analysis process and where writing itself, is considered a method of inquiry (Richardson, 1994).

The third phase turns to the theoretical lenses chosen for the study. Data was scoped and re-analyzed for findings connecting to: (1) theories of imagination; (2) embodiment; and (3) feminist bioethics. This analysis focuses on the *phenomenon* of imagination, embodiment, and the themes identified by feminist bioethicists pertinent to women's experiences in engaging medical care and health care systems. This means that the data was analyzed to investigate the ways participant's enacted and experienced (or didn't experience) personal agency, autonomy, subjectivity, embodied knowledge and particularly towards illness and health in participant's body/self, medical decision making in the context of power differentials, a medicalization of the body and so on (Chapter 2). Neither is this analysis a linear process because these lenses are, in some ways, entrained and cannot be severed from any lived experience and undergirds all that the participant's are describing or interpreting. This phase allowed for a deeper inquiry into how wisdom *phenomenologically* (versus cognitively or

descriptively) is lived as an experience of being and doing, within the dimensions of human life that the theoretical lenses are attuning to specifically.

The third phase now integrates all the findings from the Poetic Inquiry and Hermeneutic-Phenomenological analysis into the final phenomenological portraits of participant's perspectives and enactment of wisdom in their lives with ovarian cancer. These portraits show the findings of the phenomenon of wisdom and the ways the women have found this phenomenon within themselves and within life. They show the meaning(s) they've come to ascribe to 'being wise' or 'finding wisdom', how embodiment is implicated, how imagination is implicated and how each woman experienced (or not) medicalization, paternalism, agency, autonomy, subjectivity (or didn't) in their medical care or interiorization of those themes while living with an illness. The researcher's subjectivity is implicated such that the portraits represent an intersubjective interpretation of the phenomenon of wisdom without making assumptions about wisdom's ontogenesis or purporting objective portrayal of knowledge about wisdom nor an assumption that 'wisdom' exists independent of interpretation. The portraits represent a process engaged between the researcher and participants and show the researcher's analysis and investigations understanding they may not represent how the women themselves would write their own portraits.

The fourth phase integrates the findings from the poetic inquiry immersion into the data, the phenomenological analysis, and the scoping of the data through the theory lenses to conduct poetic-phenomenology with the findings. The outcome creates an (approximately) one-page poem per participant. It

involves writing and re-writing, crafting the poem iteratively once again, returning to all the original data, interviews, art-collages, participant poems. It uses found poetry but also with more interpretation and greater creative freedom for the researcher to use their own poetic skill to craft a poem that elicits felt-sense, resonance, evocativeness for the reader that attune and engage them with each participant's unique embodiment and insights into the phenomenon of wisdom in their lives. It is crafting a poem that arises from the phenomenological (being and becoming) aspects of the participant's and researcher's intersubjective lifeworlds as they have met, encountered each other, through the research study process.

The fifth phase returns to the portraits and writes a final copy integrating and showing, with thick-description all of the findings to date. It is understood in hermeneutic-phenomenology that there is always a "surplus of meaning" which Kearney (1998) calls a "hermeneutic of affirmation" (p. 156) opening up the irreducible to ongoing levels of meaning that cannot be exhausted. This phase shows the poetic-phenomenology poem as the final representation within the portrait placed with the researcher's discretion.

The sixth and final phase, perhaps the most creative where the art of poetics come into play, is the creation of a final, total, phenomenological poem that integrates the poems created for each individual participant's portrait but also includes further material from the data where it gives greater illumination to the phenomenon. Creating this is also an enactment of hermeneutic-poetic-phenomenology with the researcher's interpretive lens entrained. The focus is sustaining the researcher's vigilant attunement and dedication to the

phenomenological dimensions of the phenomenon being investigated and with the rigor of a poet creating a poem that somehow conveys to the reader a deeply embodied and evocative experience of the phenomenon such that their own insights, reflections, memories and embodied life are potentially engaged. This poem is the sum of findings and shows the results of a hermeneutic-poetic-phenomenology as fulsomely and yet as condensed as possible.

A summary of hermeneutic-poetic-phenomenology analysis steps is provided in Table 3.1.

3.3.5.2.1 Analysis Method Sample Showing Poetic Inquiry Analysis Moving to Representation in a Phenomenological Poem

Two steps in the analysis process are shown here using the poetic inquiry findings using Found Poetry and used as exemplars in the theoretical lens section 2.3.2.1, *Imagination as Fostering New Horizons of Possibility: Hope for the Future*. It illustrates the movement from Found Poetry to an example of a hermeneutic-poetic-phenomenology finding using a method of Erasure Poetry, which deletes words from the found poetics to create a poem using also the visual spacing on the page. This example below focuses on the phenomenon of 'hope', as embedded in the phenomenon of wisdom for its capacity to foster hope in adversity and shows the various means participants discover for creating hope in their lives.

In this example it only the words, images, phrases of the participants. The researcher is using interpretive judgment on selection and placement on the

page but not adding their own words at this stage. This keeps the researcher close to the participant's phenomenological evocations during the analysis process. The poetic-phenomenology poem is designed to invite the reader into an awakened sense of the *phenomenological* dimensions 'hope' rather than a representation of what each participant says *about* hope. It offers a sample of the type of process engaged in the cultivation of the final poem.

'Found poem' excerpts from the poetic inquiry analysis phase for participant interviews

Carrie:

*I see myself really up!
I see myself here, in this world
winning actually!*

*I've compartmentalized
I don't wake up every day thinking
"I'm going to die"
I wake up every day thinking
"there's so much going on
I've got to make all sorts of plans to do things
live my life*

Denise

*I think the whole diagnosis
has made me realize
that I will probably think
of my future
differently
than I would have prior
to cancer
the wisdom is
acknowledging
that my thinking has shifted
what is important to me
has shifted....*

*I'm not going to be working
 I'm going to work on relationship building
 with my nieces and nephews
 I would love to
 spend the afternoon with one of them
 every month
 just connect in a different way
 with each
 these are
 the relationships
 that are important to me
 that's what I would want to work on*

*to know there is life
 beyond this world
 and when you're really thinking about your end
 that is comforting
 it will be pain free
 sunny, bright
 I just spent a weekend
 on a house boat
 so we had water, scenery
 I saw the sun rise
 it was beautiful
 I think it will be something like that
 it's beautiful
 it's nice
 and you feel the warmth of the sun*

Beth

*schedule things
 plan ahead
 planning gives me an idea
 I have a future
 I'm going to experience
 these things*

*hope is a huge word for me
 having the wisdom
 creating that feeling
 of hope*

*it makes my ability
 to get up in the morning
 go through your day
 every day after that*

*scientific advances
 give me hope
 it's not the death sentence
 it was 10, 15 years ago*

Poetic-phenomenology poem: Horizons of Hope

*up!
 here, in this world
 winning*

*(compartmentalize
 "I'm going to die")*

wake up every day

think

realize

*so much going on
 make plans
 do things*

live life

a future

*cancer
 think differently*

*wisdom is
 shifted thinking
 what is important
 shifted....*

*working?
 not going*

be relationship

love

connect

*working on
relationships*

*building
relationships
that are important*

*creating
feeling*

*schedule
hope
ahead*

making plans

*a weekend
on water
a house boat
a sunrise*

have a future

*experience
hope*

*feeling
creating
hope*

*morning
sunrise
go through your day*

get up

*every day
after that*

give hope

*scientific advances
creating*

*experience
a future*

hope

*not the death sentence
it was 10, 15 years ago*

*to know
life*

*pain free
sunny,
bright*

*beyond this world
beyond the end*

*comforting
beautiful*

*connect
wake up
feel
create
experience
a future*

*feel
hope's
warmth*

a sunrise

If the reader were to now close their eyes and engage in “reverie” on the images in this poem: a houseboat, sunrise, water, an afterlife as water, sun, warmth, making plans, scientific advances then the potential for an evocation of the phenomenon of hope, through the eyes of participant’s living with a terminal

cancer, might be deepened. Poetic-phenomenology requires from the reader a capacity for “reverie” in reading the poem.

Bachelard’s discussion of “reverie” on a poetic image as fostering a deep sense of well-being is called to mind. Imagination is implicated here as an existential *capacity* to cope with an existential *uncertainty* – mortality. The poetic-phenomenology poem aims to invoke a sense of hope’s *poesis* as the participants describe in their interviews the various ways they have found to source personal hope. As the reader approaches the poem titled ‘Hope’ they bring with them their own meaning(s) but are then taken through a visual poetic imagery of participant’s ‘hope-creating’ including Denise’s re-imagining death in hopeful terms. It may or may not speak to the reader but invites a a “*cogitio*” (cogitation) (Bachelard, 1969, p. 143) on their own evocation of hope in its *poesis* dimensions is opened up for its potentiality.

3.3.5.3 *Quality Criteria*

Finlay (2011) identifies essential dimensions of good phenomenological research, which will be adhered to in the current study:

- (a) A focus on lived experience and meanings of phenomena.
- (b) The use of rigorous, rich, resonant description.
- (c) A concern with existential issues.
- (d) The assumption that body and world are intertwined.
- (e) The application of the ‘phenomenological attitude’ (i.e. a concern with *Being* over doing).

(f) A relational approach.

This study held all these features as central by focusing on the lived experiences of participants with ovarian cancer with a lens on the existential, spiritual and relational meaning(s) embedded in their individual perspectives on wisdom. It incorporated theoretical lenses on embodiment, imagination and feminist bioethics to guide analysis. The poetic representation of findings offers thick description by using verbatim words and phrases from their interviews for staying close to the women's meaning(s) and insights as well as uses poetics for rich, resonant evocation of reverie on the phenomenon of wisdom in the reader.

One of the potentially unique features of hermeneutic-poetic-phenomenology is that the very genre of writing a poem in representing findings, as well as using poetic inquiry throughout analysis, creates a tempering constraint that demands an economy of words and forces a depth engagement with art-based and textual data in the process of creating a poem that captures the data's phenomenological dimensions. Poetics in one sense might be argued as a form of phenomenological inquiry. The methodology moves the researcher to become poet and to engage with imagination aiming at evocation rather than constructing data to argue a found knowledge with a view to gaining cognitive assent. A researcher using hermeneutic-poetic-phenomenology is successful if the poem evokes an interior experience in the reader's encounter with a taken-for-granted phenomenon, such as, this study's case, wisdom. What is evoked about the phenomenon being represented lies beyond the bounds of the purpose and intent of a poem.

3.3.5.4 *Participants*

The three participants were assigned alias names. All were in the post treatment phase of living with their diagnosis. Beth was retired and in her late sixties, widowed just over a year, with 2 adult children and five grandchildren ranging from thirteen to three. Carrie was retired in her late fifties, married, with three unmarried children in their twenties and no grandchildren. Denise was single, in her early sixties, did not have children and was still working at the time of diagnosis. More detailed demographic information is provided in their individual Phenomenological Portraits in the Findings section (Chapter 4).

Breathing Space



Phoenix Rising – Helen Butlin, needle felting art, 2009

*colours, bright colours, circles
some navigational paths through the circles
good light, like sunshine
strong colours, you need strength in your inner core
navigational paths out in the light
bright because you've got to be positive
think about bright things
so you wouldn't see gray*

by Carrie

CHAPTER 4

FINDINGS

CHAPTER 4. FINDINGS

4.1 INTRODUCTION

This chapter shows the representation of findings from the analysis. Each phase of analysis is shown in 'portraits' of the participants, Beth, Carrie, and Denise. This Findings Chapter includes two differentiated but interconnected representations of findings in each participant's portrait:

(1) Phenomenological Poem: the section opens with the encapsulation of the methodology's findings in a 'phenomenological poem'. It places participants' words, 'image-centered knowledge' and material imagination's influence on their words into 'Wisdom' as speaking to the reader in the first person directly. Wisdom is thereby 'bodied' through the participant's found wisdom and perspectives contributed from their lived experience, interwoven with my own subjectivity-as-lens from conducting this inquiry.

(2) Individual portraits: the portraits show a fulsome representation of each phase of the inquiry method in analysis. Each participant's portrait includes: (a) a short poetic representation of salient contributions about wisdom using found phrases and words from that participant; (b) a brief demographic description of the participant (c) a Found Poem as a showing of findings for that participant; (d) a portrait of hermeneutic-poetic-phenomenological findings on participant's perspectives on wisdom; (e) the art-collage and poems generated by participants in the Soul-Medicine supportive care group process and contributed with consent for the study.

4.2 FINAL PHENOMENOLOGICAL POEM OF FINDINGS

This poem, which opens the findings sections, shows where the poetic representation of wisdom-as-phenomenon through Beth, Carrie and Denise's perspectives, entrained with my own, had come to rest. It shares the findings as in 'the here and now' and is offered as emergent from immersion in the dialogue and material offered by the women with whom I journeyed.

The words and phrases are all drawn from the participant's interviews and personifies 'Wisdom' as speaking to you, the reader, through Beth, Carrie, and Denise's lives and words and between their words, and alongside them, is my own journey of this dive into a search for wisdom's phenomenological dimensions. It could be reworked further, over time, for that is the nature of poetry, but the context of poetry never reaches for saying all and everything but points towards a horizon beyond the poet's control, as it is with phenomenon in life.

The poem invites a "slow reading" (Bachelard 1960/1969) with reverie, dwelling on words, phrases or images that capture you and allowing them to work on your imagination and connect with experiences, insights and feelings that are evoked. It invites a phenomenological attitude, coming with fresh eyes as Bachelard (1960/1969) suggests, "One does not dream with taught ideas..." (p. 188) and invites, "In order to have the sedative benefits of such a passage, it is necessary to read it in slow reading. We reach *understanding* it too quickly (the writer is so clear!). We forget to dream it as it has been dreamed (p. 161). 'Slow-reading' can allow a reverie to unfold even if it takes the reader into other images

and thoughts in an interweaving departure from and returning to the text. Attention is paid, when reading poetry, to the reverberations that echo after it has been read, preferably several times at different times.

Bachelard suggests to us that, “The dreamer of reverie is present in reverie” (p. 150). A more contemporary notion of mindful awareness can assist us to understand his meaning such that with mindfulness awareness in a reverie on a poem one might pay attention to one’s reflections, to notice where we go in our minds, the sensations that arise in the body, the feelings, memories, fleeting insights that are evoked. The slower the read, the more potentially impactful. I share what was ‘bodied forth’ into poem from my analysis process.

I am Wisdom...

I am quiet

invisible

I am so close

you don't see me

I live between

the black and white

where things cannot

be seen

I am navigating

I am being in the present moment

I am doing a fresh take

you don't give yourself credit

for how much you do inside

I comfort you

to get off the couch

when too much self-reflection

takes you to dark places
steeping despair

I give you control
to take time
to not react to fear

I help you
get that feeling
that there is
more to life than
what you're thinking
right now

I am hiding in time
I form slowly
enfolded within
your navigating
a day
a night
another day
yet one more night

I am the one whispering
something's wrong
it's me that knows
in your body
push to find out

I come through dialogue
back and forth
understanding
connecting

I draw your heart
to friendship
comfort
a new idea
a plan

I am the fresh take
a spark
moving you
"get out of bed"

I am a dawning hope
your optimistic self

coaxing you
 through the day
 through
 now

I am your will
 applying my whisperings
 into the knots
 of life
 for today
 the big tomorrows
 receding
 in the messy
 practicals
 of stuff
 and things
 'aha' - a picture NOW
 while you still have your hair
 for your driver's license
 before it falls away
 with your old self
 the one who was before
 the diagnosis
 I am helping you apply
 your wisdom
 today
 so tomorrow

is hope

I dwell in body
 speaking in your gut
 rising into mind
 to glean me
 from your life experience
 helping you
 find the sweet spot
 so living
 is a comfort
 the present
 moment

a peace

I whisper
 in your heart
 when you feel
 lost
 I am in the one
 who is lost
I am found
 in the journey
 you did not want
I am gained
 on the road
 without a map
 invisible to you
 when you just see
 everyday living
 as putting one foot
 in front of the other
 and you don't see
the wisdom in that
 then I whisper
 it's easier to recognize me after
 when you go
 to connect
 with someone
 who understands
 I weave through
 dialogue
 decisions
 shared

I whisper
 oh so gently
 to a new
 minding of your life

be reflective
 be open to life
 to possibilities

recognize me
 wisdom
 in it all
 so you can find me
 from within
 to rise up

and meet a new day

*I am in your
unknowing
here
now*

*I am wisdom
in you
in all*

*I am discovered in nature
felt within
you can find me
within the folds
of your life's
curves*

*I am not in knowledge
while I am a knowledge
I am not in ideas
while I can be an idea
I am not in information
while I can come
from information*

*I come
in many different forms
from different places*

*I make you think
about who you are
how you process*

*I am in memories past
create memory now
for the future
you can't see
for the grandchildren
the children
nieces, nephews
you may not
know
more*

I am insight

appearing in reflection

*I am an arriving
a realization
I am process
start small*

*I am kindness
reminding you
to be kind to yourself
self-compassionate
kinder to your body
walking
give yourself
breathing space
connection
naps
birds singing
flowers
sun's warmth
the waves
the sand
on your
feet*

*I arrive through
breathing space*

be in the present moment

express yourself

I give you permission

*crying, grieving
you feel calmer*

*you may feel as if
you are putting one foot
in front of the other
and you don't see
you are wise
navigating
finding your way*

I am in your
 pushing yourself
 when it's tightening
 you're immobilized
 like when pushing
 a baby
 out
 and you say
 "I can't go on..."
 "I don't think..."
 I can do this...
 I can't do this...
 but I can't just stop...
 I have to
 to push
 myself
 out of bed"

I am in your pushing
 to get out of bed

I am found
 in your faith
 the faith
 that gives
 you hope
 the prayer
 that gives you
 comfort
 to live with
 what
 happens

I give you the ability
 to create hope
 to cling to the glimmer
 who has a 'go forward'
 who goes in
 to come out strong
 the one who
 has to anchor inside
 a position to come out
 with both blocks forward
 like a machine

of what you can
 in taking time
 to process
 the next steps

I am the one
 in front of the doctors
 discussing your
 Do Not Resuscitate
 wishes
 who puts your lipstick on
 who wears the short skirt
 and shows them
 you are not a wilting flower
 still solid

I am the one
 who makes them
 believe
 you are still strong

I am the wisdom in you
 that makes you part of
 decision-ing
 the care of your health
 I am in your gut
 in your feeling
 if you feel something's wrong
 in your gut
 keep pushing to find out
 I help you push harder
 and keep pushing
 and remind you to say
 'that's the way it is'
 for a number of things

I am
 accept acceptance

I am the one that knows
 doctors are wise in what they do
 but they don't know all the answers
 they can't

I am the one
 who reminds you
 everybody's working

as hard as they can
 for you
 that remembers
 you're on this journey together
 without knowing
 what the ultimate
 outcome
 will be

I remind you
 you are living to live
 not living to die

I whisper
 from the moment you're born
 you're dying
 realize life
 can be short
 for so many
 reasons

everybody is dealing
 with something
 everyone
 has to figure it out

I help you realize
 you are not alone
 in this journey
 it's part of life

in sunrise
 in sunset
 in rain
 in summer's roundness
 your life ripening

if you look carefully
 you will find me too
 in winter's icing
 where following the fallow
 spring's unfailing promise
 awaits
 in here
 in there
 in then
 and now

nothing happens instantly

take time

to

find

me

I am your wisdom

hidden deep in your being

becoming your life

passed on

in your dying

I am Beth's wisdom

I'm dying

but maybe not tomorrow

be in the present moment

make memories

now

I am Carrie's wisdom

I'm living to live

not living to die

put your lipstick on

navigating

there is no roadmap

anchor inside a position

and find your own

inimitable

way

I am Denise's wisdom

that knows

there's nothing to do anymore

but begin a process

start small

do a fresh take

and live

your life

4.3 PARTICIPANT HERMENEUTIC-POETIC-PHENOMENOLOGY PORTRAITS

This sections shows portraits for findings from Beth, Carrie and Denise: their contributions and perspectives on wisdom.

4.3.1 Beth's Portrait: Wisdom as "Be Here in the Present"

*my wisdom is this
be here in the present
that's the only thing you can control
you only have right now*

*I'm going to die
but maybe its not
tomorrow...*

Beth is 67 years old. She has two adult daughters in their forties and two grandchildren, a girl, twelve, and a boy, nine. Her ovarian cancer was in stage III at diagnosis ten months prior to the first interview. She had eighteen chemotherapy treatments followed by radical surgery removing her uterus and ovaries. Her profession before retirement was as a social service worker and she is a college graduate. In the year before her diagnosis she was widowed as her husband died of cancer after five years of living with it from diagnosis. Her multiple relationship roles are as an aunt, a sister-in-law, a sister, a mother, a grandmother, a neighbour and a friend. Beth describes her childhood as "very good" without traumatic memories and described adult life similarly. Her parents have both died in their aging "not out of the realm of normal living". She described that her greatest difficulty prior to diagnosis was her husband's

diagnosis of cancer lived together for several years until his death during the year prior to her ovarian cancer diagnosis. Beth could be described as having ‘complicated grief’ since she was still in shock from the simultaneous bereavement, diagnosis and treatment regime that began immediately, all within a year. By the time the interviews took place after the Soul-Medicine group Beth described how she felt she was returning more to ‘normal’ emotionally and starting to come out of the shock.

For Beth a central wisdom-phenomenon, her wisdom-compass, for living with ovarian cancer returned her, over and over in the day to day with its trials, emotional struggles, existential and grief, to “be in the present moment”.

Beth’s found poem was rendered from the analysis process, and represents Beth’s perspective on wisdom for living with ovarian cancer. It is titled “Be in the present moment” and shows some of the ways she personally discovered to come to this.

Be in the present moment

*My wisdom is
 be here in the present
 that’s the only thing you can control
 You only have right now*

*wisdom
 is accumulating
 all your experiences together
 and coming to decisions*

*how much you do inside
 you don’t give yourself credit for*

be here in the present

accepting whatever's
 going to be
 will be
 push through
 memories
 make memories
 right now
 breathing out
 do the little things
 for me
 keep pushing
 have the wisdom
 to create that feeling of hope
 make plans
 you can control
 the memories you make
 right now

we cope with these things in our lives
 that hit us, these milestones
 dramatic events
 we don't know how we're going to react
 until we actually...
 are confronted with it

if you feel something's wrong
 in your gut
 there's something wrong going on
 just keep pushing to find out
 doctor doesn't know our bodies like I do
 I knew for a while before
 there was just something wrong
 there was something
 in my body
 that was wrong
 I just didn't know
 what it was

now I think
 maybe
 you should have pushed
 a little more

now, I have to really push myself
 I have to push through it
 you can't just stop

*you have to push yourself out of bed
 have to not give up
 keep going*

*I find its in my gut
 I'd like to say its in my head
 but sometimes in your head
 you can twist things around a lot.
 go with the core feeling
 it feels better*

*if I think too much
 I'll leave myself on the couch*

*being remembered
 is a big thing
 I pray, "help me cope"
 I cast my cares upon the Lord
 I let God
 pushing forward
 I don't have time to
 put all your needs
 ahead of my needs*

my wisdom

*be here in the present
 that's the only thing you can control*

I'm going to die

*but maybe its not
 tomorrow...*

4.3.1.1 Hermeneutic and Phenomenological Findings in Beth's Perspective on Wisdom

Wisdom in time as inner continuum: "memories", "present moment", "time left". 'Time' became an emergent and central phenomenon in Beth's perspective on wisdom, in analyzing Beth's interviews. This phenomenon of time

was not merely about accumulative experiences resulting in 'wisdom'. Rather, evoked was a sense of time as movement, inwardly, a continuum of past-present-future working as a type of generative movement that could remove her from the present into comforting memories of the past, if it was a difficult moment, and return her to the present moment where it could become with this 'wisdom', a place of meaning and hope for the future.

There were 'mini-phenomenon' within the way time functioned as a phenomenon in "*memories*" and her knowing of "*limited time*" in the future changing her present moment choices. She relates to time as inner movement, time as "*present moment*" and thus as a 'good', imbued with a 'presencing' in body where mind's fears can be assuaged into being, in the now, a place of arriving here, to be aimed for. Yet when the present moment holds "*dark thoughts*" the present moment was also not comforting. For Beth, time as a phenomenon therefore held both positive and negative aspects. Time was sometimes overtly reflected upon: "*you only have a certain period of time left*" and "*you can live this long...possibly this long but....there's not a long period left*". The phenomenon of time is implied in statements such as: "*wisdom is an accumulation of life experience, as opposed to intelligence*" which, later on in the interview she revisits saying, "*wisdom is accumulating all of your experiences together and coming to decisions*". Sometimes for Beth the future was terrifying with shortened life trajectory. At such times of realization, the wisdom that Beth describes is for "*creating the feeling of hope*" with "*making plans*" and "*doing*"

which included being with her grandchildren, focusing on legacy and “*being in charge*” of what she can control while “*letting go*” of what she cannot.

The past in Beth’s descriptions and how she turn to “*memories*” seemed a source of comfort for Beth, particularly coping with bereavement from her husband’s death. This return to memory compelled her to focus on “*making memories*”, in the present, with her grandchildren and adult children sourcing a sense of comfort and hope for leaving a legacy of comforting memories of her in their future. Beth says, “*for me...I have past memories....for the most part....are very good....I think working through it was just memories, past memories, for the most part, very good, my husband really was my best friend.*” She continues, “*memories are part of what has helped to help me realize that I have had a very good life memories became a way of coming to terms with, this isn’t what I was expecting.*” She describes working through her husband’s death after several years of cancer and “*I basically put my life on hold for five years, while I was going through this with him. That was my choice, I realize that. Maybe if I knew what I knew now, I wouldn’t have but you don’t know what’s ahead of you, so you make these decisions.*” She turns to her memories of him, being together, the love shown in setting her up in a new apartment, where she could manage without him and describes these memories as helping her, through, with counseling, to source a sense of the love they shared, without a memory of a “*a moment to say goodbye...and I love you, we didn’t have that*”. Now, in the present, “*coming to terms with bereavement, cancer, my diagnosis, both at the same time...wisdom, yes, ...it took me some months to get there*”. Her reflections

on this process then emerge into a 'what is', now, and a 'what then will be, in light of it, sharing, "*you can live this long, or...possibly this long, but there's not a long period left...you draw on that now, 'okay, then I'm going to do these things I want to do in my life.*"

Wisdom as time in a circular wholeness: "*It's made me look at my life as a whole*". As well as reflecting on time-as-continuum Beth also alluded to a more 'circular' notion of time, where time becomes an encompassing of wholeness, the whole before the part, in, "*it's made me look at my life as a whole*". While moving on a continuum of time describing challenges, grief, hopes and comforts, "*be in the present moment*" came through the phenomenological analysis as a central guiding phenomenon or 'wisdom-phrase', a type of 'compass' because Beth returns to this phrase throughout the interviews.

"Be in the present moment" was more than a thought. It acted upon her and she upon the notion into something to be embodied, experienced, a place of arriving and returning to, through her days and nights. As a 'wisdom-phenomenon' it evokes a sense of intentionality guiding her and was described through the interviews in her relationship with time, mortality, relationships, mothering, grandmothering and coping with existential and spiritual struggle in her inner life where she found it was important to not "*go to dark places*". Beth uses mortality awareness to catalyze action in the present, "*I'm going to die...but maybe it's not tomorrow*" and so she describes making plans for tomorrow as keeping her alive and hopeful ... "*for today*".

Wisdom as prayer in a process: “You’re going to have to accept acceptance.” Beth also uses and faith to source comfort in the present moment. She quotes a phrase meaning-full for her and to which she turns to repeatedly, “*I cast my cares upon the Lord, I write that down every night*” to return herself to the present with hope. She states, “*at some point, you’re going to have to accept acceptance*”. Others gave her prayers that comforted her pointing to the role a sense of spiritual community played in fostering comfort.

Wisdom as labour: A “work” in “pushing through”. Beth’s process of handling time as both ally and difficulty was described as a process of “*pushing through*” and describes giving birth to her children illustrate her meaning of this phrase. She continues, “*it’s pushing myself...it’s tightening...I’m immobilized but I have to push through it, you can’t just stop. Like when I had my children....both times...“I can’t do this...I don’t think I can have this baby”...like overwhelmed....“I don’t think I can do this....I don’t think I can do this” same idea. I can’t do it but I have to you have to push yourself out of bed.*” She also uses “*working through*” a difficult present moment as a means to experience “*be here in the present*”.

Returning to “*be in the present moment*” emerged as a central wisdom-phenomenon, her ‘wisdom-compass’ so to speak, and best captures Beth’s own wise-way for living with her diagnosis to source hope for the future and draw consolation from the past to help her with “*living today*”.

(Re)claiming subjectivity and agency: “Why didn’t I push harder?” Reclaiming ‘subjectivity’ aligns with a constructivist paradigmatic view that individual’s have an interior “I”. This “I” is subjective, changing and transforming

over a lifespan. It moves a person into life with acts embodying personal agency (influence) in their lifeworld that can be empowered, repressed, subjugated or overly inflated by social privileges in ways that interact with power relations and other “I’s”, as well as in relation to the collective socio-political matrices shaping their life worlds (Campbell, Meynell, & Sherwin, 2009; Grosz, 1994; Grosz, 1995; Koggel, 2009; McLeod & Sherwin, 2000; Sherwin, 1998).

Beth reviews her former ‘self’, prior to diagnosis through a lens that suggests a sense of loss of agency by describing a struggle she had in reflecting that she didn’t “*push harder*” for a diagnosis. She tries to use her retrospective knowledge of life in her body filled with symptoms diffuse, all ascribed different diagnosis and seemingly harmless at the time. Now, hindsight becomes the lens through which she views these to give a sense of passing an unclaimed agency to her daughters, urging them to be more proactive in getting medical attention for symptoms in their bodies, “*like, I tell my daughters, yeah, you have to ask to have a CT scan done...I don’t know now....maybe I should have listened to my mom “have a hysterectomy and get rid of all that stuff”...maybe I should have listened...just to get rid of it all*”. In this, there is an echo of the tension described in the literature view between “common wisdom” (Chapter 1, Section 1.3.1), which may be medically obsolete in light of new knowledge and the implicit wisdom held in lay viewpoints that might well still be pertinent. Beth wonders about listening to her mom and alludes to a generational matrilineal challenge to discern the question of what we take from our mother’s ‘wisdom’, as a form of

historically acceptable 'common wisdom' and what we reject in the face of current medical expertise and discourses of biomedical knowledge.

Advising her daughters with her hindsight, in light of her lived experience of bowel and uterine issues throughout her life to urge them to push for early detection, is perhaps one means for Beth to reclaim some of her subjectivity and agency that she is expressing she did not have to get her own diagnosis sooner by not "*pushing harder*". By empowering her daughters with knowledge she did not have, which may or not have made any difference, she can perhaps be considered as enacting agency in the present moment as a mother, and woman, by encouraging them to claim their own agency, and epistemic power, to get diagnostic surveillance sooner, given their greater risk factor with Beth's diagnosis. She continues, "*I'm not blaming the medical people for not...I didn't push it either and after somebody tells you this I go and look at all this literature on it it's like, oh, geez, like...I had those things...I had those symptoms...why didn't I push that agenda forward a little bit more?*" She presents a feeling of something she could have done that might have made a difference to her life and well-being. A natural human tendency to frame the present with hindsight which nonetheless reflects a theme that in Beth's view, there was something, medicine, that could have been "*pushed*" upon "*harder*" revealing a sense of reflection on the question of agency and subjectivity in relation to a system with perceived power over her situation.

Responding to 'medicalization': "*After menopause...it's like you're done*". Beth's description of how she feels treated in her medical care as a post-

menopausal woman invoked a sense of meaning to “medicalization” (Pauly Morgan, 1998, p. 209). Without obvious symptoms to approach and investigate medically, combined with her age and, Beth implies, her gender, she experiences feeling left aside by medicine’s purview of concern raising a sense of experiencing. She states, “*After I went through menopause it’s like you’re done...I knew I should...you’ve asked yourself that...like I knew I had cysts on the uterusall when I was a young woman, they were always benign...and it’s kind of like, you know....should I have demanded a CT scan?*” In this reflection is a linking, somehow, of Beth’s late diagnosis being related to her gender and age where as an older, menopausal woman “*it’s like your done*” in the medical gaze upon a woman’s body.

These reflections connect with Beth’s hindsight on her health concerns in her twenties as being framed with a self-imposed label, familiar to women, of “*worrying too much*” and its medical term “hypochondria”. This term can point us to reflect on its common use, applied in dismissive ways in a popularized ‘diagnostic’ parlance drawn from less nuanced, earlier twentieth century psychiatric diagnostics. It evokes echoes of attitudes towards women where “*hypochondria*”, applied to a woman, brings a reminder of modern day versions of the Victorian diagnosis of ‘hysteria’ as a diagnosis for removing women’s wombs for states of mind and emotions (Rimke, 2003) where “*hypochondria*” was a way to rigidly render a woman’s whole person with symptoms, as ‘only’ symptoms of an ill mind.

Beth's account of questioning herself for "*not pushing*" and her discovery, on diagnosis, that, in her view, her "*worry was legitimate*" speaks to central theme in a feminist bioethics of reclaiming subjectivity, agency and epistemic power in face of a system that tends to not hear 'worry' from women about their bodies as a legitimate knowledge. Standardized assessments in oncology used prior to each clinical consultation with physicians (for example, the Edmonton Symptom and Assessment Scale (Bruera, Kuehn, Miller, Selmsler, & Macmillan, 1991) ask for 1- 5 Likert scale self-assessment on anxiety. Many are referred to supportive care assessment and chart notes reflect "Generalized Anxiety Disorder" specific to the cancer as a catalyst. Beth's quote above shows how psychiatric diagnostics, in understandings of their common use in culture, can become internalized with a dynamic that can oppress us from 'hearing' our own embodied intuitions, or at least our human subjectivity with compassionate, inquiring, non-judgmental eyes as potential sources of embodied knowledge.

This quote brings her inner dialogue into a medicalized view of internal states of anxiety, worry whereby embodied intuitions about potential disease emergence are more likely to be discounted, by ourselves first, in this type of inner dialogue, and potentially be an internalized medical gaze placed upon those symptoms with ourselves assigning diagnostic labels to them as an illness of the mind. She reflects in the interview:

...since I was young...I always thought 'I'm going to have cancer'...don't know why, always felt it, it's just something...and I decided I was kind of like - oh what's the word...hypochondriac kind of thing ...ovarian? I just didn't see it coming...the KIND of cancer, a shock, not the diagnosis, I was just hoping I was being...you know...worrying too much, I thought, 'I'm just worrying too much'...I don't have to worry about it any more.....The worry

was legitimate. I guess my thing is ...I should have been more in tune...I reflect back now more and I should have pushed more to have things looked at instead of just 'oh well, its indigestion' or 'its just diverticula'...it's not...you know...it's not...I didn't push it...Doctor doesn't know our bodies like I do now I think 'maybe you should have pushed a little more'.

These narratives and descriptors were reinforced earlier in life as her own worry exaggerating her concern when investigations in young adulthood proved they were relatively 'harmless' to her health. Beth's account of these reflections, now framed by hindsight show how she is engaging with an social-medicalized narrative of "hypochondria" and "worrying too much" as the lens her symptoms were viewed through before, now reframed on diagnosis which is catalyzing reflection on her own life-long embodied experience of symptoms with her digestion and her uterus. Once she did her own research upon diagnosis she discovers a different lens through which to view her past symptoms that provoke this inner dialogue, shared in the interview, that questions herself, in lack of agency, not 'pushing more' for further testing and particularly in "pushing" for investigation post-menopause. Beth reflects,

I didn't necessarily go to the doctor about it but...I've...when my husband got diagnosed it was like...well, this is weird because this is always something I've thought...I always thought I was going to get when I would have any kind of feeling of unwellness. I don't know whether it's paranoid. If I had a feeling of unwellness I thought...oh, they're going to find I...have cancer. And I know as a young woman I had cysts in the breasts and they always turned out to be benign but I always thought, you know, never thinking it would be ovarian, I never even in my brain went there but just, you know, it's probably going to be breast cancer it's probably going to be colon because, you know, problems with my digestive – you know - I just didn't realize how connected those are at a very early stage which if I knew what I knew now I probably would have been pushier about my body parts being examined because when I read about it now like the digestive and the things that bother the colon and bother your digestive system are related to your ovaries...I had those symptoms....I had problems with my

stomach twenty years ago and it was 'you're just allergic to foods' and the same when I had it checked out with my colon, 'oh, you've got diverticular...

On the one hand, her worry is naturally 'human'. At the same time, pulled out through this lens, is the researcher's view that it also reflects one of the subtle ways social discourses, used oppressively invoke self-doubt, self-questioning, self-dismissal, and can dwell present in interior dialogue without a reflexive realization that these are 'given' lenses, an external 'gaze' interiorized that controls our own views about our own subjectivity. Evoked in reading the quote is perhaps a sense of struggle that can come from retrospective analysis in this type of inner dialogue, where Beth articulates wondering if she was perhaps not in a state of hypochondria. Were those symptoms, rather, clues? She questions her silences and 'not pushing' showing a mechanism that is powerful in enacting hindsight about personal agency, or lack of it, regardless of whether claiming more agency, in Beth's case, by 'pushing' would have made any difference.

This foregrounding of her inner dialogue is not to imply that she 'knew' she would get cancer and was denied this knowing. It is to simply illustrate some of the ways an interiorized form of colonization can take place through socially created, invisible processes such as medicalization. This may not be what was happening within Beth, we cannot know. But a feminist bioethics lens can offer the suggestion that some consideration be given for how socially scripted constructs, internalized, can shape our inner life. Such internalized scripts and ways of viewing one's body, oneself, with given, prescriptive discourses that may

not in actually be our own thoughts but rather socially prescriptive ways of viewing our bodies. We can consider how they can cast self-doubt just enough to subvert subjective agency to proactively speak, advocate and place our questions about what is going on, in our bodies, into public spaces such as clinical discourses functioning in a material reductionist view of persons as has been moulded by a biomedical paradigm of 'the body' as a site of medical action.

It is a feminist bioethics lens that reminds us to investigate with a critical reflexivity, these types of collective social contexts where sharp power differentials have been reified to the degree where there can circulate, pre-reflectively in our hearts and minds with stealth and invisibility. Their invisibility sources a form of power over our voices rendering them silent, claiming our subjectivity to label what might be an embodied issue, with 'worry'. Our inner dialogue enacts its power to silence ourselves dismissing what is not considered legitimate knowledge before it is placed into speech in dialogical relationality with clinicians who function in the power structure for the 'patient' as 'agency-brokers' in medical care which gives or withholds access to vital goods, such as tests and diagnosis and treatment for one's health. It is the lack of *questioning* this action of silencing of certain types of speech, discourse, patient to doctor, with an internal mechanism derived from social scripting that a feminist lens of embodiment and bioethics would call our attention to in Beth's reflections about her inner dialogue expressed in the interviews, shown through the reframing lens she uses about her past symptoms, in light of her present diagnosis.

There is possibly also a familiarity to her described dynamic of an inner self-confrontation about whether she somehow *failed* in accepting the medical experts opinions of her symptoms when younger and not “*pushing more*” on them. A sense of self-doubt, perhaps even failure, in the quote weaves through a tension of trusting and accepting expert opinion and questioning not only their opinion but also *herself* and her own judgment with hindsight. The failure being taken on as her own in a wondering, “*if I knew what I knew now I probably would have been pushier about my body parts being examined*”. This reflective analysis is not discussing whether any medical investigations would have changed her trajectory. It is the dynamic of what can happen in contexts of circulating power differentials where self-doubt is internalized and not reflected on critically as revealing *potential* symptoms of power dynamics, conceptualized by feminist bioethicists, as medicalization. In feminist theories of embodiment, this is conceptualized further as a colonization of interior subjectivity, an internalized oppression of our own view of ourselves, changed through external social-matrices and their discourses where language shapes our view of what is our ‘real’ to ourselves.

It is the mechanism of internal silencing that medicalization can invoke that is being raised in this representative analysis of her reflections which feminist theories of embodiment and feminist bioethics pay very close attention to and foreground as one of the more subtle, pervasive and difficult to ‘prove’ phenomenon within dynamics such as ‘medicalization’ in social contexts. This is not easily overcome in a clinical discourse, even with the most well-meaning

physician because the mechanism internally is functioning out of awareness and attempts to solicit insight from the patient, will potentially be subverted, preemptively, by a patterned behavior of speaking what is acceptable and the unspoken remains in silence dwelling beyond even the patient's reflective awareness.

In a gendered female body a fear of being labeled a 'hypochondriac' or, in more contemporary diagnostic labeling frequently used in oncology care as I've experienced it, as having a Generalized Anxiety Disorder (who wouldn't with cancer?), remains very much a part of many women's inner narratives, heard in my counseling office countless times, and echoing through in Beth's reflections. While a genuine state of acute and anguished anxiety can be provoked by cancer, generating in the mind's perseveration and obsessive ruminations an appearance of Generalized Anxiety Disorder, a DSM diagnosis, and often be triggered into activity beyond the range of manageable by cancer, one can still question if this is simply a 'psychological' state. With this in mind, urge the feminist bioethicists and theorizers of a feminist view of how we construct 'embodiment' through subtle, but powerful, social matrices with their discourses and language, it nonetheless behooves us, they recommend, to foster a critical attunement to the labels and their power to silence other forms of knowledge.

Beth's reflections highlight how much it is critical for the 'patient' to experience agency in presenting what might in fact be embodied knowledge, or a salient aspect of narrative that, in a narrative medicine lens, might contain critical differential diagnostic guidance and tease out what is in fact, anxiety and worry

triggered by the trauma of a cancer diagnosis, and what is arising from something else contributive to their medical care. If it truly is rumination, the space, free from fear, to present the 'worry' is the problem being addressed, not whether or not a diagnosis could or should have been made. The self-doubt, the worry of "I should have pushed harder" open us to reflecting upon these internal mechanisms that medicalization, as a philosophy of what 'body', 'person', and 'care' mean in contemporary medicine and how these meanings are enacted in clinical contexts.

Beth's reflections invite a pause to reflect on the effects, in her, as a woman, this philosophical lens of psychiatric labeling of internal distress states, and ways of viewing human beings as recipients of health care which severs 'tumour' from 'generalized anxiety' in ways that sever the patient's care into different diagnostic labels, with different specialists providing responses to each label, and each having a pathological basis for needing intervention. We might consider what these splits to personhood have created, particularly for women, (remembering Beth's self-labelling of 'hypochondria') since the nineteenth century.

Embodied knowledge: *"If you feel something's wrong in your gut..."*

This finding in Beth's perspectives with a lens using medicalization through which to view her experiences of power relations, and verbalized dynamics of interiorized 'power' (or lack of) and 'voice' in relation to extrinsic power and 'voice' in social worlds, leads to an invitation to consider another form of

subjugated knowledge within biomedical discourses and that is, 'embodied knowledge'.

Beth alludes to an embodied type of 'knowing' when she distinguishes an embodied experience of 'gut' from 'thinking' for directing her medical care with pain medication. This comment was made after the dictaphone was turned off at the end of her second interview. I asked permission to turn it back on. She had spoken with an intensity, as if communicating something of meaning and importance to her. I asked her if she wished to repeat what she said for the study. She gave me permission to record it, perhaps speaking to a sense of significance to Beth that this be contributed to this study on 'wisdom', her own wisdom, and connects to how her choice to contribute to this research study afforded this moment of 'claiming' an agency to pass this embodied knowledge on.

Beth spoke, *"If you feel something's wrong in your gut, there's something wrong going on, just keep pushing to find out...it was too late for me...But I knew for a while before there was just something wrong, there was something in my body that was wrong but I just didn't know what it was."* Deep poignancy in these words and they moved me as both researcher and one who has heard this so very many times in my office. Hard as it is to tease out whether this 'embodied knowing' is known only in hindsight and could not have been 'outed' prior to the knowledge of diagnosis, nonetheless, hints towards reflecting upon the legitimacy embodied gut feelings are afforded, or not, in clinical discourses between doctors and patients. There is no way for a physician to order an

expensive diagnostic test for a patient who has only an embodied intuiting of “*something’s wrong*”. Physicians and patients are equally constrained by the biomedical paradigm that has discounted and subjugated embodied intuiting as a form of ‘knowing’.

(Re)claiming epistemic power: *“I decided to take myself off medication”*. Beth reflects, “...especially at the very beginning when the doctors had me on pain medication I was thinking, ‘gosh, if I can’t live my life normally I don’t really...I don’t really want to be here’”. I asked Beth what got her through this feeling of not wanting to be here. She responded:

I just said, ‘it was just me. I think it’s the medication. I think the medication is making me have the inability to function...to get off the couch. I decided to take myself off medication. I didn’t realize it did things to you... I couldn’t do anything... I weaned myself off [so I could] go for a walk, drive the car... Feeling bad mentally, emotionally doesn’t help me physically I know this from years of living with anxiety...I struggle with anxiety...I had to push myself to do stuff...have to not give up...keep going...I find its in my gut... If I think too much I’ll leave myself on the couch...

Taking herself off the pain medication when viewed through the feminist bioethical lens invokes a sense of Beth’s effort to make a powerful choice about refusing medication for pain, resisting her doctor’s recommendation and prescription. It can be seen as a decisive act that might be framed in as a reclaiming of epistemic power towards mobilizing her subjective agency for making individualized, ‘N=1’, choices in her medical care.

Beth describes that living with anxiety in her life *helped* her with this decision and her personal, embodied knowledge of ‘anxiety’, considered a disordered state and a mental health issue by the psychiatric lens, is framed by

Beth as having afforded her an intimate, personal knowledge, a form of *episteme* about herself, that assisted her with this decision. It is a costly decision as it requires her to push through physical pain to gain a better quality of life. Yet despite this trade off, she found the wherewithal to trust her capacity to “*push through*” the consequences of pain in weaning herself off the medication.

To do this, Beth describes *how* she made this decision, saying, “*I find its in my gut, I’d like to say its in my head but sometimes in your head you can twist things around a lot....go with the core feeling ...it feels better...*”. This gives us a ‘felt-sense’, an embodied ‘feel’ for a potential meaning(s) of embodied knowledge. Framed with the feminist bioethics lens, it might be viewed as a reclaiming of epistemic power through a relational agency with her physician who afforded her also, with relational agency, to dialogue, discern and to make a collaborative medical decision. An example of shared decision making within relationality, an ethic of care.

Beth’s story exemplifies a claim on epistemic agency in the biomedical conversation space with her physician and her reflection reveals how her decision fostered a ‘horizon of hope’ of improved daily life using her skill of “pushing through” physical pain, her power in and with her embodied being, for an improved quality of life.

Beth’s collage of friends’ cards: “*I’m not alone*”. Beth’s art was a collage of the cards friends and loved ones had given her at the time of her diagnosis. She kept it visible in her home for a reminder of the love and support around her to mitigate loneliness and the depth of her grief that could be

overwhelming from the loss of her husband and her own diagnosis. She reflects, *“I’m extremely lonely right now...when you think about it, loneliness is all internal. I feel sad, it takes a lot of your energy feeling lonely I’ve never been comfortable with my own thoughts”*. For Beth, mitigating loneliness is through relationality, *“sometimes I phone somebody, talk to a friend, daughter, sister, I talk to them...talk to another when I’m feeling lonely...you have to find something, whatever it is for you, for me it is reaching out to other people, for someone else...volunteering, doing something.”* Embodiment is quietly embedded in this relationality whereby ‘bodies matter’, people, in their embodied relationality heals loneliness, an alienation from feeling connected, belonging, and being ‘at home’ with oneself. If healing ensues, how is relationality not considered a medicine? Beth’s art collage (Figure 4.1) dwells in her home as a form of ‘medicine’ for this loneliness, mediating the relational to her, when she is alone in her home. Beth reflects on her collage, sitting near us in the interview and points to it, *“I collaged cards from friends, I’m very lucky to have all these people, in my life that care”*. She describes what the collage gives her, all the cards people have sent placed on a bristol board as sort of icon of connective relationships holding her in care, saying, *“lot’s of people, support, hands extending...I’m lucky, it’s uplifting, for a few seconds...for a few, you’re not so alone, I still have it to look at...people are wonderful.”*

This shows the potency of created art, from her own hands, acts upon her sense of un-well-being in loneliness, turning this inner distress into a sense of well-being, for *“a few moments”*, reminding herself of the love around her. Art as



Figure 4.1 Beth's collage of friends' cards: "I am not alone".

'icon', created from the materiality of her own life. This was offered in her dialogue in the interview on wisdom and thus by implicitly tying this act of creating to a wisdom, she might be viewed as offering to us as one way she found, *phronesis*, and *sophian* wisdom, practical and intuitive, creative wisdom, for "*creating that feeling of hope*", drawing on relationality to assist with forming her own personal wisdom for living for today.

Beth's poem from the Soul-Medicine supportive care group. This was the poem written by Beth's dyad partner in hearing Beth's story of strength in a time when she didn't think she'd make it through. The women were encouraged to pick a story to share with their partner that felt comfortable that day, that it didn't need to be the worst possible time or trauma to mitigate triggers for retraumatization. Beth chose a story from childhood when she and her siblings were lost in a forest. While this is not a story derived from her experience of ovarian cancer similar echoes can be felt of Beth's descriptions above of feeling alone, and loneliness as a difficult experience being mitigated by a return to relationality, connectivity with others, who care. The wisdom Beth offers to us from her experiences with ovarian cancer reverberate through this poem, drawn out through a very simply poetic inquiry using found poetry and erasure poetry by her dyad partner in an exercise that takes fifteen minutes for both partners to share and write their poems revealing a simplicity, and perhaps a beauty shaped by attention to the phenomenal, in people's stories through a relational, poetic inquiry.

Alone

*a trip to northern Ontario
 siblings lost in the woods
 struggling to find a return plan
 separation
 but
 they found their way back
 thinking mom and dad had left them
 gaining perspective
 insight....there is a way
 they rejoined their family
 a memory
 to this day
 they found
 a way*

4.3.1.2 Summary of Findings for Beth

Beth's 'wisdom-compass' returned her time and again to "be in the present moment" a phrase emergent throughout her interviews in the analysis. Time emerged in its phenomenological aspects within her embodied experience of ovarian as a central, guiding, inner phenomenon moving her through her daily life, like a compass towards the wisdom she contributed to this study, her perspectives on wisdom in general, and in her means of finding 'a way' through each moment, each day, to live today and push dying, into the a future tomorrow.

In relationality with medical systems of care and its clinicians, "push harder" was Beth's wisdom, which was linked by her own embodied knowledge from the pushing involved in birthing her children. The 'present moment' is seen as having a dual nature, constituted by both positive and negative emotions, which made it both a focus to turn towards and a difficult experience to try to transform. It was an experience that was difficult enough for Beth to instinctively use the analogy of giving birth with her feeling at that time that she can't go on,

but having to, and using this 'birth epistemology' as an image-centered knowledge for her discussion on wisdom and her 'finding' of 'a way' through.

This wisdom is passed on her to daughters and others who rely on medical systems to care for women's health, particularly menopausal women whose symptoms can be masked due to perceptions of age, gender and also when a woman has diffuse medical issues such as bowel, stomach and uterine symptoms that can be explained by less serious differential diagnoses. Beth lives with a wondering about whether "pushing harder" would have changed her prognosis. She claims, tacitly, some retrospective agency, an agency she doesn't feel she claimed on hindsight before diagnosis, and turns into a future agency for her daughters that she hasn't live herself by urging her daughters to push for surveillance and be more intimately aware of their bodies to hear the signals that something is wrong. This might viewed as an epistemology of motherhood, women as mothers passing on their wisdom as a deposit in the embodied lives of younger women to live a different future than they themselves have lived. Embodied "knowing" in your "gut" is Beth's wisdom for other women to learn to listen to because "*doctor's don't know your body like you do*".

Beth's wisdom offers us more than a simple platitude "be in the present moment" that is hard to attain and popularized in spiritual, self-help literature. This wisdom-labour to return to the present to where "be in the present moment" moves her both to the past for meaning and comfort from positive memories and turns her towards the future by making plans that she could look forward to, as well as focusing on creating memories, now, in the present, for her daughters

and grandchildren, in the future, as a legacy. It is not presented as easy and I've offered the notion of 'wisdom-labour', drawing forth her own birthing analogy as an embodied knowledge framing the invisible, yet equally agonizing, wisdom-labour, to try to evoke the enormous 'labour' her wisdom has cost her. Labour is used not in the industrialized society's sense of labour, but as the embodied, life process of giving birth, drawing on her use of birth as a way to describe her meaning of "pushing through". Each day, she 'births' a self that pushes through, lives the day. Each day, as hard as giving birth to each of her children was.

Through this wisdom-labour, she has, in a sense, literally birthed a more timeless wisdom linking us to the wisdom offered through the ages by sages and poets, but necessarily lived into, embodied and worked out into being her own lived experiences, for a few moments, through her own life. This wisdom-compass, phrase, "be in the present moment" comes to us filtrated, distilled, aged and matured, in embodied processes that cannot be plucked, abstracted, from a book of knowledge about wisdom's distilleries and modulated aging storehouses and be gleaned from reading them without similar processes of wisdom-labour, birthing wisdom into our own embodied lives. While taking up another's 'compass' such as Beth's, "be in the present moment" might catalyze within us a movement of deeper integration of our own unique wisdom-compass 'formulations' in our own lifeworld and embodiment of wisdom.

Beth's wisdom insight "be in the present moment" functions it seems, more as a guiding 'compass' rather than a state she 'attains'. This wisdom insight, a daily practice to live by, emergent as phenomenon to act upon her life,

for Beth to act from, generates for Beth, in her day to day, a means to live with hope, comfort and way to, in her words, “accept acceptance” of the fact her lifespan is now truncated irrevocably.

4.3.2 Carrie’s Portrait: Wisdom as “Navigating”

*wisdom is
navigating
you realize how strong you have to be

you need a lot of strength here

navigate it
but don’t exhaust yourself navigating it

I’m not living to die
I’m living to live*

Carrie is in her late fifties. She was diagnosed in spring a year before her study interviews. At diagnosis she was stage 3C for ovarian cancer. She had surgery one year and sixteen rounds of chemotherapy prior to the interviews. She is one of four sisters with whom she is very close. She has several cousins and all family members are actively involved in her life. Her life roles include being mother, sister, daughter (a mother alive in her nineties), cousin, close friend, neighbour, sister-in-law. Carrie is married to a professional who has worked in a form of health care for many years. They have three children in their twenties. Before retirement she was employed as an administrator in a research context and volunteered in schools and hospitals. Her husband’s mother died from cancer around the same age their children are with Carrie’s diagnosis.

Carrie described her diagnosis as particularly hard for her husband, evoking grief and fear because of his previous loss. Carrie describes herself in the second interview as, “factual, pragmatic, helpful”. Indeed, zest and humour is a notable aspect of Carrie’s interviews peppered with stories, dialogue and laughter throughout our time together and in her participation in the support group. Carrie is not a woman who pulls her punches and casts a critiquing eye, with humour encasing salient insights, on her experiences, particularly in her medical care.

“Navigating”

*I have my own inimitable way
I always get things done*

*wisdom...the diagnosis
is seeing things
that aren't clear*

*I've had to go in
going in to do what I had to do and come out
you've got to come forward
you can come out of that time
like a wilted flower
you've got to come out solid like steel
don't be a wilting flower navigating this
I don't think it occurred to me
how much I needed that time to really digest myself
sort of anchor inside a position
to kind of come out with both blocks forward
because you've got to come out like a machine*

*you send your mind elsewhere
your mind is one of the best things
you can really work hard
at controlling it
pushing it to other places
and pushing your body through*

just put your lipstick on

*you have to get them to believe
that you're still solid
you're not going anywhere...yet
perception is everything*

*I don't wake up every day thinking
"I'm going to die"
I wake up every day thinking
"there's so much going on
I've got to make all sorts of plans to do things
live my life*

*I'm not down yet so
I don't intend to go down actually
I have a 'go forward'
your whole body just goes forward
a reason to get out of bed is really important
once you get out and start
one foot ahead of the other
just keep moving*

*you know
keep going
I see myself really up!
I see myself here, in this world
winning actually!*

*quit with the what-if's
find another way to do something
distract yourself
get good with activity
good karma with good people*

*find people
that bring you up
finding the sweet spot
in relationships
if you don't have wisdom
you're not even recognizing what you're doing
as a patient
you definitely need to be wise
and in charge*

*wisdom is...
navigating all that stuff
you realize how strong you have to be*

keep on keeping on

*making plans, events
putting it all together*

*a glimmer of hope
I've clung to my glimmer*

I'm not living to die

I'm living to live

4.3.2.1 Hermeneutic and Phenomenological Findings in Carrie's Perspective on Wisdom

Wisdom as: “*navigating*”. Carrie proclaimed an outright denial at the outset of the first interview that she saw her reflections as wise. However, through the variety of questions engaged in both interviews that invited her stories and reflections on her lived experience as well as perspective on wisdom she began to describe situations where she explicitly discussed wisdom and then offered personal insights on wisdom in itself, drawing in her experiences, during the second interview.

‘Navigating’ seemed to dwell as a phenomenon behind her way of living with ovarian cancer. For Carrie experiential wisdom from the past informs her process for living with ovarian cancer particularly when “navigating the system” and the times of “incarceration”, which is her preferred word for hospitalization.

Carrie returned a number times as a ‘data source’, if you will, to a previous late adolescent experience of extended and excruciatingly difficult hospitalization after a boating accident leaving her with two very badly broken legs. It happened in the year she was to start higher education, significantly impacting her

adjustment. This experience and her narratives, word choices around it, forms a central crucible from which Carrie draws much reflective insight for emergent perspectives on wisdom as a phenomenon in her life in the progression of the interviews.

Carrie's interviews return, similar to Beth, in a kind of movement back and forth to and from the image-centered word of 'navigating' and how it is used. It is an image-centered word because it almost inevitably solicits an embodied experience in the reader of their own experiences of 'navigating' to interpret her meaning(s). Any experiences of navigating, in the reader, be it driving a new route, sailing a boat and so on, hold the potential that phenomenon have to draw the reader in, with in their mind's eye using the capacity imagination provides, to evoke memories and hold them through the view the image provides to interpret present meaning (knowing) to understand Carrie's concept of 'navigating' existential, practical, embodied, and spiritual experiences with ovarian cancer.

Carrie shares a number of stories, past and present with the cancer, to show her meaning of 'navigating'. These stories are told as illustrations for me, the interviewer, that show how she drew on inner resources for this act, both internal and also embodied through action, to navigate the cancer diagnosis and the medical system. In the interviews she weaves back and forth between the past experiences (mainly the accident), her encounters with the medical system of specialists and hospitalizations, and the present experience with ovarian cancer to exemplify her reflections on how she is living "navigating", as her tacit, embodied knowledge, slowly teased out through the interview process. This

included reflective contributions spontaneously offered on her insights emergent from the group process, on wisdom.

Navigating as internal: “Going inward to come out strong”. Carrie initially describes her wisdom-finding process as a movement inward in order to push outward stating, “*you have to go in to come out strong*” and “*not be wilting flower*” to cope with this particular diagnosis. After her initial diagnosis she describes needing time to “*digest*” and then “*anchor inside a position...to come out with both blocks forward because you’ve got to come out like a machine*”. She is describing the time immediately after the diagnosis when Carrie let her family go on the holiday they’d planned well before the diagnosis. She chose to shut herself away at home after they’d all left, with the windows covered so that neighbours’ wouldn’t know she was home in order to process the enormity of its impact. She describes this time as follows:

It was close to ten days I was able to do stuff for myself with myself... in a life where you are the mother, the daughter, the sister-in-law you never get twenty minutes to yourself, to think the only time you might get is the middle of the night... in the fifty minutes unsleeping thing. You go through this life where you’re always called or doing something, or requested to go somewhere, you’re involved in some way, so for this whole week nobody knows I’m here... immediate family is gone. I just learned about the diagnosis it was a really nice time for me to think, forcing me to disseminate information - how I was going to sort of move forward... It wasn’t terribly long after I was into surgery to this day, that is the enormous overwhelming piece people don’t appreciate.

Carrie describes using her art hobby as a way of “*going in*” to “*come out strong*”, especially at the beginning during the ten days she chose to be alone at home. She describes how:

...in those ten days I gave myself breaks...I like news, I like to know what's going on, I have to monitor that too, how much you can listen to...I allow myself those kinds of feelings...a little art work too. I just set up my water colour paints, I'm terrible at it...but I go away, I can be gone, all of a sudden it would be dark and I'm 'What happened to the day?' and 'When did I eat last?'...you can just lose yourself, that's the beauty of art. If I could come back and have a bit of talent that would be a nice thing! You've got to come forward you can't come out of that time like a wilted flower. You've got to come out solid like steel not to the point where things are bouncing back off you but you've got to come out pretty strong...".

These stories offer that a part of “*navigating*”, in Carrie’s life, is making decisions that allowed her to reflect, be alone, engage in activities like painting that could soothe distress by “*disappearing*” and navigate the emotional devastation in her own, private, way.

Navigating as mind/body interacting: “*Your brain’s got to go somewhere*”. Carrie also describes her own differentiation of body and mind and how she uses her mind as a ‘navigating’ resource to “*push through*” a difficult present, be it with physical pain or distress:

...you get all the physical stuff but then you just hunker down...I can actually send my mind to some nice spots actually...it can go elsewhere so I can get through a lot of physical pain because I always know there’s an end...wisdom... is a survival of the fittest thinking some of those things it really pushes you, you realize you’re stuck in a hole and you can’t just stay in the hole you’re body’s not coming right away but your brain’s got to go somewhere so you might as well start working at the one at the pieces of the body that can at least do something....

She can be perhaps considered as creating, in psychological language, an internal loci of control, which might also be viewed as an aspect of her wisdom, or as I’ve suggested, the image of a wisdom-compass, with her mind as a control

centre, being able to “*go elsewhere*” from the present, “*to some nice spots*” and change her embodied experience of the present.

She describes a process of reflecting on her extended hospitalization in late adolescent during these first ten days after her diagnosis alone in the house and describes how she mobilized this embodied, integrated knowledge for navigating the current situation, her diagnosis, the medical consultations and the medical system. She describes navigating pain and side effects of treatment by using her mind, which was within her control, when her body was undergoing surgery, blood transfusions and treatment, which she could not control.

Navigating is framed also as active in a “*pushing your body through*”, using mind to do so and, like Beth, she draws on a uniquely gendered, female experience, of giving birth to describe her meaning of this type of “pushing”. However, her ‘wisdom-resource’ and analogy is different from Beth’s for elucidating her insights on ‘finding a way’ now, using her own uniquely personal experience of birth with her own body. Whereas Beth’s experience was to illustrate the moment of “I can’t do this”, Carrie’s image-centered knowledge that offers her birth experience to illustrate ‘pushing through’ brings a different sense of the experience, reflecting:

I even did that with my pregnancies, no epidurals, I wanted to deliver them all without extra help...you send your mind elsewhere, your mind is one of the best things, your body has, it’s a great thing, you can really work hard, at controlling it, pushing it to other places, and pushing your body through.

Navigating involves her mind as a method to navigate difficult situations, such as pain, evoking a Decartian sense of the body yet imbued with none of the

meanings he has come to be considered as creating in a Cartesian 'split' of 'mind over a machine like body' that has contributed to mechanistic views of the body in our present day. Rather, Carrie's 'machine' is linked to labour in giving birth to a baby giving access to a material imagination at work, embodied, visceral, materiality forming an epistemology of 'knowing' drawn into analogy to describe a more abstracted type of birth experience of how to control one's inner state, now, when much of it cannot be controlled, as in birth.

In the context of Carrie's birth experience, we see the power of mind as a living, organic force engaged in birthing new life, a whole new being birthed with mind able to override enormous physical duress to labour this new life into the world. It is a "pushing through" that evokes her "go forward" movement in "navigating". Birth, once again, a source of image-centered knowledge applied, as an embodied, living and indwelling epistemology of the 'knowing' of the mother who has given birth to draw on in a time of similar acute distress including physical pain to keep living, today, life in as much fullness as possible.

Navigating towards a future: *"I can't conquer this....I go forward"*.

Carrie meets the future with a similar "*pushing your body through*" stating, "*I can't conquer this....so I go forward*" because "*I'm not living to die...I'm living to live*". This was selected as the 'haiku' of the poetic inquiry on Carrie's interviews, filtered through poetic inquiry that begins this portrait. Living becomes a form of navigating the day to day for Carrie and a task to be focused on, a job to be done, here and now. Going inward and navigating means she finds a resources inwardly to then "*push*" and "*go forward*" navigating in the present and forward

into a future she wants to live for: She says, *“I just think that, “I’m not down yet so I don’t intend to go down actually! I feel it in my heart, my mind that’s just the way I think of this whole process I have a ‘go forward’ your whole body just goes forward I go forward, yes...”*

With an “inimitable” humour, a word Carrie uses to describe herself, Carrie describes how she insisted on going out on the boat with her family with her colostomy bag to gain access to nature to sustain her sense of normalcy and well-being:

...even the summer how it worked out, I couldn’t drive a car but I could still do it in my boat. I love my boat...I had the bag [colostomy] everyone is gingerly making sure I get on the boat, like there’s a whole process! But once I got in the boat I was like ‘I’m in charge now!’ It’s a twenty-two foot boat with an inboard! I couldn’t kayak all summer...this boat is a solid boat... I go there whenever I can. All summer long I was going back and forth sometimes my specialist is like ‘you shouldn’t be going up today’ and I’m like ‘hmmmm, I’m sure I am!’

Neither is this inward movement and harnessing of an inner “go forward” for navigating the diagnosis a process that maps into any heroine theme of “conquering”. Instead, Carrie ties this inner capacity to simply her modus operandi borne of necessity and learned at a young age from the long hospitalization with severely broken legs and subsequently starting university on crutches. She describes her view on the ‘warrior’ over cancer notion and the ways people advise her to beat it saying:

...you get plenty of people also telling you if you just do yoga, down doggy, you’ll be good to go! I’ve never been considered the softest touch! I ignored a lot of it actually then, when people would push in I would just say, it’s not like that...The other line people had a lot initially was ‘you’re strong, you’ll get through this’ and I would say, ‘far greater warriors have been taken down by far less’...So it’s not about the strength, it’s not about

the warrior in me...strength isn't going to make the difference in my mind from any research I've done...but... how have compartmentalised,,, I am a warrior.... but I'm just saying that I can be - I can conquer the world but I can't conquer this - I mean this isn't a conquerable thing... I just think that, you know, I am not down yet, so - yeah, and I don't intend to go down actually.

Carrie describes sources of strength for this movement inward to come out strong as a process of refocusing on what is important which includes:

...First World problems that really goes way back off the burner family, relationships, friendships that becomes hugely in focus quality time with people, and yourself nature, instead of the mall, spend another day in the kayak...because otherwise you end up at the bottom of the well if the ladder's not coming down, how do you climb out best not to get below the bottom rung so make sure you always can get a hold of that rung...it's just like everything; you know once you get out and start, you know one foot ahead of the other, just keep moving, you know keep going.

Making plans is one of Carrie's meanings for "go forward". She says, "*I think a reason to get out of bed is really important....that day I chose to do a day trip with my cousins if I had not done it I do think I'd have wallowed that day away even though I didn't feel like my best because I'd committed. I'm one of those people if I commit to something I don't like to let people down.*" Reasons to get out of bed, formulated, in Carrie's quote, to make plans, engaging with life to live living to live born from the bed and the part of her that 'pushes forward' to want to get out of it into life.

Discussing these aspects of "go forward", as Carrie, navigates her life now a differentiation of wisdom from optimism is discussed. Carrie is quick to emphasize that does not subscribe to positivity as a means for overcoming the disease. In her words:

I think that partly has to do with wisdom but partly may be optimistic I haven't had the wind taken out of me yet people always say, "if you're positive, you'll live". I'm not deceiving myself because I'm positive doesn't mean that's going to change the outcome but I just think I am going to be here hanging out I might as well enjoy it as much as I can....

Carrie's navigating as a "go forward" functions in some way as a resistance to giving up or giving into an inevitable death, "I'll just keep on keeping on like that. Like keep on making plans and events and, you know, putting it all together....living to live. I'm not living to die." She continues on:

...some people 'start dying'...they get some diagnosis they start going in the other direction I'm not judging but that's not something, "oh, I'll take a page out of that book" that's not the way I'd approach it I don't see the benefit I don't see that being helpful to anyone around you.

Living to live is the shore Carrie aims for, drawing on her avid sailing passion throughout her life, using the types of skills needed to sail, practical, technically savvy, intuitive, to navigate daily life and all the ramifications and impact of the diagnosis on her physical, emotional, mental, spiritual well-being.

Navigating daily life: *Doing things! Makings plans!* Carrie shares, "I've compartmentalized. I don't wake up every day thinking, 'I'm going to die'. I wake up every day thinking, 'There's so much going on, I've got to make all sorts of plans to do things, live my life'".

Carrie tells a story of a day trip she knew it would benefit her well-being to go on. She leans on support of family to enjoy a day trip despite medical advice not to go. I share it in full here because it captures her way of storytelling her responses to the interview questions and as well, her spirited way in life, in her

words, her “*modus operandi*” that seems so central to her own wisdom for navigating the impact of ovarian cancer:

I had cousins that were very supportive. They'd all planned on this big road trip, lunch shopping and I had a terrible night, terrible, me and the washroom – we're not more than minutes apart. I woke that morning and called my GI guy 'How do you put the cork in, I just need a cork!' My eldest was saying, "you're not going" I said, "Oh, yes I am, these people have committed we have a big plan for today I just need a cork" He said, 'You haven't slept all night'. I said, "I don't give a damn, I'll get through this day I'm going to look good, I'm going to get my lipstick on, I'm getting up there, getting my skirt on, getting in the cork and then....'. He says, "well at the very least, you've got to down Gatorade'. I said, "sure, sure and glug, glug, I've got the Gator in I hate that stuff, I gag. I ended up having a day that took me away from my other world. If I'd not gone I would have probably wallowed all day, I really would have, I couldn't have slept it would have been a terrible day. Sometimes when you're forced to get out there and act like a regular person you do it. I laughed, had fun then I came home and crashed. It was great. That's my MO, it's a way for me but it wouldn't necessarily be a way for some others.

This stance afforded Carrie the means to ‘navigate’ medical decision making, in tandem with physicians, to aim for a *poiesis*, by a ‘magnetic north’ of a conscious intentionality, a goal as it were, for “living to live”, a better quality of life, today.

Carrie shares another story where she went ski-ing and “*ended up with sixteen people at the dinner table, people I didn't invite...those kinds of things just happen!*” “*Making plans*”, “*going forward*”, “*doing things*”, all living for a future Carrie chooses to live for, every day, emerge as part of a ‘wisdom-compass’ in Carrie’s wisdom-as-navigating way of living and being in her life, now, with ovarian cancer.

Navigating as relationality with nature: “*Some people get soft in the city*”. Nature features tacitly in Carrie’s many descriptions of navigating because

she draws on her experiences of learning how to navigate boats in, with and against the elements in a manner of skilled survival.

...if I have a choice between a shopping mall and the woods I'd go for the walk in the woods which people looking at me wouldn't necessarily know...I grew up with access to a farm, bush...even when I went to university, sometimes I would just go up and get a canoe, my dad, my family...we'd just canoe down the river, you're in your own element, plus you've got to survive...like all of a sudden, that stick comes and flips your canoe over, intuition takes over, you have to figure it out...whereas some people here get soft in the city...it's a joke where we go up north...“citiots” they call them. I've never called city people ‘citiots’ but I must admit, there are times I've always had that strength of being more out in nature you just have to be absolutely resourceful.

Her storying of learning from the elements, in the context of reflective conversation on wisdom, invokes a sense of relationality with nature, teacher, nature as dynamic partner in the task of getting to another place where a movement forward is the necessity, goal and praxis. I've framed this as a form of relationality since there is a dynamism, a push and pull, a 'weathering' but with the learnings gleaned, it has provided something more than simply a hardening of strength because Carrie draws on the kayaking, walks, and sailing experiences as an epistemology, a way of 'knowing' for navigating the present situation with ovarian cancer.

Embodiment includes in Carrie's 'navigating' a sense of nature's presence in dynamic relationality with her life and present experiences as she draws on the strengthening of mettle gained, so to speak, and the practical, skilled wisdom learned from navigating nature as a kayaker and sailor. Yet, as when a “*stick flips the kayak*” and she has had to learn to use every skill and strength she has, so “*pushing*” with ovarian cancer and righting herself in life is highlighted by Carrie

when its been utterly upended, in tandem with unpacking her meaning(s) for 'navigating' as a metaphor for a way of doing things, living her life, engaging the medical system, finding resilience. She shows us that "*navigating*" is not always a peaceful, easy, or calm experience and the kayak flipping analogy provokes a sense of a 'do or die' experience which is felt in much of what she says about living with ovarian cancer. Wisdom perhaps is not something that happens on a Sunday picnic, nor is lived and embodied without a sense of acuity to living it.

Navigating as relationality with people: "*Finding the sweet spot*".

Carrie's life is a fulsome web of close relationships with her immediate family, her extended family, neighbours, friends and acquaintances. This is presented as both strength and a challenge for her "*navigating*" of ovarian cancer whereby relationality is both the great gift and, as well, one of the "*greatest challenges*".

...its all the social, emotional and mental stuff that's far more challenging than you actually think... That's not the first thing you realize until you start to be confronted with it, always trying to find that sweet spot.

She shares stories of a number of scenarios where she shows how she navigates these relationships. Carrie describes how in, "*...finding the sweet spot in relationships I've become a lot more ruthless. I think, "I've walked one day in this shoe..."*". She describes appreciating her daughter's skill in hustling visitors out of their home, "*the visitor was at the front door with my daughter guiding her before she knew what was happening!*"

Carrie describes navigating a societal context that she experiences as lacking in awareness of what ovarian cancer's prognosis is and provoking significant misinformation from well-meaning advice givers. She remembers:

...all the people start inundating you with their theories of how you can cure yourself - 'just do another, another scoop of yoghurt'. All the ideas, it is unbelievable because people don't actually know what ovarian cancer is they just think, 'oh it's a cancer'... everybody has an aunt that has cancer...you have to hear these stories.

Carrie offers a practical wisdom in her strategy for making sure people get tasks to help to prevent an overwhelming deluge of visitors. She gives her mother a task of helping her with the gardening when she could not get her flowers into the soil so her mother would have a place in the family life, a way of helping her daughter, Carrie, and a way for Carrie to help her elderly mother in her early nineties cope with an overwhelming grief that meant every phone call required Carrie's support for her mother in tears. Carrie links this to wisdom offering, *"I just think wisdom is...navigating all that stuff, figuring out who's right to be with... the wisdom is to find people that bring you up."* This is how she proposes *"finding the sweet spot"* by knowing who to be with and when, keeping the family circle protected and tightly knit, keeping acquaintances in an outer circle and letting family handle the stream of caring front door visitors. Carrie also acknowledges others are a source of wisdom also and suggests, *"...seeking out others that have wisdom that fuels you too, tap into people, into those interesting things they come up with."* Carrie states that for her, in some ways, relationships are one of the most challenging aspects of the diagnosis and its impact, linking this insight to her reflections on wisdom for living with the diagnosis. She suggests:

I think it has an enormous connection to the wisdom piece - you have to have a certain amount of wisdom you can't go blindly on, it's one thing to do with the physical aspects of the cancer take the drugs, chemo do all

that stuff but it's the mental, emotional games you have to play that you can help yourself, protect yourself but also maintain relationships with other people that you're not shutting down but that they're not draining you....

A 'wisdom-compass' highlighted as navigating relationships, to a degree of "being ruthless" encompasses the practical, skilled, wisdom that 'navigating' as an image-centered phrase connotes when it draws on Carrie's meaning(s) of kayaking and sailing.

Navigating role changes: "Move out into a passenger seat". Carrie describes navigating role changes describes changing roles as wife, mother, daughter to an elderly mother, sister, friend. She describes herself as "more in the driver's seat" and that this diagnosis has challenged her to learn to take a "passenger seat" more in daily life and relationships: "I do tend to be a little more in the driver's seat of life so I've worked hard to move out to the passenger seat sometimes sitting in the back seat...it's hard".

Carrie describes that it was hard to see the impact on her young adult children and husband is relieved to see some normalization to these relationships is happening now she is past the acute treatment phase. On the other hand, she saw them rise to the occasion and take over roles for her that typically had been hers previously. Similarly for her husband and mother:

the food became a real thing, I had so low energy and everything...to get involved with meal prep, which is something I'd always done, like I'd run house, so actually, that one is big I stepped back from being the main household runner I always did this massive clean at the cottage, I did that, but not entirely.....Some people don't even try to find their role...for a lot, they're just trying to plug into something...everybody they get this helpless feeling.

As ‘daughter’: “She needed a role”. Carrie’s mother is in her nineties. She has found it difficult to be in front of her mother’s acute grief over Carrie’s diagnosis. A turning point happened when she found a meaningful role for her mother with her garden.

Then I do the huge garden thing I got all these plants but nothing left in the tank to put them in the ground. with mum...I find it’s just a matter of trying to make sure she is not terribly upset but making her say less, so, my mom comes rushing over so I just sat on a chair I just looked at it, ‘looks great, wow’, not, ‘not like that’...She’s had a real hard time finding her spot she needed a role...she loved that, when she got that little piece of that role any weed had feared for their life, not a weed in sight, all summer!

As ‘sister’: “We all have our piece”. Carrie has 4 siblings, three sisters and one brother. This is a source of great strength for Carrie while role changes have been navigated and sometimes, in bumpy ways:

my siblings we all have our piece, we always have ...just now some have had to step up a little more...almost all four of us, funnily enough, hang out in the drivers seat, it gets a little crazy sometimes, we’re all the same crazy like strength!

As friend: “I felt like I was helping her”. Carrie’s describes a more subtle role change that ‘being a patient’ brings loss of a sense of personal efficacy to continue being a person who is there for and supportive of others. Carrie describes how she discovered a way to change this through an acquaintance connection that gave her way to be a giver and “feel normal”:

my friend who walked who was [going through a difficult time] our walks became more about her but it was helpful for me it made me feel like the normal person I always have been...put me...back in the saddle of life. I’m factual, pragmatic, helpful, four kids and the whole process...I felt like I was helping her, I was being normalized, I’d be walking for an hour and come back, totally forgotten...I’d come back feeling great I’d helped her.

As ‘mother’: A “balancing” and “walking a tightrope”. As a mother with young adult children living with ovarian cancer was about “balancing” and “walking a tightrope”, as part of her navigating, trying to let them take up roles as helpers, supports while still being their mother and wanting very much to keep their lives going as independent adults and keep their lives as close to normal, inferring as they were prior to diagnosis, as possible. She did not want their lives to stop for her sake. She believes, *“that’s the biggest job to me, being a mother...”* with *“their needs, like a tightrope...their needs and your own supporting and getting what you need...”* and her grief centres around her children, describing a nuanced grief for her children, differentiated from the grief she felt in the face of her mother’s own grief, *“...my mother felt really perplexed but I felt worse for my kids she is 85, she’s had a good solid lot of years not having to worry about someone like me whereas my kids are at the other end.”* Once again, an epistemology drawn from “being a mother” might be inferred, as a rich source of wisdom’s ‘knowing’.

Carrie describes the process of bringing her young adult children into the knowledge they needed, and wanted, about survival rates but balancing what they knew about the impact they had on Carrie with making sure their life is “as normal...as positive...as possible”:

I got the percentages... I had to be very clear with my kids about that because we had a nice big session with the specialist. I knew he was going to be frank with the numbers, that’s the hardest part too I think, the gals [in the group] would concur is you have to also work to make sure they have as normal and as positive a life as possible chinks in your armour they have to see a little bit otherwise it doesn’t look real you have to show them a little bit...But otherwise...

Carrie shares that a significant part of her world now is “looking after other people”, most particularly her children:

you go into this crazy schedule...my kids come home...then you've got to buoy them up right? You've got to make sure they don't end up at the bottom of the well your job then becomes looking after other people, to be honest with you....

Carrie differentiates her feelings, as mother, for the impact on her children, from the impact she feels for her mother, as daughter, “*I felt worse for my kids, [my mom] is in her eighties, she's had a good solid lot of years not having to worry about someone like me, whereas my kids are at the other end*”.

As ‘couple’: “***We had a team approach***”. Carrie’s husband is in a health professional field and she describes the changes that happened in their roles but also the strengths that came to the fore from “*we've raised three kids together, we've often been on the same page in how we do things*”. During hospitalizations, “*the part where I really went in the back seat, I'm calling the Drug management of the treatments and stuff...he helped me with the front door as well, me and my daughter were running that part*”.

In Carrie’s description of multiplicity in roles, relationships and their interweaving webs it is possible to imagine a sense of her way, a wisdom, in her “navigating” relational complexity that includes: managing the medical statistics and its impact on different family member, in different stages of life with the different ways Carrie seeks to mitigate and “*balance*” that knowledge and its impact; navigating the “*front door*” with its opening to care and support but also the challenges many people seeking to help can bring; changing her way of

being in the home from more of a “*driver*” to a “*passenger seat*”; navigating the grief of others and her own feelings about the impact her diagnosis has on them; finding ways to give roles to people that are meaningful to them and helpful to her. Bringing the ‘wisdom-compass’ image of navigating derived from a sailing context, the image affords some means to access the navigating in relationships as with the many currents and weather systems a boat must navigate to way find, with a wise, skilled, sailor at the helm.

Navigating with embodied knowledge: “*I knew*”. Carrie also describes “intuiting” to pursue garnering an accurate diagnosis for her physical unwellness and blocked bowels. She describes this saying, “*I seem to have a fairly good intuiting, yes, even figuring out this diagnosis to be honest intuitively, I knew I had a very significant situation. I was seeing a physiotherapist, the nurse practitioner and getting those diagnostic things that I drink those ‘blugh’ and they’re all coming up... everyone has a little theory they throw out there I kept thinking no, its more than that intuitively, I knew this was a very large situation.*”

This use of ‘embodied knowledge’ is similar to her use of an embodied ‘knowing’ when she advocated for a “plug” for her bowels to join the day trip with her cousins. Her ‘knowing’ she had to go for her well-being, mentally and emotionally, can be framed as including a form of embodied knowledge that her body would survive the day and a ‘cost-benefit’ ratio form of knowledge that skillfully balanced the knowing in her body that she would get by, with the diarrhea ‘plugged’, albeit temporarily, in going.

Carrie's word "navigating" offers insight into her own unique 'wisdom-compass' and perhaps best describes her 'wise-way' for retaining control over her own daily life as well as her interactions with the health care system and its practitioners.

(Re)claiming subjectivity and agency: "I put my lipstick on!" A story that Carrie shared was where she explicitly and consciously used her appearance as a woman to act in a way that might be viewed as claiming epistemic agency, navigating a challenge she perceived with medical doctors at her bedside conducting rounds during a hospitalization. She tells her story with great humour but also with emotional intensity about the lengths, she felt she had to go to in order to be perceived as having agency for self-determination in her medical care:

In the summer I had pneumonia and C. difficile when I got incarcerated [hospitalized] these people came in and asked about DNR [Do Not Recusitate] I said, 'I might look bad to you right now' but I said, "I won't need any DNR for a long time". I said [to her husband] 'Get out my lipsticks' because I get it, I look awful, I'm pale and I put my lipstick on in front of them! It's all a visual for them sometimes they'll slay you under when you're still, 'I'm ready to go...! Just put your lipstick on! I felt awful but I probably looked worse... then I never put on one of those gowns again, either, that's also an image they have: you've got the gown...you're two feet next door. I went to the hospital with a little skirt on. I made sure I had that skirt on every morning and I did up my face I said, "I'm going to look pretty good here" because I had low blood I needed 5 blood transfusions so I needed a lot of that stuff, that's why I didn't look very good. You have to get them to believe that you're still solid, you're not going anywhere...yet perception is everything... it's unbelievable! I don't know what they're doing. I know they get a little robotic boom, boom, boom they've got so many people they've got to deal with but...

In this story we can perhaps consider that, instinctively, without concocting her act as a strategic decision, she used a transformation of her self-presentation

'as woman' as a means to obscure a certain type of gaze turned towards by her physicians framing her, in her view, as 'dying', and uses transforming her appearance to transform her physicians perception that was constraining a sense of agency about her life by offering to discuss a DNR.

Yet in bigger context of 'the system' she perceived as constraining her subjectivity and agency it was potentially, in the context of Carrie's medical status, required the physicians to hold that conversation regarding a DNR order. It may well not have been raised because they believed she was immanently dying but rather a means for the 'system' to actually *solicit* agency from the 'patient', oriented by 'patient-centered care' by asking for her wishes in light of extensive transfusions with potentially, in that moment, uncertain results. Conflicting meaning(s) in medical contexts in this way can provide challenges to patients, like Carrie, and physicians alike both trying to claim subjectivity and agency *for* the patient, and the patient *for* themselves, but with different, sometimes conflicting understanding of what mediates that in the context of medical discussions.

(Re)claiming epistemic power: “*You definitely need to be wise and in charge*”. Carrie's interview narratives were peppered with stories of ways she (re)claimed epistemic power to elicit a response, satisfactory to her needs, in scenarios where she felt those needs were being inadequately responded to within a context of power, experienced as significantly imbalanced by Carrie.

In navigating the dynamics with medical care and its 'systems an illustrative comment of Carrie's navigating is, “*If you want something...you have*

to push for it". Carrie's interviews had a recurring theme placing emphasis on "navigating" the "system" of medicine. She stated a number of times, "it's pushing them all the time" and "I keep pushing, pushing, pushing...". She links this process to 'wisdom' but expresses uncertainty as to whether it really is 'wisdom' seeing it more as simply having to "push". She describes there was, "...with the diagnosis a bunch of basic virtual stuff then the wisdom of...this isn't necessarily wisdom, just tenacity of practicalities working through the system...information that's not very black and white."

Framed as practical *phronesis* acquired from being a patient for an extended period of time in the medical 'system', it might still be viewed as a form of wisdom and, through the feminist bioethics lens, links wisdom to ways women, in this case, Carrie, negotiate power within systems, such as medicine and within perceptions, their own and others, of them as women. Being pushy is not generally viewed as a virtuous quality, particularly in women in front of power structures such as medical role hierarchies (Sherwin, 1998). While pushing can be a potent form of claiming epistemic power, Carrie pushes back on allowing her body, despite her need of medical treatment, to be viewed and treated as a site of medical intervention rather than as a person in relationship with her doctors. 'Pushing' implies something solid, resistant and runs counter to the many discourses of 'patient-centered care' circulating in contemporary health care which do not always attend to the power differentials endemic to the 'patient experience', while individual clinician practices are embodied with equally challenging complexity and constraints to meet the patients needs effectively.

From the patient's perspective, Carrie's, it requires a "*modus operandi*" that runs the risk of not being the 'good patient'.

She implies a type of calibrating of power balancing in the relationship and describes a subverting of an imbalance in the following, "...*you definitely need wisdom as a patient you definitely need to be wise and in charge you have to let them feel like they're in charge that's the balance is making them seem like they're the kings but you've got to do stuff to make things happen...*". Even from the outset after her bowels had not worked properly for two months she describes the first significant challenge to acquire an accurate diagnosis, "*Initially, it became acute before Christmas something was off I kept thinking, 'I'll feel better, I'll feel better' then, in January, just blew right up by February, I thought Houston, it's a big problem.*" She tells one doctor, "*I said...you know I'm a lot of thing but stressed from Christmas in February is not one of them! But...it was just convincing them that I had a real problem.*" She describes working hard in her medical consultations with her first specialist, then another, to be heard.

She frames her perception of medical staff's opinions of her as "*trying to jump the queue*" and that "*they just really felt that I wasn't right with my analysis in my own personal diagnosis, they kept finding ways to say that I wasn't right*" during multiple consults with various clinicians to solicit a diagnosis.

Carrie describes her family physician's own frustrations, "...*my family physician got in the game she says, 'I'm not having my toes stepped on you go off, whatever you can put at this do it'... so she didn't even have the power... she's thirty years plus in the business ...with a medical specialist husband! So*

this is the system.” Her family physician encouraging Carrie claim epistemic power from within a role as ‘patient’ as having greater possibility than her own epistemic power within the complex medical system that grafts together community and tertiary care into a ‘system’ of care.

Carrie relates “*pushing*” against the system that had assigned her a particular oncologist, once she did finally elicit a referral, but who did not invoke her trust and so, she pushed again on the system requesting a second opinion to reach the specialist she wanted. When she met with him she relates:

...the way he recognized that “Houston we have a problem after I explained, explained, explained he figured it out then moved up my surgery they weren’t 100% sure, they were postulating I strongly had to work to get to see him I had to keep pushing everyone thought, ‘oh, whatever, she’s entitled’, he of course too but finally he escalated to the level that I needed him to be I keep pushing, pushing, pushing...He said at one point, ‘If I don’t operate on you till the end of the month (it was a couple weeks later) will you be ok?’ I said, ‘People survived the holocaust, I could be okay’. He said, ‘Isn’t that a little harsh’ I said, ‘No. It’s not at all. That’s the level I feel I’m at.’ So sometimes, its maybe using that language just kind of pushing with that shock language...They didn’t seem to understand, they weren’t getting there. I thought, ‘How can I get them there?’ It just did not feel right I felt enormously off, enormously off, my quality of life had gone down, extremely I knew there was something significantly wrong...frustration...but I’d been there before with my accident and my leg they kept telling me one leg was shorter I said, ‘get your tape out’ it’s pushing them all the time ‘you see, these legs are the same length we need to approach this from a different angle...There has to be so much political correctness with doctors.

Afterwards, when Carrie is, inquiring about surveillance processes: she recounts:

When I saw my guy, specialist, last I said, ‘what’s my scenario now? Do I see you every week, month or? He said, ‘You choose.’ Right now, I’m not seeing him at all but, I said, ‘I don’t want to fall off your radar’. He said, ‘That’ll never happen’. I said, “You see, the thing is I’ve been in this medical system longer than you have and it does happen, it happens

repeatedly you do fall off somebody's radar and you fall off the system's radar.' So I said, "just tell me what I'm supposed to be looking for.'

With this she takes up the task of being given 'epistemic agency' conferred to her, of monitoring her own body and its cues for disease progression.

Productive agency: "The system requires some proactivity". Carrie shares, "...the system requires some proactivity I've learned that so that makes a difference. I have my own inimitable way I always get things done! Nobody said, 'they don't tell you a lot of stuff' you just have to navigate yourself." Carrie seems to draw significant resources of productive agency for acquiring what she needs in her medical care and links this herself, to a value system of a feminist lens, as a source of strength, arguably a 'wisdom-resource', which she shares with her biological sisters, "...we're all the same crazy like strength! I was one of those women's libbers and all that kind of stuff...". I've placed this quote here in the context of productive agency to try to tease out a potential nuance between processes and acts that *(re)claim subjectivity and agency* linked to interactions with the medical context as 'system' and with its clinicians, as differentiated from *productive agency*, which might be more linked to having access to a *resource for agency*, an inner resource, that is used to fuel the means for reclaiming subjectivity and agency.

Productive agency might be inferred in how Carrie uses the size of her surgical scar for a sense of hope believing it was a sign of how deep and wide her surgical oncologist had hunted down removed her cancer. Much hope laces

into medical interventions from patient's perspectives and it is a proposed idea that this may be a subtle form of productive agency whereby a medical act/intervention, is taken to the realm of meaning, in the patient's world, and used to source a horizon of hope from it. She speaks of how, "...*you push so you feel like you got the best guy on the job you can never just say, "Oh well, it'll all be fine". His percentage gave me hope. Funny, stupid things gave me hope like the scar. I'd asked the nurses how long the scar would be...it was actually twice as long! I knew he's going in hard, looking for everything those kinds of things. The scar wasn't his concern.*". She took hope that the aesthetics of the scar was *not* his concern but rather getting out all the cancer, with the surprisingly large scar to show for it, was.

Navigating medicalization: "respect is huge, the way they get involved with your body". Carrie discusses hospitalization as "*incarceration*" from both her ovarian cancer experience and from the lengthy hospitalization as young adult after an accident in which she badly broke both legs. It implicates 'incarceration' as within a radical power imbalance such that she feels herself to be 'prisoner', without agency, but sources productive agency to navigate this 'medicalization' of 'patient' as 'prisoner', in her own worldview of hospitalization. She says, "...*you end up in these situations like people that have been captive in prisons... you have to have things that make you feel good...*"

For Carrie, claiming epistemic power involves gaining respect. She gives the example of the loss of power over her body and implicitly her dignity as a person and woman in the gynecological examination process, which is a

repeated event during the course of ovarian cancer treatment. In a feisty manner she recounts her perspective:

...respect is huge. Even the way they get involved in your body disrobing you the way some of them can be a little more brazen that way for guys, they don't care as much about this stuff but just, you know, say to them 'What would you think if you were staying in a room with six women and they just whipped your thing off, your penises, and started probing around your little thing' and they'd be like, 'Nothing little about it.'Like they have a whole different approach they're not women that's the thing you're lying down and then they're finished they don't say, help you up and say, 'Now you can sit up,' you're still lying there and you're like, 'Can I get up now?' and there's four other men standing here you want to get back up and sit there, be back with the program... Rushed is a big thing make sure any person any medical training program not stand there with their hand on the door. I've had that hand on the door after you've waited three hours to see them and they're standing there with their hand on the door, they don't realize you've waited that kind of time - just act like you matter. It's like you're just one more number, one more file.

Particularly noted by Carrie, she observes, “...it seems to be different for everybody you have no one to talk to that's a big difference with breast cancer they have huge support groups there's all kinds of people they can talk to that was difficult I just did my own homework on this as much as I could but talking out, other stuff...”

Carrie describes the appreciation she received in the supportive care group that she volunteered for the study from and the alienation she had felt prior to this purely because of her specific form of cancer:

I like the fact there were people out there like me – ish (with the dx) these women also have no ability of tapping into any support system I thought maybe I missed something, everybody else is going to the party, I'm over here by myself, trying to get in there is no support the group was seeing others that were that support system it was nice to see that felt good to be able to talk to other people in a similar situation I don't spend much time talking about this particular thing to anybody else.

Carrie describes how she believes a woman needs to be navigating ovarian cancer treatment in the medical context and contrasts being pushy with not being a “wilting flower”. She encourages other women diagnosed with ovarian cancer claiming agency from her contribution to the study stating to a future audience, “...*don’t be a wilting flower navigating this you realize how strong you have to be you can’t let them walk over you because honestly, they will if you want something, push for it don’t just say ‘okay’ push, push, push they’ll push back and they’ll be cursing you or whatever but you just got to keep be friendly to the people that it works for and just be strong...*”.

Carrie’s art: “Phoenix”. Carrie’s art was a picture of a phoenix (Figure 4.2). Often used a symbol of strength from ancient myths about the phoenix rising from death in ashes from a fire causing its rebirth. The phoenix’s tears in legends are also purported to be healing for mortal wounds. Below she describes this art in one of the interviews and it’s meaning for her.

While Carrie’s art-collage was of a phoenix which holds within it symbols of rebirth, transformation, the old being burned up in flames with the new emerging into a new life cycle, tears that heal mortal wounds – all associations that can be found in ancient myths about the phoenix that circulate through contemporary stories in films and books (Harry Potter being a recent popular use of phoenix mythology) these associative meanings with the phoenix did not emerge strongly in the phenomenological analysis. Rather ‘navigating’ was more phenomenologically interwoven with her perspectives offered on wisdom while the phoenix dwells as deeper symbol of her ‘way’ in living with it, wisely.

Phoenix Courage

*accident happens
bad timing
made to feel an outsider*

*not wanting others
to see my grief*

*one person
pushes through
the wall*

courage

to let someone in

a support



Figure 4.2 Carrie's art: "***Phoenix***". Carrie's poem above was created by her group partner in the dyad exercise for finding one's strengths. Carrie chose to tell her partner about the time she was hospitalized with severely broken legs after a boating accident as an adolescent. Her partner wrote this poem from her story.

4.3.2.2 Summary of Findings for Carrie

'Navigating' was the recurring phenomenon in Carrie's exploration of wisdom in the interviews, even when 'navigating' was not specifically used to describe a particular process – such as how to handle guests who might or did overstay their welcome. Carrie grew up kayaking and later sailing, and navigating felt to be integrally connected to this 'elemental' learning about navigating in the uncontrollable forces that impact a sailor or kayaker thus seemed to emerge from the analysis as her 'wise-way', her 'wisdom-compass'.

Her stories of her life and experiences, many told with humour and zest and even including her story of getting her diagnosis. Each story describes a process of navigating existential, spiritual and emotional distress; navigating dynamics in relationships after diagnosis; navigating being mother, daughter, wife in the new reality; navigating the medical system and consultations with specialists; and navigating living each day fully and meaningfully pushing back on the mortality awareness encroaching on her capacity for "not living to die... living to live".

Whereas Beth's wisdom-compass phrase, "be in the present moment" brought forth a sense of time as both continuum of arrival and leaving, returning to and departing from the present into past, future and with the present moment as both shore of departure, journey, and destination birthing and rebirthing a self who can be in the present moment, Carrie's wisdom-compass phrase of "*navigating*" evokes her many uses of "*pushing*" as a "*go forward*" towards

somewhere that leaves “here”, departs from “here” and navigates to keep “*winning*”, with a “go forward”, “living to live, not living to die”.

4.3.3 Denise’s Portrait: Wisdom-as-Process Through “Do a Fresh Take”

*do a fresh take
beginning a process
life can be short*

journey together

*live your life
and do a fresh take*

Denise is in her early sixties and has worked in health care in an administrative role for her life long career. This role exposed her to extensive knowledge about medical diagnoses and their treatments. She was diagnosed with stage III ovarian cancer approximately ten months prior to the first interview of this study. She had radical surgery and completed her first course of chemotherapy. Denise had higher education and has been single for her adult life. She has no children. In her immediate family she has four siblings, a living mother, a cousin with whom she is close and describes having lots of friends. Her life roles have included being a leader in health care administration with expert knowledge that others have drawn on within and outside of her workplace; she has, in many ways, been a mother to her own mother and understands the mothering role from this perspective; she is a sister, a niece, a cousin, an elder in her spiritual faith group, a friend and mentor.

Denise's wisdom-phenomenon, her wisdom-compass, emerged as "do a fresh take". Denise titles her art-collage with this phrase for the group and returns to the collage at the beginning of the second interview where these words included in the collage became a focal point in her conversation about it.

"Do a fresh take"

wisdom

is process

it takes time

do a fresh take

beginning a process

think about who you are

how you process

what is important

has shifted

taking time is wise

self-compassion

breathing space

reaching out

connecting

relationships

talking back and forth

understand

to gain understanding

reflect

realize

gain insight

apply it for the next step

always changing

always growing

start small

begin a process

do a fresh take

faith really gives you hope

*for now
for this moment*

*from the moment you're born
you're dying
life can be short
we all have to figure out a way
to get through it*

*you are not alone
in this journey
it's part of life*

*my life will be different
from this point on*

*work has no meaning
in terms of who I am
in relationships
you're giving of yourself
if after work
I don't have those relationships
I'll have nothing*

I don't want to have nothing

*be kinder to your body
self-compassionate
try not to be so hard
on yourself*

*walking
breathing space
feel sun
warmth
sand on your feet
hear the waves*

*an afterlife
can be comforting
we are all on this journey together
life is short
work on relationships
create a memory
that will be remembered*

cry

*grieve
give yourself permission
express yourself*

then things are calmer

*I was crying
they sat with me
talked with me
encouraged me
explaining everything
brought blankets
always made me warm
not making me feel bad
about any of it
comforted me when I needed it
persevered through the system on my behalf*

I was a person to them

*wise health care
makes me part of
the decision making*

*everybody's working as hard as they can
for you
you learn to say
'that's the way it is'
for a number of things*

*you're on this journey together
without knowing
what the ultimate outcome will be*

I have to 'live life'

*live your life
and do a fresh take*

4.3.3.1 Hermeneutic and Phenomenological Findings in Denise's Perspective on Wisdom

Reflecting on wisdom culls personal wisdom: “I guess I've been wise”. For Denise, reflecting on one's experience in light of wisdom aided her to feel wiser and possibly, become wiser, by raising to her awareness her own insights from her lived experience and then “*apply them*” for becoming more of who she wants to be, post-diagnosis. She reflects,

...bit of an eye opener...this whole concept of wisdom is not something I would have called myself ...having the questions, making yourself think about who you are, how you process, I can see how some of my instincts and my decisions have been guided through my own wisdom that I've gained I guess I've been wise in some of my decision making related around my illness and that's been a good thing, it's not all been a reaction to fear and...I don't think I made that connection until just now...

Wisdom as “do a fresh take: “I think time is a factor in developing wisdom”. Denise states that time had a role to play in forming her personal experience of and perspective on wisdom. “Do a fresh take” provides Denise with a ‘wisdom-compass’, an image-centered phrase that provokes a reflectivity ‘in process’ of living her life allowing her the ability to create new worlds for herself.

She describes her week after receiving the diagnosis from her family doctor that involved immediately reaching out to a friend, crying together and followed by emailing her siblings to meet and gather their support. Immediately, “*I told them exactly what was going on. I think that involves some wisdom, it wasn't in direct fear...*”. Denise connects her process that week with wisdom, conveying, “*... it took a week to get to that place after I heard so it wasn't immediate. I*

needed time to adjust to the concept I had the cancer to deal with I needed that space but I knew I couldn't put it off. I think I needed time..."

Denise also describes how her experience of time has changed from when she was working, pre-diagnosis, to now, after and post-treatment as she recuperates saying, *"Convalescing, I think, recuperating is doing things too and living your life that's part of the recuperation I'm not used to it. I'm not used to not going to work, that was a big thing for me... now my day is mine to own but I haven't quite figured out what to do with it..."*. Yet despite not knowing what to do with 'time', she is clear she does not want to fill the time with her job once more. She is taking up the task of 'figuring out' what she wants to do with time, her time in her own life. A value shift seems to be underway when she reflects how the present is changing her sense of a possible future reflecting, *"My future is going to be different. I want it to be different now. I don't want to spend the next five years working - that's my wisdom because I realize there's not going to be value added to my life doing that. I see more value added if I get to experience different things that don't involve work."*

Denise further describes the benefits she has experienced in meditating and taking time to learn this skill, being aware of her breath, guided imagery and naps as a way of relating to time differently. She offers, "I would suggest to anybody new going through that you might want to take some time to develop that skill ...then take your naps!"

Time takes a sense of the 'wholeness' and circulating that can encompass even death. As Denise's reflects, *"from the moment you're born, you're dying, in*

some sense, you're living it, I'm living it, whereas everybody else is, not thinking about it". Time takes on an encompassing dimension that forms a 'whole' through which a lifespan can be viewed in totality, with dying as an aspect of the whole, rather than a truncating 'stopping' of time.

For managing the waiting times for chemotherapy and consults, where time can stretch out into hours of 'waiting' she implicates wisdom in knowing how to 'wait' suggesting, *"...you would want to know that a lot of time is waiting, you need to know that, it's huge, waiting, you just wait....you had to wait. I think my wisdom about waiting is that you just have to figure out a way to make it enjoyable find something pleasant to do during that time it was always sad to see people that got angry, waiting...that would happen."*

Denise's sense of time links in her discussion to reflections on time, connecting wisdom and processual aspects involving time, not chronologically as wisdom's formation, for her, but in what happens in "taking time" and how she relates to and gives different meaning to time, now, after the diagnosis.

Wisdom as "do a fresh take" in the process of relationality: "*I needed their support*". Denise describes wisdom as "do a fresh take" in relationships where she came to recognize of her siblings, *"I needed their support"*. She highlighted this as another way of doing 'fresh take' as she realized she had tended to live more independently without asking for help or even needing to. Denise references the Soul-Medicine support group as a new experience for her in finding the value of receiving and giving support. She affirms, *"...that was one piece of wisdom I got, that there is value in getting together with people who*

have similar circumstances and sharing... it's about having others who experience the same condition, same issues, then the sharing of experiences. I'm not really that kind of person but I've learned to be ...I've learned to be...". Wisdom formation in relationality might be inferred from her comments here but nuanced with an emphasis on the value of being with others with the specific context of her current situation. Relationality as an aspect of wisdom is not simply a case of being relational with any 'others', as 'who' those others are seems to be a crucial aspect of whether wisdom can emerge from the relational connection and conversation. Denise's 'fresh take' was in changing a way she lived in relation to being in a group process, before, she wasn't "*that kind of person*", yet value emerged from her decision to step into a 'fresh take' on who she is to become a support group member forming a "*piece of wisdom*" from this new take on herself, and experiences that can source something new for her.

Denise states in response to the question, "What would you offer to another woman going through this?" saying, "*pass on the nuggets....practical wisdom I'd pass on*". She volunteers 'nuggets' in practical tips when asked what she would pass on in terms of wisdom to another woman newly diagnosed. This included a very pragmatic recommendation, perhaps framed as *phronesis*, practical wisdom, that a woman check when her OHIP and Drivers Licenses were due for renewal and to get them renewed before hair loss during chemotherapy so that these hard copy forms of government issued identification do not serve as a long term reminder of chemotherapy and having cancer, signified by hair loss. She recounted a woman who "*sat with me*" advising her

drink club soda to help with mouth sores that tend to form through chemotherapy as an example of *“that kind of practical thing”* as an other example of the *“practical wisdom I’d pass on”*.

Spiritual community: *“There are times when you need others to step in...”*. Relationality can be viewed as implicated in Denise’s perspective on the connection between spirituality and wisdom. Denise includes her sense of connection to a network of others who hold faith for her, pray for her, even at a time where she feels a need to *“work on a closer relationship”* with her faith/God. She states, *“maybe it [wisdom] is realizing that there are times when you need other people to step in and be your mediators [for faith]”*. She acknowledges, *“accepting people’s faith on your behalf, that’s different for me, that people feel enough for me to do that”*. For Denise, spiritual community provides this kind of relational wisdom that includes practical acts of care towards her. One friend wrote a prayer, another group made a quilt which *“was nice and warm....it gives me comfort”*.

She describes an image of the afterlife to source a sense of hope about dying and this image includes drawing on her memory of being on the beach where *“it will be pain free, sunny and bright, I spent a week on a houseboat, so we had water, scenery, I saw the sun rise...it’s beautiful, I think it will be something like that...it’s beautiful...it’s nice, you feel the warmth of the sun...it will be something like that”*. This image sourced from her memory evokes a horizon of hope, beyond death and opens a world that is not filled with fear but rather, something beautiful. Her spiritual beliefs take image-centered knowledge,

sourced from material imagination of sun, warmth, beach, the elements and her body's remembering of them, reawakened with the image and transforms a future horizon into one comfort and hope.

Wisdom versus advice: “Wisdom comes from understanding”.

Denise touched on the topic of advice in the interview and I asked her if she thought there was a difference between advice and wisdom. Of note is the way this reflection emerged, spontaneously, through the very process of relationality in the context of the interview as it organically emerged and was not an original interview question. As a shared inquiry, semi-structured interviews in phenomenological inquiry allow for this more type of ‘emergence’ in spontaneous inquiry within an interview process. She offers her perspective, shown in full for the nuanced reflection she offers as her perspective on wisdom:

...advise and wisdom is different, advise might be something that people have experienced in their own lives and have a certain opinion on how things should go. Wisdom is sort of maybe talking about the same thing but in such a way that [I] can relate it to me or give me a way to think about things instead of advice...wisdom is more of a way for me to take what they're saying and discern what I need to apply, I'm part of the process. I can think about what applies to me knowing that whoever is giving me that is not going to be offended if I don't you take advice and you say, 'yes, ok, I might consider that' then you move on but wisdom is, I think, different, because advice you would have to be careful about the other person's feelings if they said something in a different manner....Incorporating wisdom it would be a different kind of conversation one of back and forth, them knowing that they're taking it in just as much and trying to understand so they might be understanding in a wisdom conversation whereas in advice I don't feel there'd be understanding....

Denise describes wisdom as something that comes from “understanding” with a sense of the relationality as the key ingredient for the particular conditions

from which wisdom might emerge within a *dialogue* where each person comes to new understanding from the conversation.

Wisdom as “do a fresh take” in relation with oneself: “I’m being forced to be kinder to my body”. Denise shares a personal wisdom that is in process of forming in relating to herself self, physically, emotionally and spiritually. She relates to the notion of ‘self-compassion’ as personal practice taken up in her way of living life in relationship with herself discovered in new ways through ‘self-compassion’. This practice was explored explicitly in the Soul-Medicine supportive care group process with practices and simple exercises to try at home that teach ways to reflect on one’s thinking and acting towards oneself, reframing ‘self-care’ as a form of self-compassion. Denise explains her realization of this notion, “...*self-compassion, not being so hard on myself, I’ve hit upon that as a good thing. I don’t have to be so hard on myself. I’m not used to having the need to rest to lie down and not feeling guilty. I’ve learned to do that I’ve realized it’s okay, a necessity, another way to learn to take care of myself.*” She explains further, “*I think I’m being forced to be kinder to my body... For example...sitting on the couch! ...resting, I might still resist the whole concept!.....People say, ‘be kind to myself’ and I guess I haven’t really thought about how that looks*”. To other women living through this diagnosis she’d offer, “*I would suggest they do a meditation, a type of exercise. I think it forces you to sit for an hour and a half or whatever time just reflect on your breath then whatever guided imagery they talk you through I think that process is beneficial for your body.*” Wisdom for Denise does not only emerge for herself with *time* and

reflection but also includes an ability to apply self-awareness for taking up a relationship towards herself, framed by *self-compassion*, to make the best decisions for herself.

Self-compassion links to affective dimensions of wisdom, feeling, ethical sensibility, empathy turned towards oneself. This suggests there may be a subtle differentiation between ‘self-transcendence’ and ‘ego-decentering’ practices suggesting that, at least for Denise, an orientation towards herself with self-compassion has opened up perspectives on wisdom for her. It might connote self-compassion can be a type of self-transcendence, transcending old ways of relating with ourselves that define who we are and how we live in the world to form new ways of being, a new self, to whom one is compassionate and less judgmental or harsh.

Self-compassion gives Denise a way to “do a fresh-take” in relating to her physical limitations, since the diagnosis and treatment. She says, *“I don’t why I keep on thinking I should be finished but...I guess it’s because I had planned to deal with the surgery, that’s something physical, the chemotherapy, is a physical thing, and now, recuperation. I haven’t quite figured out what that means”*. Following on in this reflection and the link it may to wisdom she offers, *“...there is wisdom, I guess in recognizing that my body’s still not quite there which is not something I would have normally... I would have tried it, then recognized later that I shouldn’t have done it. I’ve been healthy up to this point so I never really had to think about that going out and doing things I don’t like it one bit, it sucks!”*

Self-compassion also includes being supportive to herself in her grief experiences suggesting, *“I’ve gone through all that treatment ‘we’ve done what we can’. My life will be different from this point on a grieving process... it’s hitting me now the surgery, the treatment you had something to do and now it’s...it is what it is...it’s okay to experience what you’re experiencing giving myself permission you’re still working through that process.”* Permission to grieve as an act of self-compassion, for Denise, is also a new perspective she’s come to and offered on wisdom.

“Do a fresh take” on ‘work’: “What are people going to remember?”

“Do a fresh take” has perhaps been one of the most radically life-altering change to Denise’s meaning of “work” such that it has transformed from ‘work’ meaning her paid job to become a desire to “work on” “relationships” in her life such as her siblings and with her nephews and nieces. Earlier in the interview process she discusses her ‘work’ as the job she has held for thirty-five years. At the beginning, after the diagnosis, she says, *“I still went to work, it’s kind of surreal, you’re still doing what you have to do but in your mind you’re thinking, you want to shout at these people, say, ‘this is meaningless ...this is what I’m dealing with”*. Yet she returns a number of times in the interviews to her emerging clarity that ‘work’ is “meaningless” and will “leave me with nothing” if she does not change her focus, or, in her words, “do a fresh take” on her life. Later in the interview process she reflects again on this theme and her changing relationship to meaning about ‘work’, *“...there’s value for the job but for me personally what are people going to remember? Not the fact that I spent a lot of hours working*

but the interaction I had the memory I created with somebody that's going to be value so I want to work on that, now, and not....I would not have been like that pre-diagnosis. I wouldn't have changed my life. I'm in the process of doing that".

Denise's reflections contour a process of identity shape-shifting around meaning in relation to 'work'. Simultaneously, this is forming a different 'self' who is 'working', affording a fresh take on identity, meaning in life, and what Denise would like to be the focus of her life all changing towards a different way of being in relationality.

...work has no meaning in terms of who I am, what I'm about. Relationships you're giving of yourself to, that's going to impact who I am, who I will develop continually into. Relationship building will impact who I am as always changing and growing. I've had to learn to rely on other people. I've never had to do that before. If after work I don't have those relationships, I'll have nothing, I don't want to have nothing.

Denise describes this process creating more clarity for her sense of her life and how she wants to be in it:

I'm becoming more clear about what I want my life to look like, how I have to go about doing that. It's going to be connecting more with people, which is not something I'm used to doing! I want to continue that change I don't want to go back. "Fresh take" it was the words that spoke on my collage, little sayings that I liked. It's the beginning of a process of looking at different aspects, what I want out of it, provided clarity in what I wanted like that. I wanted to change my thinking I wanted to connect, again, with walking..and eating... well it started with the words "fresh take". I wanted to do it... take the opportunity to do a fresh take on things. I do feel changed."

Wisdom-as-process catalyzed by "do a fresh take": *Reflect*", *realize*", *recognize*", *apply*". In the quote, we can see the movement of a process Denise named as part of her perspective on how wisdom is formed:

being “*reflective*” and “*reflective back*”; “*recognize it*” or “*it hit me*” or “*realization*”; and then after these, one still has to “*apply it* for the next step”, which implies embodied action of some nature, even if that means a different internal response to an event. She uses Ghandi as an example to suggest perhaps wisdom comes after action in a processual way with reflectivity and realization, two differentiated processes in the lived experience of how we come to insight:

...it's easier to recognize it [wisdom] after....he [Ghandi] probably put one foot forward at a time and said, 'this is what I'm doing'. I think you can be reflective and recognize it but there's also a way to apply it for the next step but you need to reflect ...unless I reflected back on recognizing these things as wisdom and that it's okay to ask for help in moving forward... I think the whole diagnosis has made me realize that I will probably think of my future differently than I would have prior to cancer the wisdom is acknowledging that my thinking has shifted ...what is important to me has shifted.

This insight Denise offers again points once more to a processual nature dwelling within the phenomenon of wisdom, not so much progressive as if ‘wisdom’ is an acquisition but rather as inherent in wisdom as a phenomenon that pulls towards itself, forms and releases into new insight. ‘Applying’ brings embodiment into wisdom very implicitly that without ‘applying it’ in Denise’s words, embodying it, through the lens of embodiment applied in this study, it is not somehow still wisdom. She also gives further perspective on a meaning of wisdom, “I think the whole diagnosis has made me realize that I will probably think of my future differently than I would have prior to the cancer...the wisdom is acknowledging that my thinking has changed, what is important to me has shifted.”

Denise offers her perspective that wisdom is something that happens over time but involves an active participation on her part to form personal wisdom and, as she emphasizes, apply it, live it, embody encompassed in her guiding 'wisdom-compass' of "do a fresh take".

Wisdom as accepting limitations: "*I have to start small*". Denise names the difficulty with accepting limitations due the physical impact on her body of the cancer and treatment process. "Do a fresh take" for Denise also includes accepting the limitations life has now imposed. On the one hand, "*it sucks!*" but on the other, "*I have to recognize that this is going to be a process*". She says, "*my wisdom is, I have to start small*".

Denise's awareness and movement towards 'self-compassion' as a type of practice, emergent from her forming wisdom from the diagnosis involves meeting physical limitations, "*there is wisdom, I guess, in recognizing that my body's not quite there...*".

Denise includes reframing her view of life to now include mortality as part of accepting limits in life. Reframing the disease to "*chronic*", a trend in ovarian cancer health care, has aided this acceptance and ability to focus on her priorities with the limits upon the time she has left to live. She illustrates this stating, "*I realize longevity probably is not going to be there that I will have to deal with chronic illness we'll call it that for now so, that has shifted my priorities in life...*".

Wisdom as 'invisible' to oneself: "*I think you're so close...you don't see it*". Denise infers wisdom seems invisible to us saying, "*I think you're so*

close to it, you don't see it. You just see it as everyday living, or getting up, putting one foot forward and sometimes, that's all you're thinking about so you don't see wisdom in that. You don't see wisdom as the act of wisdom...when you go to connect with somebody. ...then you see it after." Denise continues on in her reflection on this seemingly occluded aspect to wisdom:

I think you can be reflective and recognize it but there's also a way to apply it for the next step but you need to reflect...unless I reflected back on recognizing these things as wisdom and that it's okay to ask for help in moving forward I might more readily call somebody up and say this is what I need because I recognize that it's a wise thing to do... So, I think that's how one can apply a wisdom... maybe instinctively you would have done the same thing moving forward but without this conversation I wouldn't have called it wisdom.

For Denise, reflection is a key element for gaining wisdom through her experience that can be applied to how she makes choices to live her life in the future.

"Do a fresh take" on wisdom: "Wisdom comes in many different forms". On the phenomenon of wisdom itself, Denise acknowledges she has come to realize that "*wisdom comes in many different forms*" and from unexpected places such as "*a book, a sermon, a friend, a story on the radio*". She further names and highlights a tension that Beth and Carrie also acknowledge, whereby, in Denise's words, "*wisdomis not something I would have called myself*". She describes that the process of reflecting on wisdom as a phenomenon in life and within her own being, through the supportive care group process and the two interviews was "*bit of an eye opener*". The reflective, processual, and relational dimensions that the groups, the interviews afforded

Denise seem to have played a role, in her view, on an emergence of awareness of personal wisdom. In the invitation and volunteering to contribute...a space formed to invite reflectivity that allowed for Denise's personal wisdom to emerge in the process inviting it. Perhaps this highlights further embodied and relational aspects to ingredients that wisdom needs for its emergence into "*reflective*" awareness and "*realization*" so it can be further embodied, or in Denise's words, "*applied*".

(Re)claiming subjectivity and agency: "*I started to cry*". Denise comments, "*unfortunately, chemotherapy is not a nine to five affair*". Denise's describes crying on the day of her first treatment when the doctor did not order her chemotherapy drugs in time for her treatment, "*I had to go for ambulatory chemotherapy where he didn't put in the orders they can't do anything. I had visions of me leaving the hospital without going for treatment. I started crying so a nurse, she saw that she talked to me and you know, it worked out.*" We might reflect on her story about tears and the nurses response to consider how tears, rather than a sign of weakness, came into play for a 'humanizing' of both her nurse and herself restoring agency to both when an error prevented chemotherapy starting. While the nurse was providing excellent care regardless, Denise's tears created a 'human' moment, with an emergence of empathy from the nurse in a stepping aside from tasks and efficiencies to care for Denise and her tears.

I offer a reflection on Denise's tears to be viewed as more nuanced form of (re)claiming subjectivity in a medical system that, on that day, in that moment,

failed her and the nurses response, as a humanizing subjectivity, as a representative of the 'system' in that moment, that cared and so perhaps, in Denise's tears was an evocation of 'health care', albeit, of a different kind than the care-as-treatment, expected and planned for. She describes later again how the nurses "*comforted me when I needed it*" and "*persevered on my behalf and I got a sense they do a lot of that*".

A means for claiming subjectivity and agency over the experience of long waits for consultation and treatment, a frequent source of frustration, even anger for many patients, can be considered from this story following. It illustrates Denise's ways managing the 'waiting' for chemotherapy,

...you would want to know that a lot of time waiting...I had a plan blood work, coffee, head upstairs, sit, knitting, a book you just sit and wait look around watch people sometimes I would think that they must have forgotten about me or I must have missed their calling because you would wait two hours...if not more then you began to learn that especially weeks where they had a holiday you can expect to wait a long time and that when they call you it might you be not be because they are ready for you but because they have a question about the form. I knew if that happened within the first hour it was always about the form and there were times when I closed the unit it took so long or I had to have an additional infusion of other things you spend a lot of time waiting.

Denise also describes struggle for how to move forward after treatment which might be viewed as feeling adrift from being given *full* autonomy after the intensive focus on receiving care, direction, appointments, dialogue, procedures during treatment. She says, "*that's what I'm struggling with now, I am going to have to manage symptoms, but I'm not sure, I'm going to recognize them, when they do become significant enough, I'm afraid that I'm going, to miss the boat, on it then*".

She reflects on the Soul-Medicine group's role in her treatment recovery process, as well as other groups elsewhere, *"I learned a lot through surgery and chemo but you're learning and doing it there's nobody there to say 'this is what you're going to experience next, this is what is going to happen, these are going to be the symptoms', you sort of learn that as you go through it then once its done there's nothing to do anymore except live your life. I found that support groups would help me with the next step."* Attending the group placed herself in focus, (subjectivity) and took impetus, action, courage, (agency) to step out of her comfort zone, discussed earlier, and into a group support experience.

Embodied 'knowing': *"it's made me question my gut feelings"*.

Denise describes doubt in her experience of intuition or gut feelings since she did not have any such 'knowing' about her cancer as she relates she's heard other women have, *"I question that [intuition/knowing] , from me right now, I felt...it's probably not rational, but I didn't have any gut feelings early on, pre-diagnosis....it's made me question my gut feelings."*

Empathic knowledge (embodied): *"Doctors are wise in what they do...they can't know all the answers"*. Denise expresses empathy for the nurses *"persevering on my behalf"* in the chemotherapy difficulties stating, *"I think that's the nature of the process in the system. I thought about what can they improve. I'm not sure if there are ways to do that, they were trying to do the best they could within the context of the system..."*. This perhaps illustrates a form of empathic knowledge. Denise describes a similar empathic knowledge embodied in empathic touch, answering questions, offering warm blankets from her nurses

in chemotherapy as providing a preservation of subjectivity and agency. Denise's experiences of meeting the humanity in her oncologist and nurses are described as the embodiment of wise care in her health care. Additionally, Denise identifies that she "*is beginning to appreciate her doctor's philosophy*" and "*I've recognized I needed medical help through this process*". Affording physicians their humanity and subjectivity is perhaps illuminated by Denise's statement, "*doctors are wise in what they do but they don't know all the answers ...they can't*". There is an empathic quality to this statement, as well salience.

Denise too shares a story where it might be considered how a physician exemplifies empathic knowledge of personal experience, to offer Denise a personal story that helped her to accept chemotherapy ahead of her own mental timeline of when she thought it would begin. What he shared would not be found in a textbook or medical education yet, it drew on his own lived, embodied experience to communicate empathy and support for Denise's struggle to make a decision to push chemotherapy till after the immanent seasonal holiday. An empathic knowledge formed part of a conversation where power was shared to negotiate an outcome acceptable to both doctor and Denise in shared decision-making, a relational ethic guiding empathic care, from both.

The following example illustrates an empathic knowledge possibly aided from her being an 'insider' in health care through her career. She offers this insight, "*...despite the flaws in the system where you can't proceed without orders they were doing their jobs doing the best they could as a patient you can't get mad at your doctor for not putting in the orders but, if he was in surgery like*

he was with me one time for five hours, then you understand his time is busy.”

She offers us a means to consider how an empathic lens through which to view her clinicians' humanity, their subjectivity, affords a 'patient' agency by creating a way of talking of to herself to frame a situation when doctors forget chemotherapy orders and waiting can be hours at a time for treatment and consultations, without yielding all agency into powerlessness and an ensuing anger.

Using this empathic knowledge Denise offers a potential reframing of system constraints through empathy to restore an agency to both patient and clinicians, all constrained, most trying to share power, most trying to give and receive subjectivity, most soliciting ways to gain, broker, preserve agency, personally and in 'other'. Denise identifies that there is a *shared* experience of a loss of agency for *both* patient and clinician within a system with power greater than both saying, *“...you can't get angry the staff are doing their job you have to realize that everybody's working as hard as they can for you. You realize they are not doing it intentionally it's just because that's the way it is you learn to say 'that's the way it is' for a number of things.”*

(Re)claiming epistemic power: *“I can control when I do things for it”.*

Denise suggests there's a need to *“take control”* as part of the process which might be viewed as her way of identifying a need for epistemic power over her treatment process as much as being a recipient of it, suggesting, *“...if there's an opportunity for you to take control of some of that because this diagnosis you*

really have no control so it's not that I can fix that but I can control when I do things for it...".

An example of when Denise took control was a decision she made right after surgery to defer starting chemotherapy treatment despite the news from her oncologist that it was recommended she start immediately. She says, *"I did have some control about when I wanted chemo to start, they wanted it to start December 23rd, I said no...I wanted Christmas I didn't want to have to worry about how I was going to feel so we started December 29... for wisdom if there's an opportunity for you to take control of some of that because this diagnosis you really have no control so it's not that I can fix that but I can control when I do things for it."*

For Denise, understanding from her doctor 'why' a certain course of treatment is important and helps her when she hears about alternative approaches, for example with surveillance after treatment, through other patients with different physicians. For Denise, the physician *"taking time is wise"* and enables her to partner with her treatment decision making, which, when framed in the lens of epistemic power can suggest time, dialogue, assist a person to claim epistemic power in their own medical decisions. This is linked to being 'wise' from Denise's viewpoint, *"...working out of a hospital I realize how busy everyone is. I think taking time [in the clinical consult] is wise because it helps you buy into and process a course of treatment or non-treatment and its philosophy it helps me move forward..."*

Denise identifies a very positive experience that can illustrate some meaning to when epistemic power is shared with her doctor:

...make me part of the decision-making, even though there is one course to go through I was still allowed to make the decision on whether I do chemo or not. They always gave several options... they never talk about outcomes. You're on this journey together without knowing what the ultimate outcome will be. I was a person to them... The way he approached things, the way he connected with the various family members to include them which they don't have to do... he always sat and took the time.

Responding to ‘medicalization’. Denise did not describe moments that were able to offer illustration or insight into this concept from her care in terms of how her personhood, her gendered experience was influenced by the treatment and clinicians. It is possible that one reason for this might be that Denise had an insider viewpoint from having had a career in health care and perhaps therefore held a broader knowledge of physicians in their diversity, their expertise, humanity and personhood as well as having discussion skills from years of working with physicians directly, thus potentially, a greater sense of agency. Perhaps physicians were more ‘human’ for Denise, certainly her compassion for their constraints in clinical care was evident in some of her statements (see above) and her positive experiences of epistemic power might suggest a different experience or standpoint to Beth and Carrie.

Denise’s art collage: “Do a fresh take”. Figure 4.3 shows Denise’s art collage, titled “Do a fresh take”.

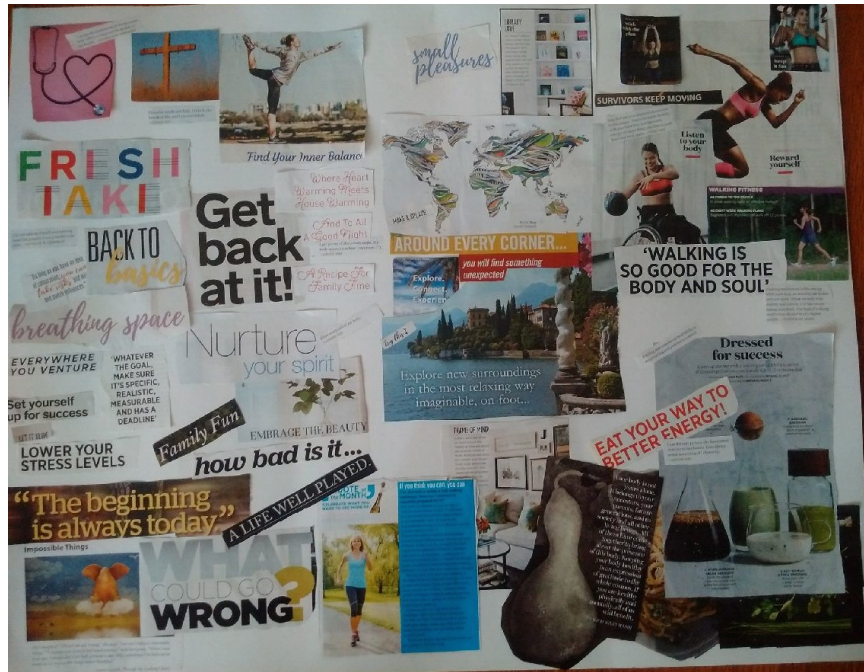


Figure 4.3 Denise's art collage: "Do a fresh take".

4.4 EXEMPLARS OF FINDINGS FROM THE THEORY LENS OF IMAGINATION

This study attends to imagination's role in wisdom formation from Beth, Carrie and Denise contributions. Imagination's role in forming and conveying their wisdom is represented by the image-centered knowledge embedded in their dialogue through the interviews. As discussed in the Methodology section (Chapter 3), four foci were used as an analysis lens that draw on Bachelard's philosophy of imagination: (a) hope for the future, (b) the attitudinal state of 'reverie'; (c) image-centered knowledge, and (d) 'material imagination'.

Bachelard's aim was to reveal the conduit imagination plays in human life and language for couriating meaning. He showed, in his analysis of the poetic image in literature and poems, how this tends to happen so simultaneously that imagination's role of transmitting 'image-centered knowledge' one to another in our discourses, particularly when crafted into a powerful poetic image, is almost untraceable if it is not being specifically studied. The theoretical lens focusing on imagination, embedded in the study, afforded an investigation into imagination's role in generating wisdom, experienced and communicated in the interviews. This takes up Bachelard's project: to reveal the role invisible role that imagination plays as an inextricable aspect of human being and knowing. He was arguing, as a philosopher of science, that imagination's presence in our human generation of knowledge was all but erased in the scientific paradigm's trajectory to gain and describe knowledge about the world around us, and human life.

In analysis of the three participants' perspectives on wisdom, these four dimensions of Bachelard's phenomenology of imagination were explored during data analysis. The final poem representing findings was crafted around each of the images they used to convey their wisdom, gleaned while living with ovarian cancer. Each image they used in their narratives can be found in the final poem, along with others discovered in their interviews from the analysis process. However, to further illustrate Bachelard's philosophy of imagination, underpinning the methodology and his philosophy's relevance to imagination's role in wisdom formation, some examples are now given within the four foci drawn from Bachelard's philosophy and culled from Beth, Carrie and Denise's interviews.

4.4.1 Imagination as Fostering New Horizons of Possibility: Hope for the Future

For Bachelard, as noted previously, "Imagination...faces the future (Bachelard, 1994, p. xxxiv). Carrie describes a way she 'sees' a possible future using the inner 'eye' of her imagination as a way to see forward into her life with ovarian cancer:

***I see myself really up!**
I see myself here, in this world
winning actually!*

This way of seeing in Carrie's words conveys one way that new possible futures are born for her. Bachelard (1983) writes, "The imagination invents more than objects and dramas – it invents new life, a new spirit; it opens eyes which hold

new types of visions” (p. 16). Carrie shows us with image centred phrases, a way that she ‘sees’ a new vision of her future as “winning”.

Carrie also describes a capacity of ‘compartmentalization’. This is an image-centered knowledge describing an inner action: the act of putting something in a compartment. By doing so, she can focus on other things in a future that isn’t filled with ovarian cancer in her imagining of it. Instead, the compartmentalization allows her to imagine plans, concrete and tangible, in the near horizon, so she can “live her life”.

*I've **compartmentalized**
I don't wake up every day thinking
 “I'm going to die”
I wake up every day thinking
 “there's so much going on
 *I've got to **make all sorts of plans to do things***
 *live my life**

Similarly, Beth relates that she creates a sense of future and hope for having a future through “planning” as an “idea” formed within:

*I **schedule** things
 plan ahead
planning gives me **an idea**
 *I have **a future***
I'm going to experience
 *these things**

Beth further states that hope is related to wisdom by one’s ability to create the *feeling of hope* through her making of plans:

***hope** is a huge word for me
 having the **wisdom to**
 creating that feeling
 of hope*

*because it makes my ability
to **get up** in the morning
go through your day
every day after that*

Beth also discusses drawing on current expert knowledge in science to source her hope:

scientific advances
*it gives me **hope***
it's not the death sentence
it was 10, 15 years ago

Beth reminds herself of the advances already made in the last ten years and the many more to come as momentum in ovarian cancer research grows. To do so, imagination projects in her mind's eye into the future, inwardly seeing science's progressive achievements for the disease, and draws from this imagining a hope in the present. She calls this an act of "*creating* a feeling of hope", a real time processual statement where she is an active participant of her own hope-making.

Denise describes a similar process for ameliorating fear of dying. She reflects on her belief in an afterlife stating this helps her with facing her "end". She draws on a recent lived experience on a houseboat to create this image, where an embodied experience is relived in her imaginal reveries to source hope in an afterlife. Denise describes drawing on this inner memory as an embodied image to see, inwardly, a future horizon in her dying where dying is no longer the end point, but rather a stage in the process of arriving arrives at a place of "warmth" that is "beautiful":

*to know there is **life**
 beyond this world
 and when you're really thinking about your end
 that is **comforting**
 it will be pain free
 sunny, bright
 I just spent a weekend
 on a house boat
 so we had **water, scenery**
 I saw the **sun rise**
 it was beautiful
 I think it will be something like that
 it's **beautiful**
 it's nice
 and you **feel the warmth of the sun***

Here, for Denise, imagination is again silently implicated in a *capacity* to cope with an existential *uncertainty* – mortality using embodied memory, through imaginal activity, comforting her in the present with a future hope.

The women's explorations of wisdom, as it relates to their way of reflecting on the future, can show us how imagination is implicated in their different ways of fostering 'a horizon of hope'. Bachelard's assertion that imagination creates image-centered knowledge takes imagination's role beyond a more traditional view that it is involved in inner 'representation' of images and makes it a potent agent in an act of 'creation' of invaluable existential experiences that move us to action. In the examples above, it can be seen how this takes place in the experience we call 'hope'. Bachelard contends that this capacity is fostered best by the experience of reverie. Beth, Carrie and Denise each describe how they induce reverie to assist them in coping with the tensions and fears generated by ovarian cancer. They each imagine a horizon in the future to source a feeling of hope in the present versus a horizon of fear and dread, or even despair. Beth,

Carrie and Denise exemplify how hope is meaningful only when it is an embodied experience in the present moving one to feel differently than despairing. Hope, through imagination, mobilizes possibilities and moves one to action as the above image centred knowledge(s) reveal showing a dynamism in wisdom as an embodied, processual movement beyond simply a static knowledge.

4.4.2 Imagination And 'Reverie': A Poetic-Phenomenological Attitude

Bachelard (1969) offers a phenomenology of reverie as a means for fostering a poetic-phenomenological attitude in life and suggests it fosters a sense of well-being. Where the phenomenon of fear can occlude hope, comfort or peace and other positive feeling states, the participants describe using modes of 'reverie' as ways they help themselves access a sense of calm, comfort, even peace when faced with overwhelming feelings.

Carrie finds nature and art bring her to this reverie state, and specifically describes using her 'mind' by "sending my mind to some nice spots". Imagination once again being the silently invisible agent of this capacity. Carrie describes:

*I like **nature**
if I have a choice between a shopping mall and the woods
I'd go for **the walk in the woods**
a little **art work** too
I just set up my water colour paints
I'm terrible at it...
but I go away
I can be gone
I can **actually send my mind to**
some nice spots actually
it can go elsewhere*

A crucial and salient aspect of Bachelard's poetic phenomenology of reverie and the poetic image is that they *integrate* the embodied world rather than abstracting from it. For Bachelard (1960/1969), it is a "poetic force" (p. 162) that during reverie animates all the senses, whether to engage in the poetic image being evoked in reading or in contemplation of comforting aspects of the world around us. Denise describes the importance of learning meditation, a form of reverie, and evokes her sense memory to source an ability to foster a real-time sense of peace and comfort. In the following quote she describes the most potent image for her that aids her to do so:

*the **sun rise** by the **water**
 is always one I like
 I'm always on the **beach**
 I always **feel the warmth**
 of the **sun**
 the **sand** on my **feet**
 you hear the **waves hitting the beach**
 I find that **comforting and peaceful***

Denise thus names valuable outcomes of meditating on her experiences of being at the beach as "comforting" and "peaceful" which then shifts her perspective about the future uncertainties.

Carrie warns us of how she believes we can lose connection to this state from too much city life where we are more cut off from nature:

*you have to really pay attention
 sometimes you have to get into **nature**
 like when you're down here living in the **city**
 you've got all the concrete and buildings
 you can really **lose your way***

Drawing on nature and images of lived experiences and connecting in embodied ways with nature through memory, which relies on imagination to recall the memory as an inner image moving us from within, are offered by Denise and Carrie as possible avenues to gaining a sense of peace, comfort, grounding and reducing fears of dying. They support Bachelard's central contention in asserting imagination is fundamentally embodied. He points us towards investigating further this embodied dimension of imagination to shift present emotional states into something more bearable. In Bachelard's (1969) words, "Thus creative reverie animates the nerves of the future. Nerve waves run along the lines of images shaped by reveries (p. 160)". When offered in an interview focusing on lived experience of wisdom we can reflect on how imagination's capacity to foster a state of 'reverie' and calm is implicated in 'being wise' in facing mortality, uncertainty as way out from being incessantly gripped by states of fear and worry, as described and experienced by these women facing their dying far sooner than anticipated.

4.4.3 "Image-Centered Knowledge"

Bachelard (1946/1983) argued for the pre-verbal role of imagination as "dynamic" (p. 85). As already noted, we have seen through his study of images of nature in literature that he distinguishes two types of knowledge: one, "objective knowledge" and the other "image-centered knowledge" (p. 7). It is through imagination that "the endless exchange of the visible for vision itself takes place" (p. 30). Poetic images, art images and the use of symbolic or metaphorical

images in narrative are less likely to be considered legitimate forms of 'knowledge' in research anchored within traditions of science-based investigations. Examples of image-centered knowledge conveying personal wisdom include 'birth', 'compartmentalization', 'anchor', 'dark places', and a 'well' with 'ladder' and 'rungs' to climb out. Each are an image-centered knowledge requiring an imaginal capacity on the part of the reader to hear or read the image, and mine it for the meaning(s) being conveyed about wisdom by Beth, Carrie and Denise. Imagination both generates image-centered knowledge and invokes another to gain insight into the meaning(s) being conveyed.

Beth likens "pushing through" to describe the inner struggle with ovarian cancer and specifically, in the depths of 'pushing through' experienced when giving birth to children:

*but I have to **push** through it
you can't just stop
like when I had my children
both times..."I can't do this"
"I don't think I can have this baby"*

This provides her listener with an image to access her meaning *and* her experience of how she gets through her day and weeks. In hearing this analogy, we can imagine when we too have had to 'push hard' physically and/or metaphorically and our own insights and empathic understanding are evoked.

Carrie also draws on embodied experiences of pregnancy and birth, different from Beth's, to locate a wisdom and knowledge for living her daily life with the cancer:

*I even did that with my **pregnancies***

no epidurals
*I wanted to **deliver** them all*
without extra help
*you **send your mind elsewhere***
your mind is one of the best things
*your **body** has, it's a great thing*
*you can really **work hard***
at controlling it
***pushing** it to other places*
*and **pushing your body through***

We may not have given birth but can imagine times in our lives when it has felt as hard as we imagine it to be, to get through a situation and lived our own versions of 'pushing through'. Image-centered knowledge thus brings a simplicity through a single image, dense with meaning, yet simultaneously also widens the hearer/reader's knowing into a "surplus of meaning" (Kearney, 1998a, p. 156) that reaches beyond our personal experiences into a human experience that gives speaker and hearer a point of reference to the intangible experience being communicated. We can also contemplate even deeper meanings of the birth image, to reflect on meaning laden questions such as 'who or what is being born?' and 'who is being transformed by this experience of 'pushing' analogous to giving birth as the woman is transformed with each baby born?', and so on. Imagination provides the conduit between speaker and hearer for meaning and depth understanding.

Similarly mining image-centered knowledge, Carrie describes how she coped immediately after hearing her diagnosis from the surgical oncologist consultation, after which she chose to stay behind from a family holiday for ten days in solitude at home:

*I don't think it occurred to me
 how much I needed that time to really **digest** myself
 sort of **anchor** inside a position
 to kind of come out with **both blocks forward**
 because you've got to **come out like a machine***

Carrie later draws on images to describe ways of preventing getting stuck in difficult emotional spaces, a well, a ladder and the “bottom rung” that one must *not* get below along with the effort one must make to “climb” out of the well. In this she is communicating to us an existential state, perhaps familiar to many through image centred knowledge of wells, ladders, and climbing them rung, by rung:

*because otherwise you end up at the **bottom** of the **well**
 if the **ladder's** not coming down, how do you climb out?
 best not to get below the **bottom rung**
 so make sure you always can get a **hold** of that **rung***

She uses image-centered knowledge in the following quote to convey her wisdom:

*you realize you're **stuck** in a **hole**
 and you can't just stay in the **hole***

Denise uses a familiar image-based knowledge commonly used in English-based societies of “missing the boat”. She uses this image to describe her fear that she will not catch the symptoms of recurrence emerging in her body:

*but I'm not sure I'm going to recognize them
 or how do I know
 when they do become significant enough
 I'm afraid that I'm going to **miss the boat**
 on it then*

A particular kind of feeling is evoked if one imagines one has missed a boat rather than simply a statement she might have made such as, “I’m afraid I’ll miss the symptoms when they recur”. To ‘miss the boat’ mediates through our own imagination the seriousness, and seeming irrevocability of missing the symptoms and facing a radical and irrevocable unknown, powerless to do anything about it, where one is watching one’s hope of being ‘elsewhere’ leave the harbour of the present and being left behind.

Denise also uses image-centered knowledge to communicate how she would have felt living through the diagnosis and now without her adult siblings:

*I would have been **on my own**
isolated while I was trying to figure out
next steps
I don’t think I’d have ever tried
to do it without them*

If you look closely at these words they would be incomprehensible without imagination’s role in invoking our understandings of each image, “on my own” with the additional image of “isolated”, “figure out”, “next steps”. Each one conveys an image presenting human experiences. If one pauses to reflect on the distinction she is making between “on my own” and “isolated”, one can feel/experience the nuancing of her meaning to enforce the depth of feeling she is describing if her siblings had not been rallied into her process. “Figure out” is also image-centered knowledge, as an abstracted meaning drawn from accounting, when we use ‘figures’ to work out a problem of a mathematical nature. This brings an immediacy to our awareness of *how* Denise approaches finding her “next steps”. To understand ‘steps’, we must draw on our own

embodied knowledge of walking and trying to find the next steps on a difficult, hard-to-find way to continue a journey. Access to the meaning of these statements is not a merely conceptual process but is wedded to an inner, albeit more subconscious, conjuring of the image to mine their meaning. Some images are so familiar that this process does not enter our awareness because the image-centered knowledge shorthand is so complete due to their familiarity; but, as Bachelard points out, imagination's role is nonetheless present as a knowledge bearer, albeit unacknowledged.

4.4.4 Material Imagination: Nature, Embodiment and the Poetic Image

Bachelard's (1946/1983) unique theory of the "material imagination" (p. 134) offers insight into the potent effect of embodied experiences and word-images drawn from nature. He notes their power to express and ameliorate existential tensions such as death-birth, loss-hope, alienation-home.

Scoping for images that can elicit insight into Bachelard's meaning of material imagination seeks specific images and descriptions in the interviews that require a direct link to our own material, embodied world for their understanding. It scopes for the organic world densely embedded in particular images. Bachelard focused on the organic and primal elements of fire, air, earth and water to study how they are entrained within language and poetics in his philosophy of material imagination collapsing the Cartesian split of 'mind' from 'body'. He argues that imagination is fundamentally and principally material, drawing on the organic world and its primal four elements to source language,

meaning and expression in human life. He argues that embodiment is deeply implicated in imagination and that material imagination dwells below the image encapsulated in discourse without even the speaker realizing the organic world, in image form, is present, dwelling in the words and sentences to describe an embodied experience. Bachelard asserts how the organic, primal elements from which humans are made rises into language and provides us with a point of connection for shared meaning.

To illustrate, an example of material imagination from the research interviews is Beth's use of 'dark place' to describe the emotional, mental and spiritual experience she prefers to not go to and works to avoid through her wisdom to be "creating the feeling of hope":

*I have to not give up
 keep going
 go with that core **feeling**
 in my **gut**
 it **feels better***

*if I think too much
 I'll leave myself on the couch
 go to **dark places***

*too many moments of
 self-reflection
 can get you
 in a **dark place***

Our embodied, organic experiences of darkness are invoked to grasp Beth's meaning describing an existential, spiritual and emotional state.

Denise's earlier quote above showing her visual image in meditation, also illuminate's Bachelard's philosophy of our material imagination. Denise draws on material imagination, her body's sensory memory of sun, warmth, sand, waves to

Without the hearer's own embodied experience of the meaning of 'glimmer' by experiences of darkness and glimmers of light appearing within it, this abstraction from the material, organic world and its application to an existential state, hope, it would not likely hold as much meaning for the listener. Furthermore, she uses "*clung* to my glimmer" to communicate an experience. It is not 'hold onto' implying a firm grasp. "Clung" requires in us an embodied knowledge of the difference between 'clinging' and 'holding', to understand the tenuous nature of her sense of hope. Both are image-centered knowledge drawn from our embodied life and organic world.

These illustrations invite us to consider further Bachelard's unique concept and meaning in 'material imagination'. In it he contends that human imagination is fundamentally embodied and integral to perception of the world around us, to make sense of our lived experience and shape it with language for communication to another. It is embodied, material imagination, he argues, that invokes experiences, past, present and imagining a future to hope for... or dread, and conveys to another through images that hold potential to evoke their own emotional and visceral response to what is being conveyed.

4.5 CONCLUSION

This chapter has shown the findings in the final phenomenological poem representing Beth, Carrie, and Denise's perspectives on wisdom. It has offered the phenomenological portraits of each which began with their demographic and

biographical sketch gained at the outset of each interview, followed by a representation of findings that quotes their verbatim words, phrases, images invoked through the interview process and emergent as pertinent to an investigation on their perspectives of wisdom, all shaped through my researcher's lens, interpretively. Foregrounded, was a 'wisdom-phrase' that was framed as a 'wisdom-compass' operating sometimes pre-reflectively and sometimes reflectively in their contributions about the ways they found 'wisdom' and formed a 'wise-way' through the struggles and vagaries in daily life with ovarian cancer. The phrase was used throughout their interviews and formed a type of 'action' on their lives as a 'magnetic north' towards which a *poiesis* of wisdom was opened as possibility within their daily life.

The final section of this Findings chapter has offered illustrations for the theory lens of imagination used to cull images in participants' interviews around which the final poem (pp.207-217) representing the findings was crafted. Exemplified is Bachelard's meaning of imagination's role in fostering horizons of hope, assisting us to experience states of reverie, mediating "image-centered knowledge" (1942/1983, p. 7) and how material imagination forms image-centered knowledge to convey our meaning and experiences. Imagination's role in wisdom formation is thus illuminated to show that aspects of their personal wisdom were conveyed through images embedded in their dialogue. In the examples offered, imagination is shown as an implicated silent partner for couriering meaning from one person to another. These examples aim to illuminate the silent role that imagination plays in generating image-centered

knowledge to convey participants' diffuse, intangible dimensions of lived experience, and from wisdom they pass on to us from their life context. Images of birth, climbing a ladder out of a well, nature, anchors, blocks and machines are all embedded in Beth, Carrie and Denise's dialogue and invoke for us a sense of their 'labour' in cultivating wisdom for living with ovarian cancer. This section has offered these exemplars to illuminate the use of Bachelard's philosophy of imagination and the poetic image that undergirds this study. By integrating the images through the craft of poem-making, they are used to engage imagination's capacity in the reader (or hearer) to awaken a visceral resonance and deepened personal insight on the phenomenon of wisdom. The poem is thus crafted around the image-centered knowledge. Every image embedded in participants' interview transcripts was used in the poem representing the findings of this study.

Breathing Space



*the wise heart is the broken heart
the broken heart is the greening heart
the greening heart
is the wizening heart*

CHAPTER 5

DISCUSSION

CHAPTER 5. DISCUSSION

“Science describes accurately from outside, poetry describes accurately from inside [and] both celebrate what they describe.”

“Hymn to Time”, Late in the Day (Le Guin, 2015)

This final discussion chapter offers the insights that findings from this study afforded in the context of contemporary research on wisdom. It frames wisdom’s phenomenological dynamism foregrounding embodiment and imagination as less acknowledged dimensions illuminated from Beth, Carrie and Denise’s perspectives on wisdom. It discusses the implicit wisdom they contributed in light of the mapping of wisdom characteristics found in studies from the psychological sciences fields. This chapter covers: (a) poetry speaking to science: research literature on wisdom, and a map of contemporary wisdom research to situate study findings; (b) findings discussed phenomenologically with image-centered knowledge: a personal wisdom compass, an inner navigator, and magnetic north; (c) wisdom in embodiment and imagination; (d) wisdom and post-traumatic growth; (e) novel methodology of hermeneutic-poetic-phenomenology: ‘soul-medicine’ for clinicians; (f) limitations; and (g) conclusion to the study.

5.1 PARADIGMATIC DISCOURSES: CAN POETRY SPEAK TO ‘SCIENCE’?

Bachelard (1960/1969) stated, “The psychologists do not know everything. Poets have other insights into [humanity]” (p. 125). Placing this study in dialogue

with the impressive body of work by researchers on wisdom in the psychological science fields seems to be a struggle of speaking different languages from their very different 'continents' of genesis. It is speaking across paradigms from different historical times because contemporary science seems to have lost its philosophical bearings as a philosophy, claiming science is *the* description of the world and human life that we must ascribe to and orient our imaginations within, forgetting that it too, is a *philosophy* with its own limits in its ability to describe and understand 'being' and 'becoming' in human life (Haraway, 1976, 2004; Kuhn, 1967, 1977). It truly is a challenge because it is asking poetry to speak to scientists and argue for itself to be considered a worthy discourse partner with legitimized epistemological claims in scientific inquiry, and with 'image-centered knowledge' drawn from material imagination no less, when, thus far in our society's history since the industrial revolution and age of reason, poets and their poetry have been deemed as irrelevant, even useless, to science (Kearney, 1988).

This section is an attempt to speak across these opposite, even, opposing paradigmatic views as a discussion genre must 'speak', to situate the study in a broader field of research to contribute the insights gained in its findings. It is compounded by a double effort to do so by using participants, as wise persons, living a suffering in their whole being, to attempt to make this study meaningful to the medical paradigm, which has gone through its own 'reduction' to speak of illness, healing, quality of life in economy driven metrics that self-justify its own measures of success while practitioners themselves, feel the effects of still

wishing to attend to that which cannot be measured to justify the next budget's resourcing allocations.

The findings offer the opportunity for Beth, Carrie and Denise, as wise persons, to speak as experts from their lived experiences of wisdom to those who are studying wisdom and also to the medical culture of care they each had to navigate. Through this study, I firmly align with Ardel's (2004) contention, "I argue wisdom cannot exist independently of individuals....If this is true, wisdom cannot be preserved outside of individuals. Its distribution in society depends on the personal development of the people who make up society and not on the development of cultural software. The moment one tries to preserve wisdom (e.g. by writing it down), it loses its connection to a concrete person and transforms into intellectual (theoretical) knowledge" (p. 260).

5.1.1 Situating Study Findings in Research Literature on Wisdom

Considerations for writing this section of the discussion that situate this study's methodology and findings in the context of new literature from the field of wisdom research necessitates a recalling of the philosophical and theoretical underpinnings for this study (Chapters 1 and 2). Bachelard (1960/1969) laboured over a project, in which I have only scratched the surface, to find a means for poetics and imagination to be returned from philosophical and scientific exile. Bachelard's phenomenology of imagination which he conducted through his depth inquiry into the 'poetic image' underpins this study's claims to scientific and philosophical traditions that imagination can generate a knowledge, whereby the

poetic-image is restored to an epistemology that gives reverence to the irreducible, *poiesis* and poeticizing dimension of knowing and knowledge mediation. The poetic image, Bachelard (1960/1969; 1942/1983) argued, contains a dynamism and potentiality to release 'knowing' about lived experience from within the poet to awaken a unique 'knowing', resonant, rich visceral, reflective, insight orientated, image-full response, in the reader, as an ontogenesis of new insight, illumination, and transformation in their lives. This study has taken up Bachelard's work, to bring his philosophical project to extend an invitation for dialogue with the psychological discipline's investigations of wisdom with Beth, Carrie, and Denise's contributions drawn into a lens that aimed to show embodiment and imagination as deeply involved dimensions in the phenomenon of wisdom as aspects of human and humanizing 'wisdom-labour'.

The notion of *poiesis* is defined in the Oxford dictionary (2012) as "creative production" and connotes "to make" and links to the meaning of "poetic" which defines as, "creative, formative, productive, active". This term is used a great deal in this section so it is worth highlighting again that the English meanings, seem to impoverish the ineffable, creatively transforming dimension of *poiesis*. I, therefore, use the notion of *poiesis* to connote the creative, spontaneous emergence of wisdom in the individual through their lived experience. Wisdom as *poiesis* is used to encompass a notion of 'the whole' rather than 'a part' because wisdom has been viewed as a "multidimensional characteristic with the whole being great than the sum of its parts" (Thomas et al., 2017, p. 71). Additionally,

poiesis has been chosen as it further elucidates an embodied dimension of wisdom anchoring it with Ardelt's (2004) argument that persons are wise and wisdom disconnected from personhood becomes more related to knowledge, transmitted, but not necessarily transformative until it is embodied in wise persons acting in the world. That said, considerable progress in the cognitive sciences has been made in mapping wisdom characteristics creating theoretical underpinnings for the field of wisdom inquiry such as the Berlin Wisdom Paradigm (Baltes & Kunzmann, 2004; Baltes & Smith, 2008; Baltes & Staudinger, 1993, 2000; Glück & Baltes, 2006; Smith & Baltes, 1990).

These studies from the psychological and human development sciences were referenced in the introduction to illustrate how the wisdom-primer of the Soul-Medicine groups indeed held an array of interventions that allowed for wisdom-resources to be mobilized and wisdom elicitation to be crystallized into the awareness of participants as a 'claim' on their efforts from living with cancer. These contemporary researchers have also allowed this study's finely attuned focus on imagination and embodiment since models such as the 3Dimensional MORE model of wisdom (Glück & Bluck, 2013), and Ardelt's (2004) shift in the focus from wisdom as an "expert knowledge about the fundamental pragmatics of life" (Baltes & Staudinger, 2000, p. 124) to wisdom as anchored in the experience of "wise persons" (p. 260), and incorporate the cognitive, affective, reflective dimensions of wisdom and their dynamic inter-relatedness.

Brienza's et al.'s (2017) highly contributive study to the field of wisdom research states, "Recent insights from research on personality and social

cognition both call for greater attention to state-level processes for a deeper understanding of psychological phenomenon” (p. 25). As the introductory section to this chapter argued, a study of phenomenon in lived experience requires a phenomenological approach (Bachelard, 1960/1969; Heidegger, 1927; Kearney, 1988; Merleau-Ponty, 1945/2006). Phenomenology requires no categories and does not ‘measure’ characteristics in quantity, which are essentially ‘symptoms’ of the phenomenon itself. Even phenomenology cannot capture the totality of a phenomenon, and cannot identify, nor address, all the ‘parts’ for phenomenology will always be required to stop short of ‘naming’ and ‘concretizing’ and ‘operationalizing’. Phenomenology, however, *can* point towards a phenomenon’s presence and features and, as exemplified in this study, bring illumination and embody its dynamism within poetics and fulfill its aim of drawing the reader into their own inquiry into the phenomenon, within their lived experience.

This study designed and implemented its novel methodology of hermeneutic-poetic-phenomenology. As methodology, it can explore the ‘whole’ that integrate the ‘parts’ and show, with a poeticizing revealing, some of the ways that humans become *poiesis* of a ‘wise life’ and so to illuminate an ineffability inherent in wisdom with less constraint than conceptualizations of phenomenon wield. Such a methodology has potential to inform the work of researchers who explore, with equal rigor, an examination of wisdom in its ‘parts’.

It was Küpers’s (2005, 2007, 2013), Trowbridge’s and Ferrari’s (2011; 2011), Yang’s (2008) Glück’s (2009), Aldwin’s (2009), and Ardelt’s (2005) calls that research turn toward *Sophian*, embodied, and processual dimensions of

wisdom that informed this study's investigation of hermeneutic-poetic-phenomenology as a methodology for studying wisdom. Very specifically, it was Küpers (2007) work on studying wisdom in leaders through phenomenology and Küpers (2005) call to attend to *Sophian* forms of wisdom and embodiment that provided an affirmation of the structure of the Soul-Medicine groups as a potential 'wisdom-primer', not about wisdom, but to assist with mining for personal, embodied wisdom, and led to extending an invitation for volunteer participants to be recruited from these Soul-Medicine groups.

5.1.2 A 'Map' of Contemporary Wisdom Research to Situate Study Findings

There are researchers in a growing emergent cognitive science research field studying "wise-reasoning" (Ardelt, 2011; Brienza, 2017; Brienza, Kung, Santos, Bobocel, & Grossman, 2017; Grossmann, 2017; Grossmann & Kross, 2014). Others have turned towards dynamic models of wisdom and developing measures that can capture more of the dynamic interplay in wisdom between the affective, social, cognitive (Ardelt, 2003; Glück & Baltes, 2006; Thomas et al., 2017; Webster, 2003; Yang, 2014). Other studies have focused on further integration for bio-psycho-social research on wisdom (Thomas et al., 2017). Furthermore, studies have sought to refine existing scales and measures developed in earlier research that identified wisdom 'characteristics', as well as exploring new ones (Baltes & Kunzmann, 2004; Baltes & Smith, 2008; Baltes & Staudinger, 1993, 2000; Glück, 2017a; Glück & Bluck, 2011; Hu, 2017; Webster, 2007; Yang, 2017).

In addition, the influence of gender (Aldwin, 2009; Glück et al., 2009) and age (Ardelt, 2018; Pasupathi, Staudinger, & Baltes, 2001; Smith & Baltes, 1990; Thomas & Kunzmann, 2014) have been studied. Social-ecological influences on wisdom drawing in factors of education, socio-economics, culture (Brienza, 2017; Hu, 2017; Igarashi, & Aldwin, 2018; Lee, Choun, Aldwin, & Levenson, 2015); life contexts such as end-of life (Ardelt & Edwards, 2016; Montross-Thomas, 2018); post-traumatic growth (Linden, 2008; Nijdam, 2018); social contexts such education (Sternberg, 1998, 2001); and clinical care (Farrington, 2015; Vishnevsky, Quinlan, Kilmer, Cann, & Danhauer, 2015; Wykretowicz & Saraga, 2018) have been described. Books integrate the global expertise and richness of wisdom research (Ferrari & Weststrate, 2013; Küpers, 2013; Sternberg & Jordan, 2005).

Qualitative research methodologies are highlighted in Glück's review article (2017b) as generating different types of data using autobiographical data (Glück, Bluck, Baron, & McAdams, 2005), grounded theory (Montross-Thomas, 2018) and video technology (Hu, 2017; Thomas & Kunzmann, 2014).

Wisdom's implicated cognitive-psychological features such as self-distancing and ego-decentering and self-transcendence has also become of interest of late (Grossmann, 2017; Grossmann & Kross, 2014; Levenson, Jennings, Aldwin, & Shiraishi, 2005); as has self-determination and meaning (Bauer, King, & Steger, 2018) and connections between subjective well-being and wisdom (Ardelt & Edwards, 2016). Weststrate and Glück (2017) noted "Exploratory processing of difficult life experience is positively associated with

wisdom” reinforcing clinical impressions that people living with life-threatening cancer, are in a ‘wisdom-priming crucible’ from which insights about wisdom formation and individual’s perspectives on wisdom as it is embodied in their lives might be effectively culled with appropriate methodologies. (Weststrate & Glück, 2017, p. 800).

This body of research informed and supports this study’s methodology of phenomenology and joins an emerging interest in this methodology as a means for investigating wisdom. Recently, phenomenology has been taken up to study clinicians’ *phronesis*, their practical, experientially integrated knowledge and tacit wisdom. Saraga et al. (2018) used Interpretive Phenomenological Analysis (IPA) (Smith, Flowers, & Larkin, 2009) which adapts a number of streams from the phenomenological and qualitative research tradition to offer a method integrated with relative ease into clinically based research. Saraga et al. (2018) conducted their novel study for its use of phenomenology to study *phronesis* in physicians nominated as ‘wise’ with mentoring roles in teaching additional to clinical practice. Findings presented a phenomenon of ‘engagement’ as a salient, guiding dimension of wise medical practice. Saraga’s (2018) further call for a phenomenological approach to medical practice for keeping the ‘whole’ patient, in view, supports the approach taken in this study. This joins with other calls for new integrative methodologies for studying clinician *phronesis* such as practice theory (Bontemps-Hommen, Baart, & Vosman, 2018).

This very brief mapping of the wisdom research field provides a context in which to discuss this study's findings and contributions. First presented is the 'whole', then, will follow the 'parts'.

5.1.3 'Embodiment-as-Wisdom-Labour'

The imagination theory lens culled image-centered knowledge, which has coalesced into three central 'symbols' encompassing phenomenological dynamic, inter-related dimensions in Beth, Carrie, and Denise's 'wisdom-labours'. So named because Beth and Carrie used their experiences of giving birth to their children as an 'image-centered knowledge' for mediating the deep, costly, painful processes they've engaged to labour forth personal 'wisdom' from living with ovarian cancer. Using their lead 'embodiment-as-wisdom-labour' is used as an overarching, image-centered lens through which to read this section based on a view that embodiment encompasses wisdom in human life and perspectives on wisdom and in itself, forms the 'labour' of gestating, birthing, and nurturing wisdom in our lives. It can also draw on the imagining of creative labour in the artisan cultivating a work of art, which in wisdom's case would be a wise life, lived. Labour as an image-centered knowledge can effectively encompass both meanings and more, with embodiment being the circumference encompassing a life of personally formed and lived wisdom, as well as the condition within which wisdom is laboured from.

The following three 'symbols', as aspects of 'embodiment-as-wisdom-labour' are used to explore the phenomenological dimensions of their wisdom

contributions and they might give the reader a way to mull on their own wisdom-labour in these differentiated aspects. These are: (a) an inner '*wisdom-compass*'; (b) engaged by an '*inner navigator*' as a personal heuristic for living life; and (c) each orientated toward and by a processually transformative '*magnetic north*'. This '*magnetic north*' of wisdom's presence, *in potentia*, has can draw us into a culminating '*wisdom-poiesis*', rendered visible within a life journey, embodying, over time, a wise life, reaching consummation, a birth, in our crowning into dying. A person's dying thus becomes, simultaneously, a revealing of a person's life, in its wholeness, as *poiesis*. If a reader has read the phenomenologists, or has been exposed to earlier psychiatry, they will hear the echo, simply rendered differently. The lenses from which I draw for this, is explicated with citations later.

The '*wisdom-compass*', '*inner-navigator*', and '*magnetic north*' of *poiesis*, are imagined from the deep, labyrinth type journey into analysis of the findings and presented as 'found', not necessarily as the *only* phenomenology of wisdom perspectives. Nonetheless, they are suggested as images from which to intuit and glimpse an inherent dynamism to the phenomenon of wisdom found through this study. Beth, Carrie, and Denise's contributions have shown us their 'ways', wise-ways, of living in the face of radical physical, psychological, spiritual, existential tensions and life-limits, provoked by their diagnosis. They've shared their means for becoming wise, 'laboured' into visibility, in one way, through the findings representation, and in another, through their wisdom's embodiment. This embodiment is situated in the materiality of their lives quietly being lived wisely,

albeit, as each stated at the outset of their interviews, occluded to a large extent from their own perspectives.

Along with these images of a ‘wisdom-compass’, an ‘inner-navigator’, and a ‘magnetic north’, Kearney’s (1998) reminder is offered that an image, “...generates a surplus of meaning...proof of a level of meaning which is irreducible to a retrospective correspondence...” (p. 156). Noted also is Kearney’s (1998) caution (in his discussion on imagination in Ricoeur’s philosophy) that, “images can serve to mask as well as to disclose meanings” (p. 155). Thus, these images will inevitably also constrain meaning and insight if adhered to rigidly or taken in any literal sense of a ‘model’ or ‘essence’.

5.2 FINDINGS DISCUSSED PHENOMENOLOGICALLY WITH IMAGE-CENTERED KNOWLEDGE

5.2.1 A Personal ‘Wisdom-Compass’

Emergent in Beth, Carrie, and Denise’s findings was a ‘wisdom-phrase’ encompassing a specific wisdom-phenomenon that both acted upon them, as wisdom, and which also elicited their wisdom in given moments. Each of their wisdom-phrases was selected through analysis to encapsulate this image-based notion of a ‘wisdom-compass’. The image of a ‘wisdom-compass’ draws attention to “organic nature of materialized images” (Bachelard, 1983, p. 8), image-centered knowledge (Bachelard, 1983, p. 7), and his restoration of both to their fundamental context of embodiment as a “poetics of the perceptible, in the

poetics of tactility, the poetics of muscular tonality” (Bachelard, 1969, p. 202). This image of a ‘wisdom-compass’ hopes to mediate the notion of wisdom-at-work in our lives whereby wisdom as a phenomenon acts in its dynamism as a type of ‘compass’ drawing us towards itself as orientation, guidance, a type of “wisdom-praxis” (Küpers, 2007, p. 184), as we are forced to negotiate the struggles and limits of embodied life.

Beth’s recurring wisdom-phrase, worked into her day to day as a type of compass was “be in the present moment”; Carrie’s, “navigating; Denise’s, “do a fresh take”, each functioning as a catalytic and orienting part of the process of becoming wiser. Each encompassed wisdom-as-process whereby their ‘compass phrase’ provoked reflective, affective, and cognitive processes that wrapped them around a ‘wisdom-labour’ for living their life, now. Each phrase also encompassed the dynamic between their daily labours to live life from the praxis their compass afforded, sometimes prereflectively, sometimes in awareness, towards a ‘becoming’ of the wisdom that they found they could articulate to make contributions in the interviews.

Additionally, these wisdom-compass phrases did not form of their own volition but rather seemed to be emergent as an orientating means for an inner navigation, named as an ‘inner navigator’ that could take a wholistic wide-angle lens perspective to integrate ‘what was’, meet the ‘what is’, and create a possible future worth living for with and a pragmatism, *phronesis*, of working ‘a way’ through to live towards that future. Each one’s wisdom-compass afforded an inner guidance for responding to life situations, relationships, existential and

spiritual tensions, mortality, embodiment as gift and suffering. Each one's 'wisdom-compass' was in one sense, somewhat taken-for-granted in daily life yet found in their data as something into which the 'whole' of their perspective(s) on wisdom seemed resonant with an invisibility to wisdom, as Denise highlights, that it is invisible to us and "so close you don't see it". Yet, over the micro-moments where this happened, day in and day out, Beth, Carrie, and Denise, met by me in the groups and interviews, and met by the reader through my interpretation of their contributions, can be encountered as 'wise'. A wisdom *poiesis* (magnetic north of the pull into becoming of wisdom) is rendered visible, even to themselves by the end of the second interview, through a process of reflecting on their acquired wisdom. "My wisdom is" began to open sentences as they opened to the possibility of having wisdom gleaned from such hard struggle and 'work' to offer.

Of note was that in this methodology, a 'central' phenomenon or salient exemplar was not being explicitly sought. Yet it emerged as Denise and Beth's 'go to' when they needed 'a way through' something, and for Carrie, it emerged in the data as her tacit 'go to', it was her embodied way of being with "modus operandi" illuminated well by the frequently used image-based word of "navigating". Their 'wisdom-compass's image-based phrase was chosen as it best captured the spirit, felt-sense and something of their personalities as I, the researcher and support group facilitator, experienced each participant. Each wisdom-compass phrase was also selected because it was resonant, in the researcher's view, to the whole of their two interviews without eliminating

particularly salient story-themes or insights on wisdom. These image-based phrases each evoked a sense of how the recurring phrase functions as sustaining source of inner guidance, a balancing 'magnetic north' and a means to hold out a horizon for themselves of what to do when a way through was not in view.

Their 'wisdom-phrases' thus seemed to function both as compass and as a 'magnetic north' pulling them towards wisdom and a wise-way, in a given moment, and, also simultaneously, as a way of *being*, dwelling both out of awareness, and at times, fully intentional, as a compass 'is-itself' differentiated from the one who holds and uses it. Their wisdom-compasses afforded them the possibility a 'wisdom-*poiesis*', evidenced in the findings, from their navigating moments, days, weeks and years of their life. Articulated or not, their wisdom-compass was operative, in one way or another, with the 'phrase' culled from the findings, as they *were* living their lives, getting out of bed, putting one foot in front of the other, and made contributions to this study that evoked a sense of wisdom, at least in me encountering them.

As with standing on the planet there is no location called 'east, north, south, or west' but a compass is the tool with those labels providing orientation guided by a magnetic north. A compass is not the journey. It requires 'know-how' to use it and implies the experiential dimension of wisdom that Beth and Denise highlight where wisdom is an "accumulation of life experiences" and "a process". It draws in the 'expertise' dimension of 'wisdom', where technical knowledge (*episteme*) greatly assist us with the use of a compass such that differentiate a

seven year olds use from a seventy year olds, but both can learn acquired tacit knowledge gained through experience.

This draws in the clarity highlighted in Glück's (2017b) review article that there is general consensus in wisdom research that age does not necessarily have a bearing on wisdom if reflectivity has not drawn the life-learning from experience. This shows a crucial significance to the integration of tacit and reflective 'knowing' forming personal wisdom-in-life and the reflective-process aspect of wisdom as an evolving of 'becoming wise'. The compass image as a dimension of wisdom's phenomenological dynamism in our lives captures the need for embodied action to make the 'thing' of a compass meaningful and purposeful, just as we must take given wisdom, lay and expert, and 'hand-make' a wise life from it by using it with a destination and intention, a purposefulness, of 'arriving somewhere', to guide us through the process of the journey – towards wisdom.

It further joins with Heidegger's (1927) insight that inherent to phenomena in human lives, *intentionality* makes the phenomenal become reflective and embodied into awareness out of pre-reflective phenomena. As well, he gave insight that phenomena inherently have an intentionality as an inherent dynamism within them. In other words, they act upon us as much as we, on the phenomena. A phenomenon creates us, as we create our insights and embodiment of its presence. This has implications for wisdom, especially as it is sought to deepen its presence in contexts such as health care.

With this in mind, the findings of this study reflect this such that Beth, Carrie, and Denise's 'wisdom-compasses' were not a wisdom 'product' that can be viewed as a 'knowledge' separate from their process of all that went into those phrases emerging as a type of 'compass' in their daily lives, not always consciously. Yet an intentionality to "live today" and hand-make personal meaning from that within ovarian cancer, pulled them into uniquely shaped 'wisdom-labour' embodied by their wise living and was further revealed, to them and myself, in their interviews and culled to further crystallization in analysis.

Such a wisdom compass can be imagined as possessing four points, which might be considered as the (North) embodied, (East) the cognitive, (South) the *sophian* (creative, intuitive, philosophical), and (West) the affective (feeling versus emotion) with its empathic, ethical sensibility. This is not original, as foreshadowed earlier. It is a simplified rendering of Jung's (1971) science of depth psychology studying the psyche and developing his theory of typology that is common parlance today such as 'extroversion' and 'introversion', Intuition, Feeling, Thinking, and Sensing (an early and depth formulation of embodiment) as functions in our psyche, and these are tied in further below (Hilman & Von Franz, 1998). His 'compass' of these four interactive dynamisms in the human psyche provides a helpful orientation to the compass points given above and for the findings on how wisdom seemed to function, phenomenologically, within the participants' contributions.

Heidegger (1971) also integrates a 'four dimensional' perspective on the phenomenal world in human life and existential interior life. His last work on the

poeticizing act of language strengthens his interpretive turn in phenomenology to argue for the phenomenal as 'pre-indwelling' emerging into form in language emerging in our speech that is striving to express the intangible. This turn crystallized the insight that language is fundamentally interpretive thereby rendering an objective description of our lifeworld, a philosophical impossibility. Heidegger (1971) writes, "In saving the earth, in receiving the sky, in awaiting the divinities, in initiating mortals, dwelling occurs as the fourfold preservation of the fourfold...to take under our care, to look after the fourfold in its presencing" (p. 151). The wisdom-compass as a four directional, dynamic aspect of our psyche orienting towards wisdom, if we so choose, therefore has precedence in both existential philosophy, and psychiatry with both sources drawn into Vos's (2014) article on meaning and existential givens in psycho-oncology to orient contemporary investigations in this field.

Further layering of this compass-image can highlight that a compass requires *wise-reasoning* skills in its use. Brienza et al.'s (2017) Study 4 findings "confirm theory arguing that wisdom is related to adaptive psycho-social functioning" with wisdom related to "balanced thinking and attention, adaptive emotional functioning, and a more social orientation" (p. 16). Their general summary of all eight studies highlights that their study has allowed them to "establish the connection between wisdom related cognition and balancing of interests, trade-offs, and inferences one makes about the social world" (p. 25). A 'wisdom-compass' can thus be viewed as also connoting a *balancing* phenomenon to wisdom as developed in earlier studies by Sternberg (1998) and

which emerged as salient in Brienza's et al.'s (2017) multi-study research on dimensions of *wise reasoning*, shown as integral to the social domain. It connotes the inner calibration required to negotiate life's opposing tensions – for example, despair as one directionality, hope another. It brings to bear the means for finding direction and use of the compass to move into embodied action in one's lifeworld. This notion of 'balance' in the holding of multiple tensions featured strongly in Beth, Carrie and Denise's perspectives on finding wisdom' and the social, relationships with self-other-world.

For example, Carrie described many tensions and "finding the sweet spot" in relationships; Beth, a balance between "self-reflection" and "dark thoughts"; Denise a balancing within transformation of identity between "work" as former job, and "work" as relationality. Balancing is seen in these examples as more than a reflective process, while reflectively expressed. It is also more than affect regulation, while this would be implicated. Each of these micro-wisdom exemplars of 'balancing' include many of the characteristics of wisdom mapped in research but the 'something more', a phenomenon of 'balancing', is seen in just these small examples.

Another very recent grounded theory study connotes this notion of balance in wisdom. Montross-Thomas et al. (2018) conducted a study with 21 hospice patients (aged 58-97) and presented a model of wisdom as the base of a see-saw between "active acceptance" and "galvanized growth" with the process being a "pervasive battle that when paradoxically embraced, could lead to contentment – even when the worst of life or death is placed before us" (p 6).

This is resonant with Beth's comment "at some point you have to accept acceptance" and Denise's reflection on her changing identity from a focus on work to relationships, "that's going to impact who I am, who I will develop continually into...as always changing and growing". Yet the see-saw is bi-directional and conjures in one's imagination no place to move towards, unlike the aspect of '*wisdom-poiesis*' that the wisdom-compass symbol affords, orientated around and toward a magnetic north, whilst the see-saw image certainly reflects the inner equipoise strived for amidst multiple tensions and possibilities and limits in life. A compass holds a similar 'equipoise' but also connotes the wayfinding that wisdom requires of us while simultaneously needing a stable orientation to 'something' (magnetic north) and a direction taken into the unknown, oriented by the compass points, as wisdom necessitates in a life filled with uncertainty.

Additionally, a compass moves with the traveller, yet remains constant while always pointing 'beyond'. Orientation with a compass works with this 'beyond' as magnetic north conjuring to imagination the effort, wits and instincts required in wayfinding on a life journey bordered by mortality. As phenomenon, the 'wisdom-compass' phrases seem to function as action upon the women's lives, mind sets, emotions, choices, instinctual responses rather like 'magnetic north' acts upon the compass to guide the traveller. Their 'wisdom-compasses' sustained and provided inner guiding propulsion generating uniquely personal responses to life in 'wisdom-moments' that can be described as micro moments

of wisdom-*poiesis*'. This offers perhaps a more dynamic image of wisdom for us to imagine with than a balancing see-saw between polarities.

The 'wisdom-compass' symbol can thus bring to mind a connection to the '*finding*' dimension of in the phenomenon of wisdom. In the phrases and stories they shared, Beth, Carrie, and Denise's 'wisdom-compass' seemed present, dwelling phenomenologically within them and acting upon them as a type of personal axiom, or life-view, applied in a variety of ways through a necessitated quest for their unique, 'wise-way' through the vicissitudes in their life. However, a compass needs a hand to hold it, a wise mind to use it, an imagination to spur a vision of hope, a direction to move towards, and embodiment to move the traveller towards a destination.

For this reason, I've linked 'wisdom-as-compass' to a notion of an 'inner navigator', our wise being, to guide the journey.

5.2.2 An "Inner Navigator" to Use Our 'Wisdom-Compass'

The concept of an "inner navigator" in a psychological sense (not essentialist sense) is not without precedent in psycho-oncology studies. The 'inner-navigator' as symbol integrates a personal 'wisdom-compass' as a *process* involved in forming personal wisdom and a 'wisdom-compass', as well connotes the 'fruit' that the process of wayfinding-in-life ripens into as personal wisdom such that we become 'wise-navigators' of life's vagaries.

Vos (2014) asks in light of meaning and the existential givens in experiencing cancer as two necessary aspects to be attended to in psycho-

oncology care. In light of these givens he asks, "...how can people trust, develop and utilize their inner navigator?" (p. 14). He further calls for more studies to answer such questions. This study, and the Soul-Medicine supportive care groups that the participants were recruited from, offers one response to this call and proposes such an inner-navigator as containing symbolic meaning for the phenomenon of wisdom in its aspect of 'the one who is navigating'.

To support this notion of an inner navigator Vos (2014) cites existential philosophy and its therapy tradition in existential and meaning-centered therapy (Frankl, 2000; Heidegger, 1927) as well as more contemporary developments in meaning-making psycho-oncology interventions (Breitbart et al., 2015; Holland, 2003; Vos, 2014). He further acknowledges studies that have examined unconscious processes that have explored this 'inner navigation' from within, in Jung (Jung, 1960, 1968). While it cannot be a 'known' in any objective sense, this 'inner navigator' as a dynamic within the human psyche might be considered as an inherent dynamism within phenomenon as human beings experience/relate with them, regardless of the specific phenomenon content. The 'inner navigator' can be imagined as the aspect of our being that can orient toward a phenomenon, such as wisdom. Furthermore, wisdom has been connected with the quest for meaning-in-life and self-determination more explicitly (Bauer et al., 2018) and self-determination, along with meaning-making, connote a 'someone' who is determined and making meaning. I propose this 'someone' to be viewed as our 'inner navigator'.

Vos (2014) provides us with an illustration of its meaning, stating that an “inner navigator is not merely an analytic, heuristic skill, but an *affective, holistic intuition* (Pretz, Sentman, Totz 2007)” (p. 9). He uses the Heidegger’s (1927, 1971) analogy of how this functions in a person who is building a physical house to become ‘home’. He illustrates how the human psyche similarly seeks, enacts, and navigates from an inner pulse to live with a sense of ‘home’ in life enacted, envisioned, and intended-through-action in every nail hammered, every wall raised, in the process of creating a dwelling as both physical and existential/spiritual home in our cosmos. *Poiesis* thus has embodied holistic, affective, intuitive, aspects.

Vos’s (2014) philosophical framing of an ‘inner navigator’ is offered as a lens through which to imagine and reflect upon the notion of ‘inner navigator’ within the structure and dynamic of the human psyche in this discussion of wisdom. This philosophy of ‘psyche’ also generates resonance with Jung’s central (1960) findings from his scientific, phenomenological investigations of thousands of people’s interiority and ‘image-centered’ inner life through investigating the psyche’s archaic layers and language in dreams. In so doing Jung (1963; 1968) redeemed the notion of “alchemy” to articulate to the scientific world of psychiatry the type of inner life the human psyche in its ‘conscious’ and ‘unconscious’ aspects (Bachelard, 1960/1969; Jung, 1963) seems to endlessly create and recreate in our identities across a lifetime. He began to generate his theory of this ‘alchemy’ through the lens of his work on a dynamic typology in the psyche. This typology had four interactive functions of Thinking, Feeling,

Intuiting, Sensing (through the embodied senses) each with their own introverted and extroverted aspects, working as an interdynamism and acting within the person's embodied life and ways of being in the world (Cann & Donderi, 1986; Hilman & Von Franz, 1998; Jung, 1971).

Jung (1963; 1968) later in life went more deeply into the original alchemical texts of the medieval 'chemists' following his love of Latin, as close to a first language for him as Swiss German (Von Franz, 1998), and devoted his last volumes to contending that these early scientists were peering into 'matter' and formulating a psychological 'alchemy' for human transformation that included material dimensions to imagination as a productive knowledge, differentiated from the conceptual formed in thinking processes, similar to Bachelard's philosophy of 'material imagination'. Jung (1963; 1968; 2009) traced the medieval alchemists' efforts to when their secret worked reached a dead end in the late eighteenth century, preceding the emergence of psychiatry as the field of science gained its stride also peering into the unconscious life embodied in materiality. Without needing to argue whether his theories of the psyche are valid for present day sensibilities, I have brought his work to stand alongside Vos' (2014) philosophical framing of a notion such as an 'inner navigator' in the human psyche that orients us towards ways that we live within the tensions life provokes and still create a life that is lived.

It seems to me to be, alongside the phenomenological philosophers to whom I am indebted, that somehow within the structure of phenomenon, as humans peer into them, there is a dynamism between how we orient towards

them and how phenomenon act *upon* us, seemingly from far beyond our awareness, to foster a *poiesis*, of themselves, wisdom, hope, for example, at least in moments, but over time, across a lifespan, possibly becoming a fundamental orientation of the life that was lived, revealed in hindsight. The same is true of more negative phenomenon such as stigma or inculturated forms of oppression.

Within this framing, I invite a consideration of how each participant's 'wisdom-compass' *seemed* to integrate an inner 'alchemy' of thoughts, imaginings, behaviours, spiritual and existential states. As compass, it was moving them, with some kind of orienting 'inner navigation' to a *finding a way*, in specific moments, particularly through the difficult ones, inwardly, towards a 'good' created within their imaginal life, as a horizon of hope, through a *Sophian dimension* of wisdom (as the creative, intuitive, philosophical, imaginal). This allowed for a movement, guided by an inner navigator *finding-their-way* towards an inner vision/image of a horizon of hope that could foster a sense of wholeness-in-life, for living with today. This horizon, lying beyond the difficulty and realized, if only for moments at a time, but also intuited, as a wholeness into which, their life might be lived towards, with their dying as *poiesis* of revelation of a life, wisely lived, through the challenges of ovarian cancer. The poem of findings certainly evokes this sense of possibility as imbued with wisdom, earned from their labours.

To bring this back to exemplars to illustrate: for Beth, this meant finding a way to overcome the 'dark thoughts', which involved more than simply thinking

better thoughts. Her 'wisdom-compass' phrase 'be in the present moment' anchored her to something that generated a *poesis* in how she lived a particular moment and lived it differently than the emotional-mental-spiritual struggle she found herself in, that moment. It functioned as a sort of anchor and guiding practice when watching her grandchildren at Christmas when grief poured into tears mourning that she may not live to see another Christmas with them. Then she heard her daughter remind her to "be in the present moment" and she realized she could, and must, make positive, comforting memories, that moment, for their future. The 'now' and 'then' was her tension of opposites. "Be in the present moment" anchored her to a meaning-making task, to turn her grief towards a work that changed her lived experience, in the moment, to both *include* grief *and* integrate meaning and action to 'make memories'. The inner navigator took a hold of a transcending function that move her through the moment without repressing or dismantling either opposite while a new Beth emerged from it, encompassing both polarities into a third, new way forward.

From then on, Beth used that phrase as her 'go-to' of sorts to respond differently to distress states or problems faced in a day and provided a way to keep returning to 'here', in the "present moment" as task, source of meaning and hope. When the present moment was difficult she used temporality to move herself out of distress in the present moment and into an imagined future by making fun, pleasurable plans or took herself to past memories for comfort so she could return to the present and "be here, now" in less distress.

For Denise a wisdom-*poesis* spontaneously arose as “realization” crystallized into image and words in her art-collage pictorially and textually incarnating what “do a fresh take” could mean in her life. She used both art-collage as ‘icon’ and the words to return to over and over before, during and after moments of difficulties faced. “Do a fresh take” created in her own view a whole new identity post diagnosis for Denise around the meaning of ‘work’ from a job to an identity of being aunt, sister, friend and focusing working on her relationships as primary. “Do a fresh take” enabled her to look differently at her own relationship with herself and to enact a different processual wisdom to foster greater kindness and care for herself in daily life. Her wisdom-compass made her engage many situations and herself differently.

Carrie’s “navigating” was exemplified in many stories moving her inward to solitude to work through the emotional impact of diagnosis and when she needed a break from city life and people, moved her outward into her close relationships, towards nature, art and fun plans and particularly aided her in managing difficult medical situations when she felt that she needed greater agency and decision making power to guide her care. In Carrie’s case “navigating” was an intuitively embodied way of living. It sourced her with a ‘modus operandi’ for her getting through and navigating a wide variety of situations, medical, personal, social, interior distress. It provided propulsion and directive towards particularly resistive behaviours (“I put my lipstick on!”) in medical and social contexts that were unhelpful, as well as generatively gave her a means for resourcing inner strength, an iron will moving *machine* like with *both blocks forward*. Thus, each

participants' 'wisdom-compass' seemed to create many moments of a *poiesis* of personal wisdom in their living with the diagnosis whereby wisdom became a creative, intuitive, holistic response moving them from within to a different attitude, interior emotional state, mental focus and new embodied forms of action.

Their wisdom-compasses seemed to dwell within the participant's contributions but not in cognitive ways that they articulated it as such. This study's findings also seem to imply that while meaning from life experiences is drawn by the participants, and connected to wisdom, this inner navigation process with a personal 'wisdom-compass' captured in their image-based phrases, while connected to meaning in the dialogue about wisdom, through their sharing of their stories was not necessarily driven by a search for 'meaning' per se, but rather more shaped by a fundamental need to "get through", "put one foot in front of the other", find a way toward "being here now" with some emotional stability, comfort, peace, hope. This evokes the a sense of 'wisdom-labour' as somehow differentiated from a search for meaning, while meaning-making is evident as a creative emergence from their lived wisdom-forming labours.

Beth, Carrie, and Denise's wisdom-compasses seemed to provide them a *what* (content) for getting through a difficult moment; a *how* for inner navigation informed by a *why* (meaning), toward which the compass could orient; together a wisdom-in-action, *poiesis*, was generated, pulled by a magnetic dynamism within the phenomenon of wisdom-being-made, through daily living. A 'magnetic north' of their lives lived as an embodied wisdom-*poiesis* was not consciously held as a

'goal' by any participant yet wisdom emerged, from their persons, in their stories of a 'being wise', dwelling in the lines and spaces between of the final poem, elicited from their lives through a reflective, dialogical, relational process. These 'found wise-ways' crystallized into reflections on wisdom to pass on, to us, perhaps as a hope for our own way-finding capacities and some 'wisdom-compass' directions ("be in the present moment", "navigate", "do a fresh take") to take up and live into, should we wish.

An 'inner navigator' using a wisdom-compass created through 'wisdom-labour' sparks and integrates, both contains and moves us, both orients and yet cannot show the destination in front of us, moment to moment. Beth, Carrie and Denise show us how a phrase crystallized in their lives, Beth and Denise, consciously, Carrie's embedded and dwelling within her stories and insights, each containing a 'hidden' image. Carrie was navigating, without setting out to 'navigate' as a conscious thought about wisdom or her own wise-way through the day. It suggests that cognitive assimilation of their 'wisdom-compass' was not a necessary precondition to their experiencing their own unique 'wisdom-compass' formed through trial and error and out of awareness, as Denise said, "invisible to us", and lived in varying degrees of prereflective to reflective ways as life 'goes on'. This brings us to another investigation emerging in wisdom research literature as to links between subjective-well-being and wisdom and I propose that while they can be connected, wisdom remains elusive as a direct correlate to a feeling of 'well-being' in its formation, or acquisition-in-life.

Ardelt's (2016) recent study offers findings that wisdom is connected with subjective well-being at end-of-life. Meaning-in-life is one aspect of subjective well-being (Vos, Craig, & Cooper, 2015) and together as a conceptual framework they give context to life experiences, typically in reflective modes with hindsight. Yet 'being wise' may not always provoke a sense of well-being. Indeed, sometimes the wise view provokes the opposite when it receives little affirmation or credibility from the social matrix around the person seeing and embodying a wise view. For example, when Carrie describes, "sometimes you have to be ruthless" when it comes to refusing people's well-meaning help, or isolating yourself for ten days after a radical, life-threatening diagnosis. It can also mean a person has to walk in the opposite direction to what seems logical and this can invoke a suffering, within, while an imperative drives a person forward to do so anyway. This draws in the creative, intuitive and holistic dimensions of wisdom that are part of human's capacity to generate spontaneous responses to adversity that can seem, to others, even if not to oneself in the moment, as wise. A *compass* can bring to mind a deeper connection to the '*finding*' dimension of phenomenon and differentiates it from a feeling of subjective-well-being thus preventing wisdom being held out as a promise similar to optimism and a happy life.

This may be perhaps why investigations of wisdom through cognitive sciences may reach limits past which, the dynamism will struggle for articulation within its language and disciplinary constructs that must, necessarily study human cognition in its 'parts'. It is not given philosophical or methodological

apparatus to access the more unconscious, intuitive, holistic dimensions of wisdom as holding positive potentiality for human living and knowing (Bachelard, 1960/1969; Von Franz, 1998).

It is therefore proposed that wisdom, as a phenomenon from these three participant's contributions, is similar to the *phenomenon* of a 'compass' dwelling in potential, engaged by an 'inner navigator' integrating wisdom-*poiesis* as a generative *capacity* and *fecundity* from their life-quest always *in potentia* yet also as a 'being-found' and becoming a 'wise-life'. In Beth's word, wisdom comes from "an accumulation of life experiences" and from this is a 'creating', a wisdom-*poiesis*, within the 'micro-moments' of finding wisdom and a 'wise-way' in life's particularities.

5.2.3 Wisdom's 'Magnetic North': Poiesis of a Wise Life, Lived, Revealed in Our Dying

Wisdom-as-*poiesis* can be linked to Leggo's (2005) reflections "poetic knowing and poetic living" (p. 443) on living a poetic life where our life reflects, "wisdom teaches us the art of living" (Ardelt, 2004, p. 268). Yet, in their day to day, I have no doubt that 'poetic' would be the last word Beth, Carrie and Denise would use to describe their experience of themselves and their lives. Yet a *poiesis* of wisdom, culled into the findings poem, emerged nonetheless.

A 'magnetic north' as the invisible 'pull' that the phenomenon of wisdom can act through in our lives can link to Jung's (1960) proposal of the "Transcendent Function" in the psyche (pp. 67-92). The Transcendent Function

is a dynamism in the human psyche that holds *capacity* to find a 'third' way through the agonizingly held opposites threatening to pull our very being apart. It is the 'finding' capacity pointed to from within our current 'self's' deep and painful encounter with the limits of our personality, our persona's (performing self (ves)in the world), and our most precious held values dismantled through life sufferings. The individuating impulse pushes us through into a subsumed future 'self' that has held the tensions of life's 'opposites' and in the holding, with all the emotional, spiritual, existential, psychological, embodied suffering this entails. This holding of the tension of opposites, often need wise guides and companions to sustain us so that the tension, rather than breaking our minds and spirits can bring the sufferer into a *poiesis* of a new 'self' as together, sufferer and wise companions, orient to a hope in a wisdom dwelling at the heart of their life and nature's way within them. This emergent self who has traversed the death of an old identity, forced upon them by life's complexities and devastations, now embodies new ways of being that transcend the former opposites (values, identities, 'lifeworlds' of careers, relationships and so forth) into a third way of being, arguably a wiser way, if a way through is discovered and mental collapse has not ensued in the suffering (Jung, 1963; Jung, 1968; Von Franz, 1998; Woodman, 2001a).

So, a 'magnetic north' in the phenomenon of wisdom, pulls on us, acts within us, to propel such transcendence towards a new way of being, a new perspective that can be held to negotiate 'this', today. The phenomenon of wisdom, if orientated towards, thus engages a 'transcending function' within us,

which, with a “wisdom supportive environment” (Küpers, 2007, p. 181), may evolve a wise self that is living the ‘what is’ differently, in a wise living of the new life from the ashes of an old one consumed by a life-altering experience. As Carrie’s phoenix art-collage captures for us.

A ‘wisdom-compass’ as an image of pointing towards ‘a way’ without ‘arriving’ at ‘magnetic north’ while oriented by it, connotes a necessary tentativeness to ‘wisdom’ in that there is truly no certainty in responding to life situations we find ourselves in, and absolutely no guarantee that we will ‘be wise’ or find a ‘wise-way’ through them. In retrospect, often, it might be viewed as ‘crazy wisdom’ that something came from the experience while the situation itself seemed appalling and our choice, crazy, at the time bringing to mind Sternberg’s perspective on “foolish wisdom” (Sternberg & Jordan, 2005, pp. 331–353). Crazy wisdom formed by using an inner ‘wisdom-compass’ does not conform to a commonly held belief that “there is a reason for everything”. Rather it suggests that somehow, somehow, as obstacles to the ‘logical choice’ or the ‘logical way’ present themselves, the crazy choice around and through them, in retrospect, seemed wise or, at the very least, formed a wisdom that is then integrated when facing similar obstacles. It is the wisdom of the river finding the ocean but with the logic of linearity and flowing around, over, through the resistances and obstacles it encounters along the way. Following the lay lines of wisdom in our lives it can feel is as if we are told to, “go straight on the road with ninety-nine curves”, a zen koan that captures the complexities that medical practitioners, or patients with cancer most certainly are forced to navigate.

These symbolic images connote a processual dynamism in wisdom as a phenomenon but without implying that *poiesis* is akin to accumulation and acquisition of 'wisdom'. Rather, the symbolism of the images reflect a dynamism in wisdom, when investigated phenomenologically, i.e. in a 'whole' as well as its 'parts' interactive and dynamic. Wisdom seems to form and reform the person in a process of making and un-making towards an embodiment of 'being wise' rather than a person who has 'lots' of wisdom and implicates embodiment itself as an aspect of the 'labour' of the process of creating wise-moments, wise-ways found, wisdom integrated through experience all moving towards encompassing a wise-life that has been *embodied* within an individual's lifespan.

These images of a 'wisdom-compass', an 'inner navigator', and a 'magnetic north' of wisdom-*poiesis* are offered as image-centered, symbolic language about an inner, ineffable phenomenon to simply present a possible cartography by which to contemplate the phenomenon of wisdom. Such a journey towards 'wisdom', as we can know in our own experiences, is almost inevitably non-linear, as is the river's process is dependent on and must work with, and around the terrain as it flows to the ocean taking up things along the way, leaving them behind in others, and always leaving nourishment as a wise life might, wherever it flows. Yet an inner compass, worked with by an 'inner navigator' who is reflective, able to "reflect", "process", "realize", and apply one's wisdom, as Denise proposes, who is also reflexive and able to critique the social world to individuate one's own wise way from collective norms and scripts, and who has an ethical sensibility that orients choices of character and responses to

oppressions and injustices enables an active movement towards a magnetic north of 'wisdom-*poiesis*' across a lifespan and be something like the river in how they move through the terrain along the way.

Without deep and dedicated attention to the poetic dimension of life in its *poiesis* aspect, studying wisdom's processual nature using cognitive science methodologies might all too easily slip into more mechanistic, reductions of wisdom. If this happens then what is learned from the research becomes 'knowledge-about-wisdom' that is then subsequently operationalized in applied psychology such as in business, organizational and leadership development in ways that miss the embodied, tacit intangibles of the conditions needed for a deep, inner formation of wisdom-as-*poiesis* for a wise life and wise living....and wise organizations through the lives of leader's living their embodied roles, wisely.

The participants' 'wisdom-compass' was more than simply an idea, taken from Hallmark cards or popularized spiritual self-help culture, nor even only a mantra. Their wisdom-compasses of "be in the present moment", "navigating", "do a fresh take" emerged from their embodied lives, selected as an orienteering 'compass' by an 'inner navigator', and pulled, drawn, by a deeply personal, often prereflective 'magnetic north', guiding them *towards* something as *orientation* in the *present*, *integrating* the past, and, *showing* a 'magnetic north' of whatever is pulling them through, *revealing* a direction to their lives as a movement toward a *poiesis* of 'being' (who they've become) through a *poiesis* of becoming (who they will be).

Magnetic north in a 'wisdom-compass' formed by the individual's unique particularity, draws us into a poeticizing summation of a 'wise life' in someone who has learned 'the art of living', through wisdom. Wisdom is both teacher within our lives and embodied revelation through our socio-material particularity and uniqueness. Embodiment is thus the circumference, the centre, and the journey in-between, of one's 'wisdom-labour' in life and wisdom cannot be dislocated from this 'facticity' when we consider wisdom in human lifeworlds. Humans are embodied creatures and embodiment is the *condition* that constitutes our wisdom-labour, birthing wisdom-*poiesis* in and through our lives.

It is suggested, therefore, that embodiment-is-wisdom-labour.

5.2.4 Summary

The previous section discussed inter-dynamic, intra-dynamic, processual, and *poiesis* dimensions to wisdom by using the symbolic images of a 'wisdom-compass', created and engaged, re-made time and again through life's vagaries, by an 'inner navigator' who is wayfinding towards a 'magnetic north' of *poiesis* into a 'wise life', lived, revealed fully, in their dying.

While none of these participants would likely feel their lives as 'poetic' or as living a *poiesis* of a wise life, others around them, however, might bear witness to an emergence of something respected, valued, loved, embraced in their lives and reflect back to them their *poiesis* of their becoming and being wise in living with ovarian cancer. This points to wisdom as occluded in our own view

of ourselves and its invisibility as an inherent part of its 'nature' and highlighted by Beth's statement, "you don't see how hard your working, inside".

Does a person living a 'wise-life' need to consider themselves wise for their wisdom to be known in the world? Does wisdom gain value and agency when articulated and shared or is 'being wise' enough for wisdom to be mediated in the world around us? These questions bring us to the phenomenological dimension of *embodiment*, highlighted as a fundamental to wisdom through this discussion previously. Within this lens of embodiment is also a discussion on the body's implicitly entrained dimension of *relationality* and also restores *imagination* as a fundamental dimension of embodied life, found in wisdom's phenomenological dynamism through Beth, Carrie, and Denise's contributions. With the theories of imagination previously laying the foundation, this discussion lends support to Bachelard (1960/1969) and Kearney's (1998) contention that imagination is its own form of knowledge generation, fundamentally arising from *embodiment* and different in species from logic, concepts, and reflectivity, while these can engage imagination in its knowledge-generating activity through image-centered knowledge and material (embodied) imagination. Various aspects within these two dimensions of wisdom, embodiment and imagination, are linked to the literature on wisdom that has pointed towards some dimensions within them, but without formal connection to either embodiment, or imagination, as agents within the phenomenon of wisdom. These two dimensions of embodiment and imagination are therefore highlighted in the next section of this

discussion to show how both connect to emergent themes from wisdom studies and directions for further investigation to which, this study may contribute.

5.3 WISDOM IN EMBODIMENT AND IMAGINATION

This section discusses findings through the inter-relating theoretical lenses of embodiment and imagination. Imagination, as embodied, is the lens through which findings for *sophian* dimensions of wisdom are discussed. The feminist bioethics findings are woven throughout.

Discussion on Embodiment includes: embodied relationality with ‘other’; embodied relationality with ‘self’; embodied relationality with nature; embodied relationality in wise care; embodied relationality with ‘ethical sensibility’ as including *empathy, agency, subjectivity, epistemic power, (re) embodying lost knowledges*; embodied ‘knowing’; embodied temporality; embodying wisdom’s invisibility; embodied reflectivity.

Discussion on Imagination includes: embodied-intuiting; embodied-creating; embodied-spirituality; embodied-imagining; reclaiming the *sophian* in wisdom.

Following these discussions of Embodiment and Imagination findings is a discussion and problematization of wisdom and post-traumatic growth. Finally, in closing is a discussion of the use of this novel methodology with learning reflections and suggested implications for further uses, followed by a discussion of some of the study’s limitations, and conclusion.

5.3.1 Embodiment

This study acknowledges a hopeful turn that is taking place in recent decades towards more embodied understandings of knowledge. Specifically there has been a call for more focus on embodied dimensions of wisdom (Ferrari & Weststrate, 2013; Küpers, 2005; Sternberg & Jordan, 2005). As Glück (2017) states, “Another domain that has not yet been investigated is actual wise behavior. All our measures focus on verbal responses, but it is likely that just like morality, wisdom manifests itself in nonverbal intuitions as much as in verbal reflection...it may be very interesting to look at how wisdom actually manifests itself in real-life situations” (p. 8). Implicit to these statements is embodiment as a phenomenon (prereflective and reflective) versus behavior as its expression (symptoms). This is perhaps where phenomenology can lend assistance studying the deeper intrinsic dynamisms within phenomenon, such as wisdom, and particularly on such an entrained dimension of human life as embodiment and a focus on wisdom as intrinsic to wise persons.

Park Lala and Kinsella (2011) draw attention to Merleau-Ponty’s central tenet, “We do not have bodies, we are our bodies” (p. 78) as salient for phenomenological research with ill and dying persons. Johnson (1990) offers to us a notion of embodied mind showing how ‘balance’, to have meaning in our minds, is drawn on learning ‘balance’ in body from the moment a toddler learns to walk, in its visceral dimension, to a young child understanding an abstraction of a see-saw as having ‘balance’, to an adolescent grasping the parent’s meaning of ‘balancing the books’. His argument is that thinking is *embodied*

thinking and how we experience the world, shapes thinking and our embodied mind's way of living, interpreting, acting in the world which can shape entire systems of beliefs and actions within individuals, societies, and for example, religions (Butlin, 1999). As such, 'embodiment' itself, cannot be reduced to a category into which *how* it manifests in individual people, embodied in the world can be subsumed. It can, however, through wisdom's reflective dimension come to insight on the role that embodiment and imagination plays in wisdom-formation. This is captured in the term 'wisdom-labour', used throughout this discussion, to reflect *both* the *process* aspects and '*birthing*'/*poiesis* of wisdom as inter-related and fundamentally *embodied* dynamisms within wisdom-as-phenomenon.

In the following section, reflectivity and imagination are discussed as *embodied* phenomenon in relation to wisdom. Other dimensions of findings that confirm previous literature findings, as well as the unique contributions this study offers, are all anchored into 'embodiment' as the encompassing context for wisdom-labour in our lives.

Anchoring each finding and aspect of wisdom, discussed below, into an embodied aspect 're-embodies' aspects of wisdom that other studies have dislocated from their embodied dimensions. This is another use of the embodiment lens used in this inquiry, The use of this lens to frame each finding on wisdom lends productive agency to locate wisdom in wise persons, as Ardel (2004) contended. Embodiment *is* an epistemological contextualization that

anchors wisdom into persons acting wisely, creating wise socio-cultural mores but that still nonetheless, are empowered or diminished by persons.

I propose that relationality and embodiment are utterly entrained phenomenon. “Prosocial” values have been identified as an aspect of wisdom by the majority of researcher’s on wisdom (Bangen, Meeks, & Jeste, 2013, p. 3). Relationality encompasses relation with self, other, and to the world (social worlds and the world as ‘cosmos’). With Ardelt’s (2004) assertion that “that wisdom teaches the ‘art of living’, beneficial to self, others, society” (p. 272) it can be argued that relationality is inherent within the phenomenon of ‘wisdom’. A desert-father in the ancient monastic world still lived in relationality with the desert and embodied world and within a relationality with his own embodied nature. Yang (2008) argues for a process view of wisdom. Wisdom has also been described as an embodied “emergent event” arising from the “space in-between” (Küpers, 2007, p. 181) rather than simply being a form of static knowledge one ‘possesses’. Embodiment, process, and relationality are therefore mutually implicated dimensions in this study’s findings on wisdom.

The interviews for the study itself additionally seemed to offer a form of relationality as a “space” to “learn the human” (Kumagai & Naidu, 2015, p. 287) in terms of learning about wisdom within our human lives, together, and wisdom was elicited. We might consider relationality as a crucial ingredient in wisdom formation and dwelling behind relationality is embodiment. Further aspects of relationality and its connection to wisdom, through Beth, Carrie, and Denise’s perspectives are now highlighted: (a) embodied relationality with ‘other’; (b)

embodied relationality with 'self'; embodied relationality with nature. (c) embodied relationality in 'wise care'; (d) embodied relationality with 'ethical sensibility'.

5.3.1.1 Embodied Relationality With 'Other'

Beth, Carrie and Denise affirm the role relationality played for experiencing and sourcing wisdom. Beth affirms there was wisdom in "reaching out to other people" and uses her art-collage of cards given by friends and loved ones as a source of hope and comfort to remind her that "I am not alone". Denise gives us insight that wisdom is more "dialogue" in a "wisdom conversation" versus a conversation of giving or receiving advice. In a wisdom conversation, "there might be understanding" alluding to a nuanced dimension of insight as somehow linked to an embodied experience that implicates emotion, connection, 'presencing', together. Carrie notes "I found a lot of strength in being around other people". Küpers (2007) specifically calls for developing and fostering embodied wisdom through "post-dualistic relational forms of wisdom" (p. 181) and also in group situations that foster a "wisdom supportive environment" (p.185). Denise describes this type of emergent experience from the *Soul-Medicine* group designed specifically for women living with ovarian cancer, which preceded her recruitment to this study. Denise discusses how conversations with friends also helped her form personal insights that she framed as her wisdom. She also identified the role of the group as an "eye-opener" for attuning to her to wisdom and her own access to this within herself and the world around her.

5.3.1.2 *Embodied Relationality With ‘Self’*

Focusing on relationality with oneself is perhaps a less obvious aspect of ‘relationality’ but it can also be seen as an aspect of wisdom in changes of attitude and actions towards oneself as we live orientated to wisdom for embodying a wise life. Glück and Baltes (2006) state that their earlier wisdom studies found that “increases in wisdom-related performance can be produced without teaching participants any new knowledge” (p. 680). Relation-with-self is a wisdom teaching that acts upon us, so Beth, Carrie, and Denise discovered more provocatively when diagnosed with ovarian cancer. Each identified new ways of being in relationship with themselves that also provoked reflection on the difference in this regard, from before diagnosis.

Denise highlighted ‘self-compassion’ as a practice for attuning towards one’s own needs revealed a prior pattern of feeling guilty when she stopped ‘doing’ compared to an absence of “feeling guilty” when taking naps after she was diagnosed with ovarian cancer. Beth noticed a change in relation to herself realizing a type of dictum of “put others first”, especially as a mother towards her children who “always came first”, and instead began to put herself and “my little pleasures” first instead, once confronted with a terminal cancer. This too was laced with guilt feelings that she named, like Denise, as part of this process.

The feminist bioethics lens identified these changes as somehow moving out of a form of inner colonization of values causing a self-sublimation for ‘other’ in a society that values extroverted forms of prosocial behaviours for women. In Beth, Carrie, and Denise’s interviews there were fulsome descriptions of their

efforts to discover different relationships with themselves in light of prosocial values that oriented them heavily towards 'other', shaping their life in the multiple, overlapping roles in their relationships. These were disrupted by a physical necessity with ovarian cancer that brought guilt feelings into awareness to them as they wrestled towards a different balance between self and other. In Beth's case, these feelings were reinforced by her "Catholic guilt" to put her children and others first, the religious ideals instilling prosocial 'for other' living in self-sacrificial behaviours. In Denise's case, the 'ideal' instilled was for work; in Beth's case, for her adult children. As mothers, Beth and Carrie both described tensions such, for Carrie, it was "walking a tightrope" balancing giving hope and positive outlook to her daughters with "the facts" about the diagnosis.

These guilt feelings were framed with a feminist lens in analysis as a form of 'colonization' because the guilt, a human emotion/state, was reinforced and entangled with social and religious scripting where 'self' was in a sense, 'exiled' for 'other' as an embodied, inscribed ideal they themselves found themselves needing to renegotiate. As hard as it might be for some to resonate with this feeling over taking naps, I can affirm from my clinical experience that guilt is one of the primary focuses in conversations as it is raised to awareness by cancer's provocation to differently respect physical limits of energy, time, endurance in relational negotiations. The majority describing guilt's diffuse grip on their lives in my practice, have been women.

Carrie also noticed changes that required putting her needs more centrally in relation to others and states, "you have to be ruthless sometimes" in not

allowing specific people into her support circle who cannot give what was needed at the time. Reflected is an experience of 'ruthlessness' required to 'sign-off' social, religious types of scripts about what a 'good friend', or a 'good person', or a 'good employee, in Denise's case, is or must do. Carrie uses solitude to relate with herself and meet personal needs, which might, by some, be experienced as anti-social when well-meaning offers of help are denied. Her time after the diagnosis staying back from a family holiday, shutting the blinds on the house and cocooning so that she could "go inward to come out strong" reflects a relationality with herself that was influential in forming her wisdom contributions to the study. It would be interesting to tease out how self-compassion connects to wisdom in a similar way as Neff (2011) has studied interactions between "self-compassion, self-esteem and well-being" (p. 1). Each negotiated a balancing of relationality in their day to day and, in fact, it was a fairly significant focus generated by their stories in their interviews.

In studies measuring prosocial and antisocial behaviours such decisions to relate differently with one's self might receive negative reactions from others and be perceived, even perhaps scored in psychological categories as 'antisocial' and thus possibly, not wise. Yet this negotiation can be acutely difficult and courageous for the individual. Relationality with oneself might be deeply implicated in 'becoming wise' whereby one honours one's unique self that has limits and limitations and sometimes simply has to say 'no', particularly through a feminist lens that brings a hermeneutic of suspicion to prosocial values that seem to inscribe women's lives, unreflectively.

I propose that paying attention to how we interpret “prosocial values” identified as significant to wisdom (Brienza, 2017; Glück, 2017b) and scored in validity tested measures are also viewed more critically through a feminist lens attuning to interpersonal, social and intrapsychic dynamics of ‘colonization’. This might be helpful for discerning unreflexive bias in how relationality and wisdom are viewed and also, how studies are designed and interpreted.

5.3.1.3 *Embodied Relationality With Nature*

Relationality with nature was an aspect of Beth, Carrie, and Denise wisdom in turning to nature for solace, hope, and also, wisdom, as shown in the final poem. A sense of connection to the earth and cosmos as ‘home’ is implicated in Bachelard’s (1960/1969) understanding of reverie when he speaks of “cosmic images” that “weave bonds between [humans] and the world” (p. 189) (gendered language changed). For Denise, a relational sense of the world included water, waves, sand, used both physically when she could be there and also in her imagination in meditative practices to invoke a ‘being there’, even when away from water and sand, to centre herself through difficult feelings and even to sustain a vision of an afterlife pushing back her mortality as ‘end’ to a threshold into a desired, hopeful, future.

Carrie describes the “elements” experienced in nature kayaking and sailing throughout her life as forming an inner strength which shows an evocation of Bachelard’s (1942/1983) “material imagination” (p. 183) where language arises, shaped by the elemental, material, organic experience of our body,

intimately connected to the elements of nature forming expression for interior states that otherwise, would be mute. The “elements” are Carrie’s teachers that she describes as giving her a strength that others formed by city life don’t seem to have, in her view, for having strength in the vicissitudes of life when your life-kayak, is upended. Beth and Denise turn to nature explicitly to source comfort, walks away from “civilization”, for Carrie, walks with friends or alone to see the flowers, for Denise.

An interbeing (Nhat Hanh, 2013) experienced with nature engages a “poetical imagination” (Kearney, 1998, p. 46). The poetical imagination, nourished in reverie opens the cosmos to us as a language and a home, even perhaps a wisdom-language ‘speaking’ to us within. As Bachelard (1960/1969) writes, “A fruit, a flower, or a simple, familiar object suddenly comes to solicit us to think of it, to dream near it, to help it raises itself to the rank of companion...” (p. 153). I have added relationality with nature, therefore, as an aspect of embodied relationality, familiar to many, longed for by most in busy urban lives, but tending to be submerged in research literature examining ‘relationality’ as an aspect of wisdom. Contemporary scientists have used their scientific expertise to weave a renewed imagination through their books of our interdependent relationship with earth as ‘home’ and source of life for us (Capra, 1996; 2010; Wohlleben, 2016).

Bachelard’s (1960/1969) suggested remedy is the phenomenon of “poetic reverie” in which we can be opened to an experience where “all the senses awaken and fall into harmony in poetic reverie” (p. 6). This different world is one

we open to in reverie upon a poetic image, or the interaction of nature, the cosmos, and our experience of our lifeworld provoking poetic images that we bring into speech to mediate our experience of the world. Differing from mindfulness practices where thoughts are viewed as streams through our awareness but not focused on, reverie responds to the desire to dwell, dive into images unfolded in nature, in life around us, in a poetic image within a poem, even a crack in a wall according to Bachelard, and to allow imagination's knowledge-generating, *poiesis* capacity to take us into an indwelling in the object of our reverie such that it dwells within us and generates a multiplicity of new images, reflections, musings and "*cogitio*" (Bachelard, 1960/1969, p. 143) or 'cogitation', upon the image. It engages mind's activities, but imaginally. I have found reverie a far easier exercise to ask people to engage in high stress or anxiety disordered states than the basic mindfulness practices with similar contra-indication, however, that unprocessed previous trauma, can prevent benefit or even be re-triggered. In reverie upon the world as one speaking poetically to us, we ourselves can be drawn into an experience *poiesis*, a 'becoming' within. Carrie and Denise particularly described these ways to hold in mind, with their mind's eye of imagination, a relationality with nature to foster wisdom resourcing within. Reverie on the natural world, with relationality embedded in the experience, can be a deep source of comfort and re-remembering of a sense of wholeness. As Bachelard found, "reverie is a source of well-being" (p. 176).

While this has a rather peaceful and aesthetic quality to its description, it is more of a life and death struggle that takes place interiorly for those facing mortality with a life-threatening disease 'inhabiting' their physical bodies and indeed for most, in experiences of deep suffering. This struggle highlights a crucial capacity of imagination to "breach from material necessity" (Martinez, Thiboutot, & Jager, 1999, p. 6) in its poeticizing agency to catalyze *poiesis*, even if only for a moment and invites a healing from disconnection and alienation into reconnecting with a cosmos, an inner self and the other. Denise's use of seeing a sunrise from a houseboat to imagine an afterlife beyond dying reflects this capacity to 'breach' from material necessity in the suffering body. Embodied relationality with nature engaged in reverie with imagination's catalytic involvement reminds us of the cosmos as a place of belonging, an inward movement to a sense of presence in and with the organic, living, earth from which our breathe is drawn.

Embodied relationality with nature is an aspect of wisdom shared through their perspectives and perhaps worthy of further study in how interacting with, meditating upon nature enhances personal wisdom for fostering a sense of well-being and connection ameliorating feelings of alienation and loneliness as well as enhancing personal wisdom-in-life. Embodied relationality with nature links back to reverie on the cosmos as "producing a consciousness of well-being" (Bachelard, 1960/1969, p. 176) and reverie might be considered as a processual aspect of wisdom formation, particularly when sourcing reveries from the wisdom of life in nature.

Emerging from the field of positive psychiatry is research on links between happiness and well-being (Jeste, Palmer, Rettew, & Boardman, 2015). There is an absence of investigations on nature's role in wisdom formation in persons, while the field of wisdom research is turning towards a study of ecological influences on wisdom in social worlds (Igarashi et al., 2018). This might suggest a further response to Smith's (1999, pp. 58–77) call for western academia's lifeworlds to "decolonize" our methodologies and critically reflect on how colonizing societies on the planet have delegitimized entire epistemologies, such as those that imbue the natural world as 'wise' and a teacher of wisdom for humans, exiling these from dominant research paradigms, and therefore...findings. Further study on nature's role in enhancing personal wisdom and sense of relationality that fosters well-being might be valuable to our understanding of embodied relationality as a dimension of wisdom. Nature also might be considered as a potentially crucial ingredient in fostering a "wisdom supportive environment" (Küpers, 2007, p. 185).

5.3.1.4 Embodied Relationality in Wise Care

Beth, Carrie and Denise could identify with relative ease situations where they did not feel they'd experienced wise care and conversely, when they did. Qualities of wise care in their views included four dimensions of *trust*, *respect*, *kindness*, and *shared decision-making*. One moment described by Denise included a doctor sharing a personal story to assist her with feeling comfortable to defer her urgently required chemotherapy treatment until after Christmas a few

days away. Another Carrie identified was when an older doctor (male) sat next to her on the examination table to break bad news rather than standing or looking at his notes instead of making a personal connection. The closeness was not perceived as intrusive but rather as humane. Stories in the interviews responding to the questions focusing on experiences of wise care or wise clinicians were numerous moments of being touched gently or having a hand held in particularly difficult moments when hospitalized or in certain sorrowful moments in consultations where grief was present; being given blankets for warmth by nurses; being given understanding for their struggle and personal experiences being shared by their health care practitioners to show empathy and resonance. Competency is expected from clinicians and none recounted expertise or competency as an exemplar of wise care presumably because this would be a given in provision of medical health care. Rather it was when clinicians were embodying humane and humanizing connection with them as persons, and as unique individuals, in need of humane qualities of kindness and respect which garnered stories of the 'wise clinician' and 'wise care' with illustrative stories of moments that had heightened trust in their clinicians from genuine, meaningful and authentic human to human connection.

Trust, kindness, respect, and shared decision-making are values, I would argue, that can only be mediated through embodiment in persons. Online medical care would likely diminish, even miss entirely, these dimensions in significant ways. Attention must also be paid to ways the matrices of the systems

in which all must engage are also embodying values that foster 'wise care' (Bontemps-Hommen et al., 2018).

Linking feminist perspectives and a feminist bioethics that deepen a focus on wisdom's ethical sensibility embodied in and through relationality might afford further insight into how ethical sensibility is embodied in women's lives and particularly in relation to systems of power, such as medical contexts, in which women must negotiate with a gendered body, their vulnerability and personal agency (McLeod & Sherwin, 2000). Findings from this study show Carrie and Beth discussing ways they felt they needed to "push" in negotiating with their clinicians to meet their needs and in both their views, they linked this to being in a gendered body as women. Inclusion of ethical sensibility emerged from a conference gathering wisdom researchers to "to develop a broad, comprehensive definition of *wisdom* that integrates the *sophia* and *phronesis* aspects of wisdom and emphasizes social justice and moral development aspects that we feel have been neglected in most of the current definitions of wisdom" (p. 3).

Viewed more broadly, ethical sensibility as involved in such a decision when a woman chooses to resist a medical decision and intervention with an N=1 lens from within her own story, is also consistent with the principles of patient-centered care where patients are acknowledged as joint partners in medical decision making on par with their providers, albeit this cultural shift is still a work in progress at the N=many level (Fix et al., 2018). This may be changing in that a recognition that physician intuition may be a powerful diagnostic tool the challenge then being how to best patient intuition or gut feelings as a valued

source of information in the clinical care process (Stolper et al., 2011). It raises use of these gut 'knowings' to the level of bioethics if viewed from a frame that considers it emergent from an ethical sensibility and enactment of wise care.

Relational ethics conceptualized by feminist bioethicists afford a framework and means to provide clinicians with an orientation towards relationality in these ways, as a critical aspect of their medical practices. The challenge is to bring beleaguered physicians and health care practitioners into the types of reflectivity needed for a type of competency that rigorously creates such relational spaces with intentionality to form a "magic bubble" of depth, attuned, phenomenologically orientated engagement (Saraga et al., 2018, p. epub5) from which to elicit a "wisdom conversation", to use Denise's language.

This can contribute to further reflection on the clinical roles such as nurse-navigators whose function is system resourced as critical for optimizing patient care within complex medical systems (Goh & Ang, 2016). Beyond the mechanics of process, it might bear more consideration on how these roles can be further supported to be 'wisdom-eliciting' for patient's to guide their care team using inquiry on the nurse-navigator's part towards the more intangible forms of knowledge that a patient might contribute. These would ask more 'upstream' questions eliciting embodied knowledge and self-knowledge in light of medical options for care, particularly when specific interventions, such as pain medication as in Beth's case, or bowel issues, in Carrie's case, need to be challenged, or resisted by the patient for personal needs to be met for quality of life. These practices exist in nursing care paradigms but perhaps further studies that further

legitimize excluded knowledge, such as ‘embodied’, can pull it, within a relational ‘wisdom-emergent’ dialogue space from ‘tacit’, almost, ‘hidden’ or ‘secret’, to provide a better dialogue space whereby *both* patient and clinical practitioner, are given a permissive, discursive space into which they can step to decided ‘what to do’.

Ethical sensibility as an aspect of wisdom thus holds significance for enactment of wise care and for wise clinicians, including their training processes.

5.3.1.5 Embodied Relationality With ‘Ethical Sensibility’

Following from the discussion of wisdom as ‘embodied relationality in wise care’ is attention to wisdom as embodying an ethical sensibility with feeling dimensions that include the (Glück, 2017b), empathic (Bangen et al., 2013; Glück & Bluck, 2013) and compassionate (Vishnevsky et al., 2015). Compelling findings in wisdom research literature frames wisdom as inherently connected to an “ethical sensibility” (Schmit, Muldoon, & Pounders, 2012, p. 42) as an aspect of relationality and a fundamental *orientation* within it. It could be considered the ‘needle’ of the inner wisdom-compass that responds to the magnetic north of wisdom-*poiesis*, the force field guiding it being the *value* placed on ethics by the inner navigator to follow its guidance, and an ethically just manifestation through enactment.

5.3.1.5.1 *Empathy*

This is identified in Glück and Bluck's (2013) MORE Life Experience Model of wisdom as a theory of wisdom's development along with emotional regulation. They include the emotional regulation of others through empathy where "wise persons can down-regulate their own feelings so as to remain able to support others in need" (p. 14). It could be asked whether wisdom exists without "ethical sensibility" (Schmit et al., 2012, p. 42). As Kramer's (2000) states, "Wisdom is reflected not only in the private realm of thought or affect but it also manifests itself in constructive action" (p. 86).

Ethical sensibility guided by empathy as a concern about injury to the other is also implicated in the difficult negotiation of self-other in the daily tensions of relationships in relation to the participants' responses to meeting their own needs and that of others. Ethical sensibility moves participants' actions and ways of being in relationality. Ethical sensibility is able to orient to other, as well as self in finding "the sweet spot", in Carrie's words, between them, moment by moment.

5.3.1.5.2 *Agency, Subjectivity, Epistemic Power*

Ethical sensibility is found using a feminist bioethic lens analysis in the ways that Beth, Carrie, and Denise discovered to embody the means to reclaim agency, subjectivity, and epistemic power in situations where they found themselves disadvantaged by power differentials as 'patients' with health care providers and the medical system in which they had to navigate and negotiate

their needs for receiving care and treatment. Engagement and elicitation of subjugated knowledges from practitioners, such as empathy and embodiment (Lorentzen, 2008; Sherwin, 1992) enacted through comforting actions, kind touch with a holding of a hand, sitting next to them instead of standing above and over them, were seen in their contributions reflecting on wisdom in relation to their health care. These types of knowledge can be framed as 'subjugated, not simplistically because practitioners are 'uncaring', but rather the constraints that practice ethics (for example around touch), resource limitations in time, clinical states of compassion fatigue and burnout induced by the work culture and many other constraints, can all 'subjugate' the human in both patient and practitioner (Chochinov et al., 2013).

The nurses' role in a restoring of subjectivity and agency for and with Denise in the difficult moments of medical processes might indicate a reflection on the relational ethic inherent to a feminist bioethics. This lens would argue that subjectivity and agency are a *co-created* experience, it takes these relational approaches in care, as Denise experienced, to restore in moments, or influence cultures of care, where these are diminished greatly for patients', and clinicians, experiences (Hargrave, Jennings, & Anderson, 1991; McLeod & Sherwin, 2000). With power differentials that render a patient at a greater disadvantage, vigilant attention is necessitated to attune and embody ways for relationality as a clinical *skill*, embodying ethical attunement, might be developed in clinicians and, perhaps even more critically, *sustained* in health care work cultures. Attuning to patient's ethical sensibility within their health care might be explored as another

type of 'subjugated knowledge' in both patient and clinician. Ethical practice being a formal discourse in medicine, we can ask with Frank (2006) how patient's voices, emerging from their own ethical sensibilities, find traction in both their care and within the systemic structures and processes that provide it?

5.3.1.5.3 *(Re)embodying Lost Knowledges*

An ethic oriented towards an epistemic redemption of lost knowledges is a final aspect of ethical sensibility that is raised in this study. It highlights how wisdom as an ethical sensibility can cultivate our attunement to excluded aspects of life and medical practices that dynamically aim to embody, and thus preserve, a sense of the human and humanizing in social matrices. This section then leads into a discussion on another finding in this study focusing on 'embodied knowing' as a 'lost knowledge' because it is delegitimized in the art of medicine, for both clinicians and patients.

Jeste and Edmonds (2016) in a commentary article titled "Evolution of the care of the dying: From paternalistic to palliative care" discuss the "dying role" (p, 228) hinting at a subjugated epistemology dwelling in the lives of those who are dying. In clinical contexts, an ethical sensibility can attune to this. What kinds of epistemological contributions to our world does a dying mother, and especially a young mother raising young children, offer to us? What might she have to offer us beyond its symbolizing of tragedy? Some early reflections from my oncology practice are offered in the poem opening the Prologue. It came from counseling many dying mothers and was written early on as I lived with an impact of

companioning them in their dying, as a mother of young children at the time myself. The dying mother's contributions to children left to defend themselves from life and the 'wicked' in others is left to us in the Grimm's fairy tales and re-woven into stories for the contemporary woman by Pinkola-Estes (1992) and Woodman (2001a, 2001b). I have often used their insights and the stories they draw them from, as 'soul-medicine' with which to source some hope that we, perhaps, as human mothers are not the only mother caring for our children. Forest helpers, wise others encountered in the darkest of hours, nature's wisdom, all reach to help the children left to life's mercies...and tenderness. An ethical sensibility in empathy can orient to what sources comfort, hope, peace through human storying, our own embodied presence with another, and the stories left to us through history in wise others who lived before us. An ethical sensibility can stay attuned to submerged further knowledges that assist the embodied experience of the 'other' us seeking support and care from us and our health care.

5.3.1.6 *Embodied 'Knowing'*

Following on from embodied relationality where embodied 'knowing' was already touched on, this form of subjugated knowledge is now highlighted as a finding in this study (Lorentzen, 2008; Pauly Morgan, 1998; Sherwin, 1998). Beth, Carrie, and Denise each gave a 'wisdom contribution' on ways that embodied 'knowing' was both experienced and formed a tension in clinical dialogues with their physicians or, was supported by physicians but likely without

a way to 'chart' their shared embodied knowing informing their clinical shared decision-making. Beth specifically urged and allowed me turn to the recorder back on to capture her statement, that women should seek medical investigation if "you feel something's wrong" investing agency in this study to 'speak' for her on this form of knowledge, she herself, has experienced.

Embodied knowing, framed in this language to locate it in the 'knower' rather than the disembodied connotations of 'knowledge', is perhaps a most difficult form of excluded knowledge to address in medical contexts (Lorentzen, 2008) and particularly in women's gendered experiences of their "women's ways of knowing" (Field-Belenky, McVicker-Clinchy, Rule-Goldberger, & Mattuck-Tarule, 1997).

Benner (1994; Benner & Tanner, 1987) drew attention to embodied practices in nursing that included intuition opening a discourse space in nursing research and education for its inclusion. Robert (2014) published a concept analysis on "nursing intuition" (p. 343) that outlines four dimensions, similar as found in this study findings on wisdom that nursing intuition includes: empirical and personal knowledge, ethical attitudes, and an aesthetic dimensions which encompasses "immediate practical action including awareness of the patient and his or her circumstances as uniquely individual, and of the combined wholeness of the situ-ation" (p. 343, hyphen is the article's author choice). Stolper et al. (2011) have investigated literature pertaining to General Practitioner's experiences of 'gut feeling' in clinical practice. Findings support a view that

trusting gut feelings was challenged, “since a scientific explanation is lacking” (p. 197) while it played a significant role in G.P’s medical practices.

As seen in these examples, ‘embodied knowing’, which might use Bruner’s (2001) reflections on a type of “left-handed knowing” in “self-making and world-making” (p. 59) is certainly finding a way into some tentative legitimization in medical discourses. Such “knowing”, is likely actively integrated by many physicians and is visible in those with whom I’ve clinically worked. Even for these physicians however, this form of ‘knowing’ is certainly not easily harnessed in formal assessment questions repeatedly evaluating patients’ symptom reporting in their clinical consultations within high volume clinics where patients are booked in multiples across ‘micro’ allotments of time. Carrie mobilized this knowledge into a productive agency to “push, push, push” on the medical system and gain an accurate diagnosis and push on for surgery sooner than later. This does not mean that the medical system wasn’t being responsive and may also be a perception of a need to advocate when ‘the system’, through her oncologist, was moving as fast as it possibly could within the limits endemic to a ‘system’.

Yet, it was Carrie’s embodied knowing of something wrong that compelled the proactivity as a *knowledge* that she had to work to get heard. Beth described ‘knowing’ she’d get “something” in her life that would threaten her life from a young age. Denise “knew something was wrong” before she heard the diagnosis. These experiences, and the many others I’ve heard in my counseling office, suggest there is an embodied knowledge in women that at times struggles to find agency and legitimacy in medical contexts and with some of their physicians and

other providers. Their wisdom was offered in the interviews for this study in the context of describing negotiating this tension.

A form of 'embodied knowing' as an aspect of clinical dialogue provokes a need for deeper reflection on the part of policy makers and health care administrations driving protocol based care within systems functioning on 'less is more' efficiencies. From Beth, Carrie, and Denise's contributions we can hear a compelling need to tap more deeply into patient's "gut" knowings to complement a physician's gut feeling and find meaningful, possible, ways to move health care culture to a place where both types of embodied knowledge are acknowledged and valued. The power differential circulating in a clinical dialogue between a patient and their physician can support a view where embodied knowledge, successfully integrated on the physician's part is elevated into a credibility for the doctor as 'diagnostic acumen' whereas the many matrices of constraints on the dialogue, including subjective bias on a specific physicians' part, may more frequently legitimize a diminishment of embodied knowledge in the patient as "being difficult". Additionally, extending this lens into the profession itself, it may reveal also a tendency for specialists to diminish the embodied knowledge of other specialists or generalists when clear 'rationale' for their medical orders, referrals or differential diagnostic 'intuitions' are not easily explicated.

This struggle for even physicians to claim agency around their 'knowing' was certainly contributed in Carrie's narrative that her family physician told her to mobilize whatever agency and social capital she could to secure a specialist appointment for investigating her "bowel situation" when it had reached a level, in

Carrie's words, that "Houston...we have a problem!" Johansen et al.'s (2012) study on family physician's 'remote' satellite positioning in relation to specialists practicing in other, sometimes very distant, locations in larger tertiary institutions speaks to a subjugation of clinical *phronesis*, and implied, embodied knowing, by being removed from the direct circle of care once a family physician refers a patient to specialists. In this disjuncture of care providers, Johansen et al. (2012) argue that a family physician's acquired whole person knowledge and embodied relationality that can inform a more expert 'knowing' about the patient's condition as it unfolds. They assert that this has informed their care and clinical acumen for that patient's needs over a longer time and affords the specialists they refer their patient's to a greater repository of wisdom' about their shared patient yet, this, they argue, is more often rendered liminal and even irrelevant.

A problematizing frame would both incite the need for harnessing this form of knowledge as a critical dimension of medical care while highlighting, at the same time, that both types of gut feelings can also be wrong on both the patient and physician side. On the patient side, in the extreme sense it can be the problem of an undiagnosed hypochondria flagging for a different type of 'wise care', often unavailable in the constraints of mental health resourcing in medical contexts. On the physician side, it can perhaps be a gut feeling that leads to over or under investigation, or also sometimes stemming from personal anxieties operating, veiled, behind the professional's interiority or operational accountability constraints.

There is potential for developing what I propose as ‘wisdom-activating’ conversation guidelines, similar to the semi-structured wisdom eliciting interviews developed for this study, for finding ways to harness, ‘embodied knowing’ in clinical settings. For example, there might be valuable implications for initiatives such as Choosing Wisely (ASTRO, 2015; Bauman, 2015; Cassel & Guest, 2012) and Serious Illness Conversations (Ariadne Lab Tools, 2018). Implications of embodied knowing in early screening of ovarian cancer with a socio-political context for are further offered in Appendix IX.

Embodied knowing has been tied to a needed ethical sensibility in medical contexts and was a finding of this study in Beth, Carrie, and Denise’s experiences of their illness experiences, in different ways, but nonetheless, present. This section has discussed potential implications of devaluing this as an illegitimate form of knowledge in clinical diagnostics for both patient and physician. In the socio-political context of funding for early screening and treatment for ovarian cancer, it is suggested this knowledge might aid both patients and physicians to attune to embodied knowledge to afford it productive agency in clinical dialogue while early screening lags behind other types of cancer and not a highly funded focus in research funding body’s guidance policies. Recent efforts (albeit skeptically received) linking patterns of Google searches regarding pancreatic cancer with a subsequent higher risk of diagnosing pancreatic cancers in individuals suggests novel techniques to “mine” embodied knowledge might be a useful avenue of research for hard to detect

cancers without robust clinical biomarkers such as ovarian and pancreatic cancer (Gigerenzer, 2017).

5.3.1.7 Embodied Temporality

A phenomenological view of embodiment includes human temporality and mortality. Beth, Carrie, and Denise's lives were circumscribed by a deep and piercing awareness of their temporality and mortal body. Suffering is endemic to embodied temporality (Boase, 2008; Breitbart, 2007; Gessert, Baines, Kuross, Clark, & Haller, 2004). Temporality, is punctuated by mortality and in the last breathe, a person's embodied life, ends. Yet, while people, their bodies, suffer and die, the life-lived does not. A 'wise-life' lives on, in memory, story, picture, legacy, the fruits of labours left behind, some live on across millennia in oral traditions, and in literary and pictorial modes. Their wisdom becomes (re)new(ed) in lives that re-embodiment wisdom passed on, in new ways, and in different cultural matrices. Pain caused by a person's life can have a similar 'life of its own' after the body dies, both in personal and socio-cultural worlds, as we soberingly know, for example, from peoples and generations in particular cultures that have lived through genocide.

In this sense, 'wisdom' as phenomenon can have a life of its own culturally and socially. But, with Ardel (2004) I believe that this is only *meaningful* from a human perspective when influencing the embodied lives of the living and that means in persons, in particular embodied individuals shaping their lifeworld through their living. For example, Ghandi's 'wisdom' unsupported by the example

of the life he lived, would be relatively impotent as inspiration for 'being the change' in others. It can be argued that *poiesis* emerges from our embodied lives and is sustained in others sparked by the inspiration our lives might offer in relation to wisdom. Temporality in wisdom, seems to be inherent, if we anchor wisdom as being in 'wise persons' in a fundamental way. Temporality in the suffering body aware of mortality, does seem, from emerging studies focusing on wisdom in people closer to the end of life, to play a role in wisdom formation (Ardelt & Edwards, 2016; Montross-Thomas, Joseph, Edmonds, Palinkas, & Jeste, 2018).

In Beth's phenomenological portrait time emerged as playing a role by creating a poignant awareness of time's quantity in her future was now curtailed and a way she found, her wisdom, to negotiate this facticity in her life, "I'm going to die...but maybe not tomorrow". "Be in the present moment" sits in between 'then' and 'now' to source what is needed today shared in stories sourcing memories from the past, sourcing hope for her legacy by "making memories...now" and played a role in forming her wisdom contributions to this study.

Time in its temporal dimension is implied in Denise's "wisdom is process" and it "takes time to process the next steps" and deeper reflectivity on meaning(s) within this being provoked by her diagnosis. Temporality and the suffering body formed Carrie's return in memory to a former time of suffering, hospitalized with broken legs from which she sourced knowledge gained from the experience about having to "push and push harder" in the medical system for the

care she needed and in the ways she needed the care to be given. Her suffering body, 'then' informed her with a personal epistemology for "navigating" ovarian cancer and all that brought into her life, including a medical system to be navigated, once again, 'now'. It also seemed to source her capacity for resilience as the one who had survived her ordeal and now faces another and "navigate" through it given the frequent cycling back to the earlier time with broken legs in her interviews to contextualize her 'finding a way' with ovarian cancer, now.

In the case of a 'wisdom-compass', or any phenomenon in life, be it love, ambition, greed, optimism, stigma, hope, peace, joy, courage, it is *how* we have formed a relationship with a particular phenomenon in life that will inevitably be revealed, over time, exposing whatever the 'magnetic north' of our relationship with that phenomenon has been. New, life-altering experiences thrust us differently into a relating with temporality, particularly when we suffer in embodied vulnerability with illness. Mortality and suffering often force a re-negotiation with temporality and the vulnerability being embodied brings creates an ultimacy of limits imposed on us by mortality, as we can see it did for Beth, Carrie, and Denise.

Whatever the 'magnetic north' of our relationship with wisdom (or for example ambition, fear etc) is, it will inevitably be revealed, over and through the course of our lives with a *poiesis* of 'becoming' culminating upon our dying into the 'who it is' that is dying and leaving the imprint of our 'being' in the world and most particularly in our relationships. Death is a final punctuation. Temporality can thus perhaps be viewed as another inherent dimension of wisdom as an

ultimate 'boundary' against which we must wrest our choices for who we will be in light of foreseeing our dying. Part of the "crucible" of wisdom-labour for Beth, Carrie, and Denise is the acuteness of their illness – the boundary is very visible with the diagnosis of ovarian cancer so the process of consolidating wisdom is perhaps accelerated. This implicates a 'mortality-awareness' in wisdom formation, inherent in many spiritual and wisdom traditions rites and practices.

5.3.1.8 *Embodying Wisdom's Invisibility*

Beth, Carrie, and Denise can be felt in the poem, as 'being wise' yet each started their first interviews stating they didn't feel particularly wise. What I identified as a type of personal 'wisdom-compass' captured by a particular phrase or axiom in their interviews in the phenomenological inquiry seemed to be occluded from participant's own views of themselves as wise but became more emergent in the dialogue. Yet, there was a movement through the first and by the second interviews towards more statements starting with "my wisdom is". Their 'being wise' that is illuminated in the final poem remained, for the most part, occluded. I seemed to be the greater beneficiary of their wisdom as a 'knowing' of their contributions as inherently wise than they, while each acknowledged at the end of the interviews that the process had illuminated for them a sense of personal wisdom gained. Yet they each lived an embodiment of 'being wise' described in their stories of how they were 'finding a way' to live with ovarian cancer.

Denise's statement about wisdom that, "I think you're so close to it, you don't see it" captures that wisdom seems to inherently constrain us from recognizing 'wisdom' in ourselves, while we may indeed be acting in deeply wise ways and living by an internal 'wisdom-compass', as Beth, Carrie, and Denise can be seen as doing. Ardelt (2016) notes "...wise persons tend to be aware of their own weaknesses and limitations, and therefore might score lower on self-assessed wisdom items than less wise individuals who might ignore their imperfections to preserve their self esteem" (p. 511). Participants' occlusion of wisdom to their own viewpoint of themselves as wise perhaps indicates another phenomenal dimension of wisdom that I propose is related to the *phenomenon of embodiment*.

Trying to see wisdom in ourselves, or our lives, is perhaps similar to peering into soil to see what dwells within it and what can grow from its nourishment. Wisdom is seen in the fruit of our wisdom-labours from being temporal, mortal, vulnerable, suffering becoming visible, sometimes and over time, in our outer lives, more often to others than us. The source nutrients and mix of elements in our beings that cause a blooming of wisdom perhaps remain invisible to us because we are embodied and cannot adopt a birds eye view until perhaps we reach an age where we have more lifespan to look back on...and only then if we are seeking wisdom with reflectivity on wisdom itself, to unveil it to ourselves from our lives (Bluck & Glück, 2004; Montgomery, Barber, & McKee, 2002).

Embodied situatedness in our own lives may also render the wisdom in another invisible to us. What may be ‘crazy wisdom’ in another’s life might be subjected to severe judgments from others as history has shown time and again in its treatment of prophets, revolutionaries, and artists breaking the norms of their craft. In clinical contexts, patients acting AMA (“against medical advice”) may be enacting this sort of “crazy wisdom” that responds to a need for inner navigation towards a goal that is not obvious to the providers around them (as did Carrie when she went on her boat trip despite the concerns regarding risk of bowel obstruction). Embodiment in time and the lived experience of temporality that life necessitates is perhaps an inherent phenomenon of embodiment that renders wisdom opaque and invisible to ourselves or others, or in Denise’s words, “you’re so close to it, you don’t see it”.

5.3.1.9 *Embodied Reflectivity*

This dimension creates a paradoxical nature to ‘wisdom’ as *both* occluded by an invisibility to ourselves preventing us fully claiming “I am wise”, while, being able simultaneously to discover our wisdom and to offer it to others in a “wisdom-conversation”, as Denise highlights for us. Denise’s insight that wisdom involves “reflect”, “be aware”, “realize”, and “apply” affirms reflectivity, as well as moments of wisdom-in-*poiesis* in a realization, as inherent in her sense of wisdom. This would affirm findings in the wisdom studies that have mapped reflectivity as a character trait of wise people (Glück & Bluck, 2013; Schmit et al., 2012). Their insights in the findings certainly mirror findings in wisdom models generated by

quantitative and qualitative research experts on wisdom that highlight reflectivity and insight as dimensions of wisdom formation (Baltes & Staudinger, 1993; Glück & Bluck, 2013; Staudinger, Lopez, & Baltes, 1997). It is reflectivity that brings our prereflective, instinctual and intuitively discovered wise ways into to awareness such that they might be “applied” as Denise highlights for us, today, tomorrow and into an imagined future framed by a horizon of hope generated from one’s ‘wisdom-compass’.

There is general consensus that time alone does not form wisdom (Baltes & Baltes, 1990; Baltes, Smith, & Staudinger, 1992; Staudinger & Glück, 2011; Yang, 2017) whereas exploratory processing of difficult life experiences, over time, however, can (Weststrate & Glück, 2017). Reflectivity linked to aging where learning from life’s lessons becomes integrated into personal wisdom connects wisdom to a process in time but not to time itself. Embodied *relationship* to time, in Beth’s words, wisdom is “the accumulation of life experiences”, reflected upon, thus seems implicated within wisdom’s phenomenology. Time is experienced in our embodiment and works upon us through both *chronos*, as clock time, and *kairos*, time as it is experienced in moments imbued within our lived experience as a sense of the timeless within ‘time’. Embodied temporarily is perhaps a key ingredient of ‘time’ and it is *embodiment* again, that brings time into a relationship with wisdom in our lives.

Reflectivity has been more thoroughly studied and discussed as an aspect of wisdom in its cognitive aspects (Aldwin, 2009; Ardelt, 2018; Bangen et al., 2013; Brienza et al., 2017; Glück & Bluck, 2013; Levenson et al., 2005) yet not

through a lens of being embodied, the situated-self, in which reflecting takes place and which is deeply implicated in reflective processes. As we have seen, reverie is a form of reflectivity but more indwelling into the embodied dimension than the cognitive-reflective processual dimension. I propose that attention to image-centered knowledge and the 'knowing' it can generate is a worthwhile line of investigation as a form of *embodied reflectivity*, such as in Denise's meditation using her beach and sunrise imagining.

Embodiment of wisdom in its reflective modes might, furthermore, be linked to include "critical reflexivity" (McCorquodale & Kinsella, 2015) which engages both reflective attunement with ethical sensibility and a critical eye upon norms that are prescribing behaviours and discourses within social worlds in taken-for-granted ways (Kinsella & Whiteford, 2009). It might perhaps be taken further to consider embodied-critical-reflexivity, especially, perhaps, for those seeking to change lifeworld contexts towards greater embodiments of wisdom.

5.3.2 Imagination

The philosophical foundation laid for this integration of Imagination, with intuition and creativity implicated aimed to provide a focus on them in the phenomenological rendering of findings on wisdom in this study. These dimensions were also given an aim to 're-body' them within the embodiment lens using Bachelard as the philosophical bedrock to do so and both these aims have involved a significant undertaking.

Aristotle held that wisdom had three dimensions, practical (*phronesis*), technical, formal knowledge (*episteme*) and philosophical/spiritual/intuitive (*sophian*) (Osbeck & Robinson, 2005). There is a contemporary appeal for renewed interest on these more intuitive, creative and holistic dimensions of wisdom often termed the *sophian* (intuitive) forms of wisdom (Trowbridge, 2011; Trowbridge & Ferrari, 2011) and particularly in relation to studying wisdom and gender (Aldwin, 2009).

Four aspects of *sophian* dimensions of wisdom emergent in the findings are discussed: (a) embodied-intuiting; (b) embodied-creating; (c) embodied-spirituality; (d) embodied imagining. Together they are then touched on as aspects that can be focused on in further study for a (re)claiming of the *sophian* aspects of wisdom.

5.3.2.1 Embodied-Intuiting

This was touched on the ‘embodied knowing’ section, I will simply reference again how the women’s wisdom-compasses afforded unreflective, more instinctually intuitive responses to life situations to generate pragmatic, knowledgeable and ‘wise’ responses which became visible as a form of *phronesis*, practical wisdom. Yet each of their wisdom-compasses and the multiplicity of wise ways found through situations, also, can arguably be framed as also an *embodied intuiting* at the liminal space between body and reflectivity in the symbol-image I provided earlier of the “inner navigator”. The inner-navigator seems to function at a more intuitive, creative, holistic level and

operates both out of cognition and in reflective processes and from both, guides responses suggesting a *sophian* dimension to wisdom-*poiesis* in our day to day navigating of life.

5.3.2.2 *Embodied-Creating*

Embodied imagination plays its role in moving the women towards a greater sense of well-being inwardly and imagination played its role in the creation of the women's art-collages, drawing from body, heart, mind a pictorial representation of meaning, hopes, aims and images that sourced a sense of wholeness as well as a 'compass' for living. The art 'embodied' something of their soul life aided by imagination, intuition and creative capacity to render their 'inner' into the 'outer' (Mahar et al., 2012; Sakaguchi & Okamura, 2014). In this activity of embodied imagination is also embodied modes of intuitiveness and the creative, emergent process of 'becoming' in their day to day, finding a way through, visioning some hope in the future such as Beth's holding hope in future scientific breakthroughs. Wisdom in its embodied intuition is also implicated in the embodied 'knowing' discussed earlier. From where does such 'knowing' arise? If it is indeed a knowledge, for example, that 'something is wrong', then an embodied, non-verbal 'knowing' that finds expression from the body that 'knows' would suggest that *sophian* dimensions of wisdom hold some critical significance deserving legitimization and ways to at least be given, not necessarily full authorial weight, but at least a voice.

Embodied creating, as an aspect of forming and even 'training' an embodied 'knowing' as a capacity inherent in wisdom has emerged time and again in patients' art whether the collage in the groups or done long before cancer declared itself that has made our hair stand on end with goose bumps and the sense of mysteries we simply cannot comprehend. Embodied-creating can cultivate the intuitive, knowing, well-being, empathic, ethical sensibility as shown in studies where creative activities are used to cultivate these ways of knowing in health professional education (Kinsella et al., 2008; Mahar et al., 2012).

5.3.2.3 *Embodied-Spirituality*

The call for more study on *sophian* aspects of wisdom and particularly in its intuitive aspects more than its externalized religious forms and rites, intersects with discussions amongst researchers on whether wisdom and spirituality are correlated or inter-related at all. According to a Delphi consensus survey with leading wisdom experts wisdom and spirituality are connected by *exception* rather than as a rule (Jeste, 2010). A Delphi process conducted by Jeste (2010) found that definitions and operationalization of wisdom are best explicated in secular rather than spiritual terms.

Wink and Dillon's (2013) study aimed to distinguish wisdom's implicated role with spirituality and religion building on an earlier study of the differences between practical and transcendent wisdom (Wink & Helson, 1997). Their 2013 study includes spiritual seekers who do not describe themselves as religious, and

religiously oriented individuals ascribing to religious beliefs/communities and specifically explored the relationship of religion, spirituality and wisdom. They report that their major findings show that personal wisdom is correlated positively with *both* religiousness and spirituality. The latter might have different features in terms of loci of control, personality characteristics and characteristics of wisdom might be differently valued and weighted, but, despite these differences, they suggest that there is a correlation despite an expectation that they would find spirituality more correlated than religiousness. Based on their study however, they declare that wisdom is not reducible or interchangeable with religiousness or spirituality and that personal wisdom should be understood in its own terms.

Beth, Carrie and Denise each had their own spiritual beliefs as well as views on life after death. Each one's 'wisdom-compass' did not however, specifically situate itself on spiritual or religious views of life and death, nor centre on their personal religious or spiritual views while each identified that their spiritual practices, prayer (Beth and Denise), meditation and mindfulness practices learned in the group (all three), walking in nature (particularly Carrie) and reflecting on spiritual themes in the afterlife (all three) played into how they viewed and coped with a new and difficult relationship with personal mortality through the diagnosis. Yet each could explicate a personal connection between their spirituality and wisdom in the interview discussions.

At the same time, spirituality and religious experiences and beliefs may well be factors in their 'wisdom-compass' process but, similar to former research, the recurring phrase that forms their 'wisdom-compass' guiding them through

their days is not overtly spiritual, or religious while each can find resonance in a variety of spiritual or religious traditions wisdom texts, teachings or practices. Suggestive in this, is that there are, perhaps, intuitive, *sophian* dimensions to wisdom that do not necessarily need to imply religious or spiritual views while they may be embedded individually into a person's ways of forming wisdom or supporting themselves in the finding of a 'wise-way' through. In addition to these investigations on the links between spirituality and *sophian* aspects in wisdom, it might be helpful to investigate 'sophia' through creative processes and their connection to wisdom, as these are embodied-intuitive processes more than reflective, while after creating, the creations can be contemplated for meaning, as in the groups with their art-collages.

5.3.2.4 *Embodied-Imagining*

From the context of existential psychotherapy, Martinez (1999) illuminates Bachelard's insight on the poeticizing, renewing power of *poiesis*, through a potent poetic image awakening a world within us:

We could say that the imagination is characterized precisely by the fact that it creates a psychic "elsewhere" and a place of human habitation beyond the space and time opened by natural science and technology. It is for this reason that Bachelard thinks of the poet as "speaking on the threshold of being" and why he describes the image as perpetually celebrating the birth of the imagination. With the birth of the image, a liberating breach is made with the world of material necessity and natural causality. Our imaginary life revives at each instance of its manifestation the original and miraculous leap of the spirit that releases us from the slumber of natural life and opens our eyes and ears to a truly human world. The poetic image is itself this inaugurating instance of a true encounter between self and other, self and world (p. 6).

This suggests significance to the potential role embodied imagination plays in healing suffering as well as sobering implications for what Kearney (1998) foregrounds in Lyotard (1979) as a “colonization” of imagination in contemporary life. Yet, imagination has not been taken up in wisdom research studies as a focus while ‘imagining’ is a technique used in some of the experimental methods that began with the Berlin Wisdom Paradigm’s (Baltes & Staudinger, 2000). They used a technique of an imagined wise friend for eliciting wisdom with multiple variations of this technique in subsequent research studies. In this study, imagination is given a central role to develop a methodology in hermeneutic-poetic-phenomenology that centres on culling imagination’s role in the phenomenon of wisdom from design, conduct, representation and in the reader, who needs to engage their imagination to read the poem and absorb the image-centered knowledge and wisdom within it. I have used poetic inquiry to reflexively engage my own imaginal life in the conduct of the study both as study and to keep a critical eye on my own influencing, interpretive lens, not for ‘bracketing’ but for balancing and questioning silences, omissions, avoidances, or ways a productive harnessing of my imaginal life might be culled.

It must be underscored, however, that Bachelard (1960/1969) argued imagination is implicitly embodied, and I situate my voice with his. Using a theoretical lens of embodiment, as well as imagination, allowed for a combing of the data for the embodied dimension of imagination in wisdom also to prevent another severing of *sophian* dimensions, particularly imagination, away from

embodied lives and into other philosophical territory such as spiritualism or a world of platonic ideals.

Findings offer a glimpse into wisdom in its *sophian* dimensions including embodied-imagining as a wisdom forming activities deep within participants' lives. Imagination stirs emotional, affective realms which can, when calibrated with reflectivity, and guided by an ethical sensibility, be recognized as dimensions of wisdom (Bangen et al., 2013; Glück & Bluck, 2013; Schmit et al., 2012).

We know from our own experience imagination can be our worst enemy (our innate tendency towards imaging worst case scenarios) as well as a positive friend (our ability to imagine positive future states). Engaging imagination as a wisdom-fostering activity that allows us to embody our lives with feelings of hope, comfort, peace, presence might be worthy of further investigations. For example, nurturing imagination's role in fostering a sense of well-being, in reverie, perhaps through the cultivation of mindfulness as the prelude as happens in the Soul-Medicine groups, can be a highly effective training ground in which to bring the body into a state where reverie might emerge.

This theory lens, and its findings might also encourage us to continue to find ways to elicit imagination's embodied role in existing therapeutic interventions with those who suffer with cancer and other life-altering forms of suffering. More specifically, how can we help patients harness imagination to create a sense of hope, purpose and capacity for wisdom even within the constraints/pressure of a life limiting or function limiting health condition? Soul-

Medicine groups certainly held this aim and many more models exist that encompass the imaginal in psychotherapy practices. Embodied imagining fosters relationality with deep, empathic and felt-sense from which arises a sense of well-being, and emergent acts in our lifeworlds from this well-being. How might embodied-imagining be harnessed further in the medical consultations patients engage in?

5.3.2.5 *Reclaiming the Sophian in Wisdom*

Representing wisdom in poetics, as this study has made an effort to show, potentially offers a *sophian* experience of wisdom as it requires the reader to soften their minds towards a contemplative approach where poetry can spark intuition, image-centered knowing, realizations, reflectivity and musings from which wisdom as *sophia*, might be awakened and evoked. Harnessing such ways to cultivate access to the *sophian* dimensions of wisdom in clinical education would perhaps be an eminently suitable means for teaching a *phronesis* in *embodied intuiting, image-centered knowledge*, and the processual dynamics of embodying a *creative 'art' of medical practice*.

Teaching the women in Soul-Medicine groups to learn to harness their embodied wisdom in all these *sophian* aspects through a low stakes activity of creating a very simple art-collage using magazine pictures, or photos, with absolutely no rules about how it should look, provided an interesting, sometimes scary but freeing sandbox to learn ways their 'embodied knowing' speaks to them in this picture needing to be 'here', not 'there', this one included, not that one.

Many times, the 'idea' they started with turning out to be completely abandoned as their inner '*sophia*', embodied wisdom, took over and they would arrive and sheepishly apologize for breaking 'rules' about the exercise to which there would be laughter and an robust affirmation on my part that this was indeed, entirely the point - that their own centre, their wisdom, would take over and guide them. Often the experience of creating would give a sense of integration, as if something deep within was woven back together in the creating. These are not new concepts and well grooved in many other academic disciplinary fields, particularly in art-therapy modalities. Rehabilitating the imaginative and intuitive, creative, *sophian* forms of *phronesis* in science trained medical students, entrained from early grades to 'think scientifically' is likely a necessary task if we want intuitively wise, embodied ethically sensibilities, who creatively embody the 'art' of medicine, to be wise clinicians leading the future of medicine. Indeed a growing interest in Narrative Medicine seeks to "reclaim the *sophian*" among providers in understanding the stories of their patients, their colleagues, themselves and society (Arntfield, Slesar, Dickson, & Charon, 2014; Charon, 2001).

5.4 WISDOM AND POST-TRAUMATIC 'GROWTH'?

"Turning wounds into wisdom" titles a study on two different therapy interventions focusing on post-traumatic growth (Nijdam, 2018). There is definitely empirical evidence in post-traumatic growth research where individual's

suffering from a physical, emotional, spiritual trauma might discover benefit and personal growth in the survival and overcoming of the residual or continuing effects of cancer as a traumatic experience (Linden, 2008; Weiss, 2002).

This study contributes to the possibility that *wisdom* can be formed from experience when living through traumatic life-changing events such as ovarian cancer but questions whether this is rightly framed as 'growth'. Cancer creates deep, residual layers of trauma that affects spiritual, emotional and psychological well-being (Boyer & Cantor, 2005; Kangas et al., 2002; Schulman-Green et al., 2008). The traumatic event of cancer and these effects have been described as type of "initiatory ordeal" (Vonarx, 2015, p. 27) immersing individuals in a task to integrate and heal the effects on their well-being. As previously referenced, Montross-Thomas et. al's. (2018) grounded theory study of wisdom with hospice patients at end-of-life suggests a dynamic balance between "active acceptance" and "galvanized growth" (p. 6). This study, however, holds some questions worthy of further, and deeper investigation, and suggests that studies which do confirm links between wisdom and 'post-traumatic growth' (Nijdam, 2018; Weststrate & Glück, 2017) need to be carefully considered and ask, 'what trauma?' and 'what growth?'

I would predict that the majority of expert oncology practitioners would confirm patients can and do experience a sense of personal growth, well-being, and life wisdom emerging from living after cancer treatment or at least a respite from pending mortality looming. However, in both my clinical experience, as well as in Beth, and Carrie's case particularly, 'growth' was not a finding, while

'wisdom' and "change", as Denise also described it, was. It suggests some deeper inquiry might serve to elucidate their differentiation from 'growth'. It suggests some deeper inquiry might serve to elucidate their differentiation.

This may be particularly relevant as new medical advances in cancer treatment are shifting from a paradigm of definitive treatment regimens intended to yield "cure" to effective treatments that seek to manage, but not eradicate cancer. By the same token, this work may be relevant to other serious, life limiting chronic disease like end stage kidney failure or heart failure where death, while not imminent still lies close on the horizon creating similar temporal urgency experienced by Beth, Carrie and Denise.

Neither was contentment described as a felt-sense in Beth, Carrie, or Denise's interviews or emergent in the findings, the difference perhaps being they were in a different phase than an initial trauma of receiving the diagnosis yet were still required to live their lives knowing the ovarian cancer will return within months to three to five years, short of being the miracle outliers in the statistics, yet they still had find ways to feel as if they were living life with meaning and purpose. The 'wisdom-compass' image presented earlier seems to better connect with their "navigating" process across an unwelcoming and unwelcomed terrain in life. In this sense, growth was more aligned with an improved ability to navigate this new territory rather than incorporating and adapting to a singular life-changing event. Denise certainly reflected a sense of "growth", using that word, in her shifts towards self-compassion and focusing on relationships but growth did not emerge as a word in neither Beth nor Carrie's interviews nor

feature greatly for Denise who reflected on wisdom as a process sparked by “do a fresh take”, not specifically pertaining to growth but discussed by Denise in the context of wisdom.

Ardelt and Edwards (2016) also studying three dimensional wisdom (mastery, purpose in-life, subjective well-being) at end of life in relation to subjective well-being found a positive correlation with wisdom. Participants were drawn from community, hospice and nursing home contexts. While contributions on wisdom emerged from Beth, Carrie, and Denise’s interviews, it wasn’t explored as to whether gleaning positive personal changes, learning, insights and ‘wisdom’ from lived experience with ovarian cancer contributed to a greater sense of well-being. Well-being happened in events, moments, sustained, was not seemingly a finding from their perspectives on finding, discovering or contributing wisdom to the study.

Well-being, a ‘wisdom-labour’ of “living to live” in Carrie’s words, was certainly strived for, in one sense, by mobilizing the wisdom contributions shown in the final poem. Yet, it isn’t clear in the findings that wisdom ameliorated interior suffering in emotional, spiritual, psychological forms of pain overall, while certainly they could share moments when a wise moment helped them through to feeling better for a short time. Beth’s analogy of her birth experiences with her children framing her description of finding a way ‘to get out of bed’, including “I can’t go on...it’s overwhelming”, truly raises a question as to the wisdom in linking wisdom too quickly as a given to ‘post-traumatic growth’. Beth was not describing ‘growth’ in using an excruciatingly difficult experience of birth to frame

her perspective on wisdom to 'live today' while there is, in the analogy and Beth's wisdom contributions, a 'something' that comes from the labour.

One reflection on this, while not a 'finding' *per se*, may be that there is a subtle societal propensity in a North American mindset, shaped by the driving force in medicine for 'cure' along with material optimism shaping a North American psyche from the founding constitution of the United States, that wisdom can make our 'soul-suffering' less painful. While there's indication that trauma and existential, spiritual, emotional pain may become potentially meaningful in a person's life as they integrate and heal in and from the experience (Abernathy, 2008; Bauer-Wu & Farran, 2005), it is possible that between wisdom, meaning, and feelings of well-being there lies some crucial differences. Wisdom may come from life-altering crisis but it may not restore us to the way we felt or viewed life prior to it and the impact, leaves its mark while wisdom may be born from the experience. Becoming wise through life's vicissitudes is not necessarily painless nor does it promise liberation from suffering. From a mental health perspective the possible *potential* for human beings to access a prereflective 'wisdom-compass' is not enough to prevent many and particularly those with mental vulnerabilities from experiencing profound depression to the point of radical despair and suicidality.

So we are left with the question, what can we offer, in our oncology treatment pathways caring for people with cancer (and in clinical teams) that can nurture the integration of a person's 'wisdom-compass' by creating a "wisdom supportive environment" (2007, p. 185). Further phenomenological and

psychological approaches to studying wisdom that include unconscious processes might be needed to find out more about this potential phenomenon, and activate it as a resource. It would be highly beneficial for health care contexts to do so if this could assist individuals to live with a disease process in their own unique way and support them to discover through modalities that engage embodiment, imagination, *sophian* wisdom to support their search for deeply personal meanings of hope, peace, joy, love, balance even if for moments, until those last days, and perhaps most especially in those last days.

A simple first step may be just acknowledging the existence of such a 'wisdom-compass' as potential for people as Back et al.'s (2014) study suggests by explicitly recommending to patient's at crossroads in health care decision-making with prognostic trajectories radically altered. They say study participant's selected "use your inner wisdom" as a third-phrase that was most preferred, after, "We're in a different place" followed by, "Here's what we can do now". Mapping the various ways a patient might do that, drawing in wisdom research and including the embodied dimensions might help a patient orient to what 'data-points' they are looking for to find their wisdom to offer.

5.5 NOVEL METHODOLOGY: HERMENEUTIC-POETIC-PHENOMENOLOGY – 'SOUL-MEDICINE' FOR CLINICIANS?

The poetic representation seeks to catalyze reflection and insight into the reader's own reverie on wisdom-in-life and has aimed to evoke a very personal,

deepened understanding of the phenomenon of wisdom inwardly, in relationship to life, with oneself, and others, including nature. This section discusses the use of the novel methodology developed for this study, reflections, learnings, potential applications in research, and personal renewal towards embodying wise care in medical practice. It offers reflections on: researcher and participant; poeticizing research; reverence for the unknowable; personal reverie and “pheno-practice”; ontology through poetics; use of theoretical lenses; poetic inquiry as a method phase in analysis; hermeneutic dimension; representation; and its situation in Gaston Bachelard’s philosophy.

5.5.1 Wisdom and the ‘Space In-Between’: Researcher and Participant

It was noted earlier that that wisdom evolves as an “emergent event” arising from the “space in-between” (Küpers, 2007, p. 181) rather than simply being a form of static knowledge one ‘possesses’. This notion of ‘space-in-between’ as wisdom formative, echoes Galvin and Todres (2008) notion of “embodied interpretation” (p. 313) arguing that experience dwells somewhere between the “first or third person position” (p. 314). The researcher herself was an integral part of the process both in facilitating the group process and then conducting the interviews. The role of the researcher was harnessed as an integral dimension of the study forming a shared investigation of wisdom in the ‘in-between’ space of relationality and its implicated role in forming personal and transpersonal wisdom. Reflective journaling is provided in Appendix VII from the interview phase with participants, tensions, surprises, process reflections are

shared on the experiences. They had previously participated in the Soul-Medicine groups that I'd facilitated and at the outset of their interviews I realized quickly what a benefit that seemed to be for starting out with a trust and rapport well established.

The spontaneity that happened in the semi-structured interviews whereby a dialogue about the differences between 'advice' and 'wisdom' emerged with Denise, was an example of the 'space in-between' whereby the shared inquiry about wisdom spawned a real-time insight. This holds forth a possibility that in seeking 'wisdom' in health care research studies, actively foregrounding wisdom as the study topic, we might, together as researchers and participants, discover and further wisdom in our lives and health care work, together, both experts, both students of wisdom.

5.5.2 Wisdom and the Value of Poeticizing Research

Brienza et al. (2017) state, "Despite many inspirational books ready to teach one how to become wiser, psychological scientists have so far been unable to provide practical and reliable methods to assess wisdom" (p. 25). Tremendous value can be gained from identifying the fine-grained characteristics of wisdom through psychological sciences for discovering what types of capacities individuals must have to be 'wise' when used in contexts of education, organizational life, particularly leadership and so forth. Yet, will a thorough application of knowledge about wisdom in such contexts create *wisdom-poiesis*? Philosopher of science, Charles Taylor (1987) would suggest it cannot:

“...in a hermeneutical science a certain measure of insight is indispensable, and this insight cannot be communicated by the gathering of brute data, or initiation in modes of formal reasoning or some combination of these. It is unformalizable. But this is a scandalous result according to the authoritative conception of science in our tradition, which is shared, even by many of those who are critical of the approach....” (p. 76)

One can hire an individual who checks all the ‘wisdom boxes’ and performs ‘wisely’ in constructed, experiential evaluation processes but will that produce a wise outcome in their inner life and for that context? Wisdom has been affirmed as a “multidimensional construct” (Bangen et al., 2013, p. 1264) and despite decades of studies on wisdom it has been noted in a Delphi consensus study that standard definitions remain elusive (Jeste, 2010). The field seems ripe for a new approach in methodology that takes up the phenomenological aim to study a phenomenon with reverence for the ‘whole’ as well as the ‘part’.

Hermeneutic-poetic-phenomenology thus holds potential to preserve the humane and human in the lifeworlds we create and in which we can find ourselves in all their complexity and tensions. Utilizing this methodology by distilling reflective journal notes, using poetic inquiry, a fast and easy way to condense the phenomenal in them, as a practice in our daily life might assist us with fostering a ‘wise-life’, as *poiesis*, through a life lived and preserve a sense of meaning-in-life and what it is we are potentially passing on, osmotically, from who we are and the ways we live and work. The poems rendered track emerging patterns, blind spots and strengths reflecting our lives and work back to us in ways that open up new possibilities and awarenesses.

5.5.3 Methodology as Personal Reverie in “Pheno-Practice”

I propose that hermeneutic-poetic-phenomenology has potential to provide a method for the study of one’s own personal ‘wisdom-compass’ operating, invisibly behind one’s life. Journaling such as “Morning Pages” (Cameron, 2006, pp. 8–17) even five minutes of ‘timed writing’ on a specific experience can be used as the ‘data’, the method is the steps outlined in the method section (Chapter 3) and this personal application of hermeneutic-poetic-phenomenology has potential to create a “pheno-practice” (Küpers, 2005, p. 221), as it has in my own life and clinical practice. Küpers (2005) describes this practice as a type of skilled, state-level practice from the formation of an artisanship that holds space for an interior phenomenological attitude that takes in the ‘whole’, as well as the parts, that attunes to feeling, ethical sensibility, reflectivity, intuition, creative processes operating out of awareness, image-centered knowledge, and material imagination drawn from deep reflection on one’s inter-relatedness to nature, all inwardly working toward the formation of horizon’s of hope, both personal and socio-political. This can move us into embodiment of wisdom toward creating with intentionality those new horizons and new worlds, wisely. “Pheno-practice” (Küpers, 2005, p. 221) is also proposed as a potential ‘remedy’ for fatigued clinical practitioners whose lives have been consumed by a seemingly endless stream of ‘parts’ in digital, socio-material medical practices.

5.5.4 A Peripheral Glance at Ontology, Through Poetics

Hermeneutic-poetic-phenomenology grounds the researcher in the fundamentals of being able to “learn the human” (Kumagai & Naidu, 2015, p. 287), deep within, in the space of human ‘being’. It engages the researcher in the deeper questions of what it means to be human, in the effort to render the most human wisdom, poetically. Imagination in an ontology of human ‘being’ cannot be accessed directly by any discipline, philosophical, scientific or otherwise. Bachelard (1960/1969) restrained himself from thinking so or trying to develop an ontology of imagination. He peered into imagination through the imaginations activity in reverie, particularly upon a poetic image in a poem and on the natural world. As we have seen, he proposed imagination’s creative epistemological knowledge generation in the world from conducting a phenomenology of reverie. He used poets’ renderings in the ‘poetic image’, and found glimpses of Imagination’s presence, ontologically as an aspect of human (well)being and human becoming.

For philosophical clarity to differentiate hermeneutic-poetic-phenomenology from Bachelard’s term ‘poetic-phenomenology’, the evoked response in the reader by the poetic image is not given potential to be a direct ‘ontological’ mediation of lived experience, poet to reader, as was sometimes implied in Bachelard’s (1960/1969) showing of his philosophy and methodology of poetic-phenomenology. Bachelard clearly uses a hermeneutic approach, which is flagged by giving this methodology ‘hermeneutic’ in its full title and

explicated in the method, situating it fully within an interpretivist philosophical tradition.

The phenomenal world we humans try to peer into with our minds in academic studies sits in a (westernized) societally created 'gap' between experience (embodiment), language (meaning) and thought (conceptualization) and the phenomenon itself in its viscerality and experiential intra-psychic, inter-psychic dynamism. This is a space and place where the 'concept' simply cannot go. At least, not without, in some way, distinguishing the living quality of the phenomenon and creating in its place a moulted shell of the phenomenon. As far as ontological claims about wisdom, or poetic-phenomenology, however, as in Bachelard's poetic-phenomenology, ontological considerations are left to the personal reveries of the reader. The question of meaning, in human 'being', is a question into which we can only ever peer, and darkly at that, with "nuances of ontology" (Bachelard, 1960/1969, p. 152). This nuance prevents ontological claims in any investigations engaging with poetics on phenomenon. It does however, acknowledge that by legitimizing poetics as a form of epistemology, in the sciences, a space is opened for reflecting upon how the ways we study lived experience, such as clinical *phronesis*, might be stifled and ossified at an ontological level, in the persons studying it, in the research subjects, and the aims of preserving clinical *phronesis* constrained, if not missed, when philosophical paradigms lending themselves to reductionism that can undergird specific methodologies, when they are applied to a study of a deeply human phenomenon, such as wisdom.

This argument is not taking a position that contends poetics are a 'good' method with which to 'show' findings in phenomenology. I have taken up Bachelard's (1960/1969) claim, that *poetics themselves* constitute an epistemology that capture and mediate in human life, a form of excluded knowledge that invokes its own differentiated, irreducible epistemology arising from the embodied, *sophian*, and dynamism of phenomenon, in this study's case, wisdom. I have attempted to show this claim as having veracity through this study.

Bachelard's philosophical endeavor that encompassed much of his academic life and quoted earlier in this study is perhaps worth bearing a repetition in light of the findings chapter, now. The translation is Kearney's (1998):

The crisis on the simple level of a new image, contains the entire paradox of a phenomenology of the imagination, which is: how can the image, at times very unusual, appear to be a concentration of the entire psyche? How – with no preparation – can this singular, short-lived event constituted by the appearance of an unusual poetic image, react on the other minds and in other hearts, despite all the barriers of common sense, all the disciplined schools of thought, content in their immobility? (p. 98).

Bachelard's claims in his poetic-phenomenology that poetics offer a means to mediate these deeply entrained dimensions of human life such as embodied perceptions and 'knowledge' such as the *sophian* dimensions, enmeshed with embodied experiencing of the world. Hermeneutic-poetic-phenomenology may be an eminently suitable methodology for application to a project of elucidating and eliciting these dimensions for a *poeticizing* of wisdom, through elicitation of wisdom-experience in participants' lives, without needing to

concretize any of the findings into the conceptual. Rather, it guides practitioners and researchers toward attending to the phenomenal, in their own lives and in mentoring clinicians.

5.5.5 An Approach with Reverence, for the Unknowable

Hermeneutic-poetic-phenomenology, therefore, makes no claims on what 'real' is within the phenomenon of wisdom but focuses on participants, and my own researcher interpretations and perspectives. It has aimed to reserve a reverence phenomenological philosophers have cautioned us to remember and assert must be preserved in any phenomenology - a sense of the phenomenon's irreducibility, what lies hidden, unnamable and unknowable, within phenomenon in life. If conducted in the spirit of the phenomenological tradition, phenomenology as inquiry, will inevitably draw us into an encounter with the mystery of being and becoming within the frame of focus on particular phenomenon, in this study's context, on how 'wisdom' dwells in being, what facilitates its becoming. It can leave this mystery with us to keep encountering over and over in our own lifeworlds with fresh eyes and a heart more widely opened to encounter life, specifically wisdom-in-life, anew. Wedded to poetics, it guides the researcher into a poeticizing of both self and research. Additionally, our lives and clinical practices will perhaps benefit from the renewing, catalytic effects that can arise in a poeticizing, phenomenological approach to research, clinical practice, and from a personal dedication to preserving, sustaining and mobilizing wisdom's presence in our lives.

Hermeneutic-poetic-phenomenology allows room for moving back and forth between hermeneutics, to attend to meaning, and poetic-phenomenology to attend to text, art, image-based knowledge, material imagination, embodiment, the processual, relationality, *Sophian* (intuitive/creative/philosophical) dimensions, and imagination's presence/activity in human lived experience of phenomenon being studied (in this case wisdom). Therefore, the philosophical underpinnings for this methodology are constrained to the suggestive and evocative that the poetic images crafted in poem writing can hold *potential* to awaken a response in a reader without any predetermination on the researcher's part as to what the response might be, nor whether it is in any way similar to the poet's original experience that generated the poem's poetic images, or the inner life of the participants in relation to the phenomenon being investigated.

Hermeneutic-poetic-phenomenology is situated in the phenomenological tradition's aim of drawing human beings into a phenomenological attitude-in-life. In so doing the phenomena studied simultaneously act upon us as we are investigating them, *and* affords a reflexive process in provision of a rigorous method for eliciting insight and revelatory presentation of a taken-for-granted phenomenon and through the process itself, in the rendering of findings, catalyze a new relationality with the phenomenon for new embodiment and (re)new(ed) 'praxis' within one's being and lifeworld as we live in it. If wisdom is sought in medicine, orienting ourselves, *phenomenologically*, with rigour and the discipline of the artisan might yield much fruit in preserving its presence in the social matrices and institutional processes in which medicine is practiced.

From this investigation of wisdom it seems to me that wisdom itself, encompasses its own self-limiting constraints on temptations to it for 'knowledge translation'. Phenomenology as a methodology, particularly in poetic representation, intrinsically resists such a temptation in both methodology as well as in the discipline of constraint to render findings in a poetic genre instilled into the researcher's craft of poem creation. Thus, the translation of knowledge is to open a glimpse into wisdom as phenomenon rather than transmitting wisdom *itself*. At best, wise people can serve as aspirational examples, the achievement of wisdom is work we need to conduct ourselves; hopefully aided through processes like those described in this study (Martinez et al., 1999; Wasserman et al., 2009). Training wise clinicians will require creating the conditions for wisdom to be attended to in embodied, meaningful ways in their clinical practice and teach students to differentiate their own practices of 'wise care' from clinical practices that are otherwise.

5.5.6 The Use of Theoretical Lenses

Using theoretical lenses as part of the methodology was an invaluable aid to deepening the inquiry and creating focusing lenses through which to peer. In the phenomenological analysis I discovered that the feminist bioethics dimension of analysis had been significantly submerged. In returning to the theoretical lens selected for this study and scoping the interviews, long poetic inquiry documents for each, it was discovered that there was rich material for this lens that had escaped the initial phenomenological analysis. Yet, the wisdom-phenomenon

(titled 'wisdom-compass') each woman seemed to have operating within their daily lives held meaning when placed into a feminist bioethics lens. This was added to each portrait and ensured its represented presence in the poem. Each woman's contributions were not consciously offered from a specific feminist bioethics knowledge or point of view. Only one participant identified herself as explicitly feminist (she used "women's libber and all that..." as her descriptor). Yet a phenomenon of discovering ways to have agency, autonomy, resist medicalization, engage specialists and nurses with empathic knowledge, subjectivity and relationality were evident in each of their stories and interview insights in muted and overt ways.

5.5.7 Poetic Inquiry as a Method Phase in Analysis

It was the poetic inquiry phase of the analysis that assisted greatly with forming a narrowing lens onto the phenomenological aspects of wisdom and proposed a sort of 'wisdom-compass' dwelling, at least *in potentia*, within. In seeking rhythm, balance, a distillation of that woman's tone, voice, images, words into a poetic rendering formed what could be described as a 'stumbling upon' a refrain that appeared, reappeared in the interviews that needed to be included, then repeated in each woman's poem and the realization that this 'refrain' was in fact, working like a 'wisdom-compass' into which the interviews as a totality could be resonant with. The participant herself was not foregrounding this to me the interviewer. Rather, it just appeared naturally and repeatedly in the flow of words and conversation echoing Denise's comment that "wisdom is

something you don't see in yourself". Yet, this phenomenon of a wisdom-compass seemed to be operating out of participant's full awareness as they grappled with the tensions of their lives with ovarian cancer.

5.5.8 Hermeneutic Dimension

The hermeneutic aspect allowed for the researcher's own influencing subjectivity to be included rather than bracketed out and engaging with the interpretive dimension of wisdom. The poems were rendered by the researcher and selected phrases and statements, images and metaphors that seemed to offer salient 'wisdom' staying with the original words but nonetheless, selecting through resonance rather than seeking out what conformed to current literature on wisdom characteristics or definitions. Many of these characteristics however, were found in the analysis and shown in this discussion. It also allowed for an integration of hermeneutics with attention to the image-centered knowledge hidden in their words through Bachelard's (1960/1969) philosophical underpinnings.

5.5.9 Representation

The final poem representing findings from this study titled, "I am Wisdom", offers one possible way to represent findings. A different researcher would have different poem of findings. This methodology is not about finding consensus, triangulating results or cross checking their veracity. It invites a researcher into a deep relationship with a phenomenon, along with the participants, and in the

world around them. All of this 'data' informs the investigation and shapes it through the heart, mind, body and imagination of the researcher.

It is, arguably, how 'Beth', 'Carrie', and 'Denise' might have also been represented, speaking as "I" through my interpretive lens and also creatively represented as speaking directly to the reader. I chose, however, to write their portraits in the third person and use their words, spoken in quotes using the third-person for their portraits, even though it is all selected by my subjective world and through my interpretive lens. This was a representational choice also, to try to provide the reader at least some direct encounter with them, by using their own words, and providing them, as contributors and participants in this investigation, 'page space' for a presence in this study with their own words and insights in a more direct voice to the reader. While the third-person voice used ran the risk of 'over interpretation, as if my framing speaks as fact about their meanings, this was a tension I chose to hold within their portraits and do my best to 'body' them as much as possible through their words.

5.5.10 Situation in Gaston Bachelard's Philosophy

The challenge was less assimilating Bachelard's philosophy as much as to transport his philosophical work into the present day health sciences discourses. I have attempted to show the relevance of Bachelard's canon of work for phenomenologists, poetic inquirers, health care researchers with the aim of examining the taken-for-granted and also to bring critical reflexivity to the project, as I did with the feminist bioethics lens, and to bring attention to the possibilities

of studying wisdom, phenomenologically since wisdom seems most needed and yet so absent in the socio-political forces shaping our world currently. His efforts to show the imagination's role in its own, differentiated productive agency in epistemology was taken up in this study. I developed it within hermeneutics that reflect an interpretivist paradigm to allow for the subjectivity of the researcher to be situated as part of the inquiry. Its aim has been to show its potentiality for eliciting the phenomenological dimensions of an intangible aspect of life, wisdom, that is difficult pin down or articulate. Furthermore, it has aimed to show how, as methodology, it can take an inquirer deeply into phenomenon such that the phenomenon also acts upon the inquirer and brings forth a new relationship, new insights and renewed connectivity with a phenomenon that may have been circulating unnoticed in their lifeworld. This study has specifically invited readers to further personal insight on themselves as potential 'knowers' of wisdom, potential generators of wisdom, and living lives that embody a *poiesis*, in their own becoming of wisdom, in a 'wise-life'.

By attending to the images, symbols, metaphors integrating them into the portraits, points of connection and additional insight were investigated moving from art to poem to portrait the analytic process. It allows for more 'right-brain sophian/intuitive/creative interpretation and intuitive associations to be engaged in the researcher which have been shown as source of valuable epistemological insight (Mahar et al., 2012).

I offer that this methodology's uniqueness allows for attention to the dimensions of *sophian*, embodied, and *poiesis* aspects of wisdom that

contemporary cognitive sciences and human development studies readily acknowledge they have not been able to tease out. Wisdom seems particularly resistant to formal logic and factually based representations (Glück, 2017b).

Poetics are a viable, economic means for accessing and representing findings in a manner that preserves and honours the dynamic nature of multi-dimensional, complex and dense phenomena. The field of wisdom research acknowledges that embodied, *sophian*, affective - including ethical sensibility, relational, and processual, aspects of wisdom are dimensions of wisdom. These are, however, less teased out by formal research and many studies acknowledge they need further investigation. What is less acknowledged is application of a critical reflexivity as to how the very philosophical paradigm in which these researcher's function and conduct their studies through, imposes a highly self-limiting constraint on what can be constituted as 'findings'.

The methodological constraints imposed by an objectivist philosophical paradigm in which cognitive and psychological sciences are situated are not seemingly questioned and the disciplinary fields in which they operate seem to afford little agency for breaching research methodologies into other philosophical paradigms, such as phenomenology, that might afford them the means to study these deeply evasive dimensions of wisdom. Rather, embodied and *sophian* dimensions have been relegated to 'discussion of findings' rather than elicited through their methodologies into findings that could further the wisdom study field into empirically gleaned insights. These disciplinary fields have not yet taken up the phenomenological project with its own rigorous 'science' of using human

consciousness as an entry point of inquiry, begun by avid scientists and philosophers, with Husserl, Heidegger, Bachelard, and Merleau-Ponty who argued that objectivist science is highly curtailed in its ability to elicit ‘intangibles’ in human life and a rigorous phenomenological approach is far better suited (See Chapter 2). Yet we can only ‘peer’ into aspects such as embodiment with the light of conscious awareness and scratch the surface which lent an argument for this study’s uptake of Bachelard’s poetic-phenomenology, for poetics, as seen in Chapter 1 and elucidated in the findings, taps into embodied, *sophian* dimensions without needing to explicate them in a categorized conceptual framework. Adorno, a philosopher in the Frankfurt school, a group of exiles from pre-war Germany who fled to the United States, is cited by Crotty (2003), “According to Adorno, the original sin of all philosophy is that it tries to grasp the non-conceptual through conceptual means” (p. 133). A similar contention, albeit without the pejorative implication, is implied in this discussion’s argument for ‘Why hermeneutic-poetic-phenomenology?’ as a science for studying wisdom to wedge a position for the findings of this study into the research discourses on wisdom.

The project of orienting a reader to a phenomenon, as a poem aims towards, is enough for an elicitation of deepened relationality with the phenomenon in the reader’s life. If a pragmatic approach to wisdom research is taken as the aim of a wisdom study such that forming wisdom ‘attunement’ and sensitization in the reader is its *teleos* (versus conceptualizations of ‘wisdom’) then the phenomenological project’s purpose of bringing the reader into a

relational encounter so that the phenomenon of wisdom can act, within them for catalyzing changes in their lives, then hermeneutic-poetic-phenomenology is situated in an exquisitely tailored position to fulfill this aim. I'd argue that this aim is enough for preservation of wisdom, in persons lives as a 'becoming-wise' and for furthering embodiment of wisdom in new ways of being. More knowledge 'about wisdom' is perhaps of less significance than having an orientation to the phenomenon of wisdom itself such that wisdom might be its own teacher, not a pedagogy, to become embodied *poiesis* within people living and shaping the culture of our times, particularly, medicine.

This study has aimed to offer a window into some ways wisdom can be formed within the matrix of deeply personal experiences through life-altering, painfully difficult, life truncating illness. Yet it can perhaps be better seen how hermeneutic-poetic-phenomenology through poetics affords a closer connectivity, felt between reader and participants, than other types of findings representation in health care journal literature, even those which have used phenomenological methodologies and which use thick descriptive quotes. The poem invites the reader into an 'encounter' with the study participants through the researcher's world. In this sense, the poem becomes a 'host' for a encounter with the reader's evoked engagement with the phenomenon, and a relationality, of some nature, between reader, researcher, participant embodies an invitation from the poem into a realm that perhaps, words, will not describe (Butler-Kisber, Guiney Yallop, Stewart, & Wiebe, 2017; Prendergast, Leggo, & Sameshima, 2009; Todres & Galvin, 2008; Wiebe, 2015).

From this study's findings it is hoped a reader might discover their own wisdom and strengths are rendered more visible to themselves. If it does, then hermeneutic-poetic-phenomenology, has fulfilled its aim.

5.6 LIMITATIONS

This study can only offer a phenomenological perspective about wisdom from three women's experiences and insights. It cannot generalize about wisdom while some reflection on possibilities has been offered for further inquiry. There was naturally significant influence from myself, as the researcher, having been immersed in counseling and support for approximately fifteen hundred oncology patients searching for personal wisdom for living with cancer in over a decade in oncology clinical practice. This created at the outset, a strong assumption that discovery of personal wisdom was possible and shaped the lens through the research was conducted. While foregrounded in the introduction of this thesis, this influence will necessarily have formed underlying assumptions in this study that may not yet have been brought to light and would distill further over time and reflection.

A significant limitation is that a more diverse range of voices is submerged in participant demographics, rendering potential voices excluded. That this study was possible reflects the significant privilege of the researcher in social and professional capital, i.e. resources of a full-time salaried role in spiritual care, within a large oncology treatment program, including empowerment from the

treatment context to run supportive care groups all of which formed compelling factors to consider this research study. The participant demographics, furthermore, reflect similarity to the demographic of the researcher. Each participant is Caucasian, college or university educated, living without physical challenges, other than their ovarian cancer symptoms and treatment side-effects. Each participant also lives without significant financial or material concerns influencing their experiences with ovarian cancer. Two were retired, living with two incomes, and one had a senior position in health care, including employer-paid health benefits allowing for disability pay. These more homogenous socio-cultural factors will have influenced participants' (and researcher's) perspectives on wisdom including its meaning(s) drawn from cultural, spiritual, experiential interpretations since wisdom is shown in this thesis as fundamentally embodied, and thereby influenced through an individual's socio-cultural matrices and life experiences. Their demographic factors further afforded a freedom of time for each to participate in a daytime supportive care group prior to the study, which was a pre-requisite for study participation excluding those who could not attend those groups.

Each woman identified the group process as helpful, even critical for culling insights into their own hard-won wisdom and cited significant benefit in sharing this with one another in the groups. This suggests there are implications for relational ethics as critical for 'wisdom finding' in a person's medical care. Without such resources providing supportive care modalities there is danger of a potential submergence of patient's lived wisdom for influencing their oncology

care if relational, dialogical, supportive means for claiming personal wisdom are not provided as a part of their health care. They might have wisdom to offer; yet without relationality, fostering reflective dialogue to guide their care, it may be excluded from a clinical consultation.

Additionally, the Soul-Medicine groups were possible in a spiritual care program within their oncology treatment pathways because it was developed in a resource-rich regional, urban oncology treatment centre. Less affluent oncology treatment programs may not have resources for any psycho-social-spiritual practitioners to offer this opportunity for a 6 week program to reflect on finding wisdom and bring it to articulation in a supportive care group. Limitations to having the time for both patients and clinicians to engage in the reflective processes for culling personal wisdom is a significant constraint within oncology care processes. This study may be suggesting a resource of wisdom in patient's contributions to their care that there simply is no time to integrate in clinical realities rendering its findings for the health care context, impotent. Patients may have an abundance of personal wisdom, yet it may remain excluded in their clinical dialogues due to system constraints. This study could not capture this tacit wisdom circulating in women's lives outside the context of their clinical oncology care due to the limited number of participants and the prerequisite of their group participation.

My influence as researcher, from the study's inception to data analysis and findings discussion was inextricably interwoven. It was challenging to disentangle clinical expertise and knowledge and thus approach the dialogue

with participants and data analysis with 'fresh eyes' from the design, conduct and analysis of the study. Appendix VII offers reflexive notes on the experience of changing from spiritual care therapist to research interviewer. In one sense, I've been immersed in a phenomenological study on lived wisdom in women with cancer for many years.

In the running of the groups as clinical facilitator, I was very aware of the potential influence skewing a promotion of 'wisdom conversations' beyond what might have naturally happened in groups not preparing for research recruitment. While participants were unaware of this potential, I, of course was. With this awareness, I noticed I back-pedaled on elicitive questions out of a concern it might be retrospectively perceived as influencing a predisposition towards volunteering. I was so acutely mindful of perceived coercion that, in fact, I noticed that acuity at times, interfered with the more natural ways I embody running a group. I found myself mentioning the word 'wisdom' less than usual, and in the first few sessions, almost not at all, to compensate for a concern of undue influence on shaping this conceptually for them in the group process. This compensatory behaviour was, at first, spontaneous and then immediately noted in reflective practice notes and clinical supervision discussion, which were both clinical/ethical mechanisms to 'out' my role and influence both as clinician, as standard of practice for the regulated psychotherapy college to which I belong, and as researcher whereby reflexivity is one of the quality criteria. I found a way 'into' this tension more fluidly with the second group from which the third participant was recruited.

By foregrounding 'wisdom' specifically for group exploration and finding 'wisdom' in the study begs us to ask: chicken or egg? Was wisdom found because it was sought explicitly? Can it be distinguished specifically as pertaining to wisdom as phenomenon or could other concepts be applied to the same data?

The ideographic nature of the findings drawn from the three in-depth portraits in the analysis must be emphasized. Another researcher might have discovered an entirely different finding of a central guiding phenomenon of each woman's 'wisdom compass', or not discovered this at all and framed findings very differently and creating an entirely different poetic representation.

The minimal number of participants cannot be cited as a limitation from within an interpretivist paradigm and due to the specific aims of the methodology, which did not target any realist, objectivist claims about wisdom. Rather than detracting from the findings on wisdom, it fully discloses and shows a polymorphic nature to wisdom in human life, evidenced by the diversity of representations of wisdom across cultures and historical eras and only speaks to the findings from drawn from these three individuals inviting the reader towards their own personal reflections and future potential studies that can take up further investigation, phenomenologically, on wisdom. However, I am curious as to further richness that might be gleaned from a study with more participants. That said, only three meant that I could dwell with each one very deeply in the iterative analysis process over almost a year, given that writing up a thesis, findings, and discussion are also a furthering and deepening of the analysis. In some ways, I

wonder if, in fact, this mined 'wisdom' more deeply and 'more' participants might have constrained the depth in the wisdom-phenomenon that I experienced myself as encountering in their study contributions. Perhaps, in wisdom, less is more?

The interview process confirmed that foregrounding wisdom as a concept to be discussed and elicited, as a personal contribution from participants can be a barrier to soliciting wisdom. Once the participants volunteered for the study, there was certainly difficulty at the outset with their claiming having any wisdom to offer with comments such as "I don't know that I have wisdom to offer but..." so the concept did present a performance anxiety type of barrier which Glück and Baltes's (2006) noted also with earlier wisdom research. This may have been a reason only three volunteered from two groups of ten participants. Foregrounding wisdom as the focus of the study in recruitment may have created a serious barrier to garnering a diverse range of volunteers.

However, the semi-structured interview style still yielded rich data. Interviews invited reflection together on the questions, invited stories related to personal events without constructing them as 'seeking wisdom' and interweaving direct questions about wisdom with indirect questions eliciting insight, thought, reflection and personal life experiences across themes of spirituality, relationships, roles in life, relational dynamics, experiences of wise care and wise clinicians in health care. The interweaving of direct and indirect questions regarding wisdom and 'finding a way through' moved the participants towards their own experiences rather than moving them into too much direct contact with

conceptual notions of wisdom while occasional questions were asked directly about their wisdom on x and y as well as on 'wisdom' in general itself through their views. This approach seemed to yield fruit in the findings.

At the same time, I found the interview guide both helpful and constraining. I knew the variety of areas I wanted to cover on wisdom with them, yet many times there were 'wisdom-moments' that seemed rich and could have benefited from more depth inquiring. This would have been at a cost of losing dimensions of wisdom in the inquiry, such as spirituality, being a mother and so forth. On balance, I would repeat the use of the interview guide while the way some questions are phrased might be different. I would possibly ask less 'direct' questions about wisdom, or reserve them for the end of the second interview, and find ways, using findings from this study, to indirectly engage the phenomenological aspects, without explicitly framing it as about 'wisdom'.

An unforeseen yet serious challenge must be noted as a limitation to this study. The findings poem, which reflects the rich wisdom mined from participants might be taken up as implying that wisdom 'ought' to be found when living hardships in life and that, somehow, one is failing if, when living with ovarian cancer, or any cancer, one does not feel wise or have much to offer the world from one's lived experiences. Submerged is the foundational strengths-based counseling approach to both groups and individual support that each woman experienced prior to arriving at their study interviews. This therapeutic approach accepts all feelings, no matter how difficult, as healthy and important and emphasizes that no feeling, be it anger, grief, despair, hopelessness, fear, worry

and so on be erased or somehow ‘therapied out’ of one’s reality. The participants knew, from my facilitation of the groups, that wisdom is framed as something radically difficult from the “tyranny of positive thinking” (Holland and Lewis, 2000) and integrates all feeling experiences as part of a whole within what it means to be wise and to continue searching for the ‘wise way through’. The grave danger with all transmission of ‘wisdom’ when it becomes disembodied from a relational, person to person dialogue, such as a document showing a poem of culled wisdom, is that it loses, as Ardelt (2004) argues, its meaning as wisdom and becomes simply a knowledge. While every effort was made in crafting the poem to include the difficult places, even “dark places” (Beth), from which their wisdom was born there is, nonetheless there is a concerning potentiality for the findings poem to further an individual’s sense of despair or disempowerment as they read it because submerged is the backstory of Beth, Carrie and Denise’s immense existential, spiritual and psychological struggles in the day to day from living with ovarian cancer. This study rests upon the assumption and evidence that living with ovarian cancer is excruciatingly difficult and its aim was to focus on showing the possibility for women to discover their capacity, as human beings, for wisdom finding as being born from such places rather than simply showing ‘findings of wisdom’ for transmission one to another.

5.7 CONCLUSION

This study used a novel methodology of hermeneutic-poetic-phenomenology to explore perspectives of women living with ovarian cancer. Each had participated in a supportive care group process prior to volunteering. Three women, Beth, Carrie, and Denise volunteered for the study. The methodology developed Gaston Bachelard's philosophy of poetic-phenomenology, situated in the interpretivist tradition, joining his methodology with hermeneutics. Poetic inquiry was integrated as part of the methodology and method. This methodology allowed for attention to be paid to a concept Bachelard proposed of "image-centered knowledge" and "material imagination", whereby the poetic image, or symbolizing image in speech, has the power to mediate one's embodied experience in evocative ways. Data was analyzed with attention to image-centered knowledge; material imagination; reverie; and horizon's of hope to elucidate their implicated aspects of wisdom and the ways participant's formed their personal wisdom. A feminist bioethics lens was used to investigate subjectivity, agency, epistemic power, medicalization. An embodiment theory lens was used to explore the ways the women's embodied experiences of wisdom were lived and to explore the embodied dimensions of wisdom as a phenomenon that is, fundamentally, entrained with embodiment. Findings were represented in portraits that show hermeneutic-phenomenological findings along with found poetry, participant art-collages and poems from the group process. The final representation of findings is then shown in a poem.

This study offers one glimpse into one possible way for how the seeking and embodying of personal wisdom might be elicited, through support, within oncology patients' experience. The supportive care groups *Soul-Medicine – For Living With Cancer* explicitly held out possibility for this to be experienced and offered processes that could assist participants to explore their 'intuiting', creatively, holistically and intentionally, to find their own wise-way in daily life. Those who volunteered from those groups to join this study affirmed in their interviews that while wisdom remained far from awareness in the living of their day to day, through discussion, reflection and group inquiry, wisdom emerged as having been discovered. The groups created a lagoon of meaning for insight about this notion of an 'inner wisdom' that can navigate the daily struggles, moods, tensions, crisis of living life and facing death with ovarian cancer and possible suffering and functioned as 'wisdom-primer' for potential participants who chose to volunteer for this study. Each affirmed the supportive care group had been a valuable, perhaps even critical dimension of their process after medical treatment in being able to hear the wisdom of other women living with the same diagnosis, experiencing connective relationality, learning practices of meditation, self-compassion, creating art-collages that could source some reminders of comfort. Dialogue and relationality seemed central to how wisdom was discovered in self and one another.

Findings were framed through the an inter-related dynamism symbolized in three images of a uniquely formed inner 'wisdom-compass', an 'inner navigator' who heuristically creates the compass and uses it for navigating daily

life, and a 'magnetic north' of wisdom-*poiesis* that orients the individual towards embodying a wise life, revealed on their dying. The embodiment lens frames an understanding of wisdom where embodiment, itself, forms a wisdom-labour that creates ones 'hand-made' compass used to guide the wayfinding in one's life journey towards a wisely lived life. This compass, and one's 'inner navigator' are formed and re-formed through reflection on one's lifespan, finding strength in adversity, openness to multiple perspectives, tolerating paradox and ambiguity, managing uncertainty, affect regulation and empathy with an ethical sensibility. In phenomenological study, these might be discovered as operating within a person's life generating potential wisdom-*poiesis*, meaning a spontaneous and reflective wisdom embodied in specific life situations to foster a uniquely personal wise-way to live through one's days. The study also invites the reader to reflect on their own wisdom and how, perhaps, this lies submerged from view amidst daily life with its tensions and struggles. The novel methodology is proposed as a possible path towards creating poetic renderings of a personal 'wisdom-compass' and for potential use in medical education training clinicians for the future of medicine to, potentially, embody 'wise care'.

5.8 EPILOGUE

Can a quest seeking wisdom, beget wisdom? The three women's contributions from this study offer to us the possibility of a 'yes' to this question...when there are supportive conditions to do so that include relationality, embodiment, *attunement* to the intuitive, creative, spiritual-philosophical, image-centered knowledge, a connection to the imaginal-reflective interior life, and a processual approach. Beth, Carrie, and Denise's wisdom-labour offers us an 'encounter' for a seeming absence of wisdom in our current world situation as a source of hope that no hard place endured or is without potential for a *poiesis* of wisdom and a poeticizing of one's life with wisdom, if one searches for it, and allows it to form in the 'distillery' of one's lived experience.

The last words from Beth, Carrie, and Denise for you, the reader,
in deepest gratitude for your presence with these pages.



From Wisdom

*I am quiet
invisible*

*I am so close
you don't see me*

do a fresh take

*I am hiding in time
be in the present moment*

*I form slowly
enfolded within
your navigating*

*take time to find me
in your living
and in your dying
when a wise life
is revealed*

and passed on

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APPENDICES

APPENDIX I: HUMAN RESEARCH ETHICS BOARD APPROVAL LETTERS

I.1 University of Western Ontario HSREB



Date: 9 July 2018

To: Dr. Glenn Bauman

Project ID: 108382

Study Title: Searching for wisdom: A phenomenological investigation of perspectives of participants' in an ovarian cancer supportive care group

Application Type: HSREB Amendment Form

Review Type: Delegated

Meeting Date / Full Board Reporting Date: 17/Jul/2018

Date Approval Issued: 09/Jul/2018

REB Approval Expiry Date: 28/Oct/2018

Dear Dr. Glenn Bauman ,

The Western University Health Sciences Research Ethics Board (HSREB) has reviewed and approved the WREM application form for the amendment, as of the date noted above.

Documents Approved:

Document Name	Document Type	Document Date	Document Version
LETTER OF INFORMATION AND CONSENT-CLEAN- June 2, 2018	Consent Form	06/Jul/2018	5
REB 108382 - PROTOCOL REVISED (V5) - CLEAN - July 6, 2018	Protocol	06/Jul/2018	5

REB members involved in the research project do not participate in the review, discussion or decision.

The Western University HSREB operates in compliance with, and is constituted in accordance with, the requirements of the TriCouncil Policy Statement: Ethical Conduct for Research Involving Humans (TCPS 2); the International Conference on Harmonisation Good Clinical Practice Consolidated Guideline (ICH GCP); Part C, Division 5 of the Food and Drug Regulations; Part 4 of the Natural Health Products Regulations; Part 3 of the Medical Devices Regulations and the provisions of the Ontario Personal Health Information Protection Act (PHIPA 2004) and its applicable regulations. The HSREB is registered with the U.S. Department of Health & Human Services under the IRB registration number IRB 00000940.

Please do not hesitate to contact us if you have any questions.

Sincerely,

Patricia Sargeant, Ethics Officer (ext. 85990) on behalf of Dr. Joseph Gilbert, HSREB Chair

Note: This correspondence includes an electronic signature (validation and approval via an online system that is compliant with all regulations).



**Western
Research**

Research Ethics

**Western University Health Science Research Ethics Board
HSREB Delegated Initial Approval Notice**

Principal Investigator: Dr. Anne Kinsella

Department & Institution: Health Sciences\Occupational Therapy, Western University

Review Type: Delegated

HSREB File Number: 108382

Study Title: Searching for wisdom: A phenomenological investigation of perspectives of participants' in an ovarian cancer supportive care group

Sponsor:

HSREB Initial Approval Date: October 28, 2016

HSREB Expiry Date: October 28, 2017

Documents Approved and/or Received for Information:

Document Name	Comments	Version Date
Other	Interview Guide	2016/08/11
Recruitment Items	Third Party Recruiting Script	2016/08/11
Other	Demographic Information	2016/10/17
Western University Protocol	Western Protocol Revisions as requested - Track changes copy	2016/10/17
Western University Protocol	V2	2016/10/17
Letter of Information & Consent	v2	2016/10/17

The Western University Health Science Research Ethics Board (HSREB) has reviewed and approved the above named study, as of the HSREB Initial Approval Date noted above.

HSREB approval for this study remains valid until the HSREB Expiry Date noted above, conditional to timely submission and acceptance of HSREB Continuing Ethics Review.

The Western University HSREB operates in compliance with the Tri-Council Policy Statement Ethical Conduct for Research Involving Humans (TCPS2), the International Conference on Harmonization of Technical Requirements for Registration of Pharmaceuticals for Human Use Guideline for Good Clinical Practice Practices (ICH E6 R1), the Ontario Personal Health Information Protection Act (PHIPA, 2004), Part 4 of the Natural Health Product Regulations, Health Canada Medical Device Regulations and Part C, Division 5, of the Food and Drug Regulations of Health Canada.

Members of the HSREB who are named as Investigators in research studies do not participate in discussions related to, nor vote on such studies when they are presented to the REB.

The HSREB is registered with the U.S. Department of Health & Human Services under the IRB registration number IRB 00000940.


Ethics Officer, on behalf of Dr. Joseph Gilbert, HSREB Chair

Ethics Officer: Erika Basile Nicole Kaniki Grace Kelly Katelyn Harris Vikki Tran Karen Gopaul

Western University, Research, Support Services Bldg., Rm. 5150
London, ON, Canada N6G 1G9 t. 519.661.3036 f. 519.850.2466 www.uwo.ca/research/ethics

I.2 Lawson Health Research Institute Approval



London Health Sciences Centre
London Regional Cancer Program

CLINICAL CANCER RESEARCH PROGRAM PROTOCOL DOCUMENTATION CHECKLIST & APPROVAL FORM

REB Approval # 108382

PROTOCOL: Seaching for wisdom: A phenomenological investigation of perspectives of participants' in an ovarian cancer supportive care group

PRINCIPAL
INVESTIGATOR(S): Dr. E.A. Kinsella

STUDY COORDINATOR: Helen Butlin

DATE

Letter of agreement received (Industry only)
CIA received and signed by MDT
Protocol submitted to Ethics Review Board
Ethics approval received
Health Canada Approval

Referred to Program Impact Committee
Approved by Program Impact Committee

Referred to Systemic and/or Radiation Treatment Program (if required)
Approved by Systemic and/or Radiation Treatment Program

Referred to Pharmacy & Therapeutics (if required)

Tissue for Biomedical Research Application submitted (if required)
Approved by Tissue and Archive Committee

Final Approval Date: 24 Oct 2016

Manager,
Clinical Cancer Research Program

Documentation to LHRI 24 Oct 2016

I.3 Letter of Information and Consent

LETTER OF INFORMATION AND CONSENT

Project Title: Searching for wisdom: A phenomenological investigation of perspectives of participants' in an ovarian cancer supportive care group.

Principal Investigator:

Dr. Glenn Bauman, London Regional Cancer Program, Schulich School of Dentistry and Medicine, Western University

Researchers:

Helen Butlin, PhD (Candidate), Doctoral Candidate, Health and Rehabilitation Sciences Graduate Program

Dr. Sandra Deluca, Director of Nursing, Fanshawe College; Faculty of Health Sciences, Arthur Labatt School of Nursing, Western University

The purpose of this letter is to provide you with the information required for you to make an informed decision regarding participation in this research.

1. Invitation to Participate

You are invited to participate in a study that is investigating women's personal experiences of living with a diagnosis of stages 2 – 4 ovarian cancer.

2. Why is this study being done?

The study investigates the perspectives and experiences of personal 'wisdom' of women living with stage 2- 4 ovarian cancer. The study will involve two interviews with women who have participated in the *Soul-Medicine - for Living With Ovarian Cancer* supportive care group. The interviews will occur after the group is completed, and will explore:

- a) How 'wisdom' might be experienced as meaningful?
- b) What might constitute 'wisdom' in your experiences?
- c) What ways might womens' 'wisdom' be experienced as a process for finding a 'wise-way' through the challenges of ovarian cancer?

3. How long will you be in this study?

You will be in the study until two interviews are completed.

4. What are the study procedures?

The procedure involves two face to face interviews of approximately 90 minutes each.

Inclusion criteria

Adults (over 18 years of age) who are diagnosed with stage 2 – 4 ovarian cancer, and who have participated in a '*Soul-Medicine*' - *for Living with Ovarian Cancer* supportive care group.

Exclusion criteria

Individuals, who are stage 1 ovarian cancer, or other diagnosis of cancer, are not eligible to participate.

Interviews

The two interviews will occur within 6 weeks of completion of the group process. Times and locations of the interviews will be scheduled at your convenience. These interviews will be 'semi-structured' and ask a variety of questions for you to offer your insights, reflections and thoughts on your experiences of wisdom. If fatigue is an issue for you, the interviews could be broken into smaller segments. The interviews will be conducted at the location and manner of your choice: at your home (or other private location of your choosing), by phone or by skype. The interviews will be audio recorded and transcribed for analysis.

Approximately 18 people will participate in this study.

5. What are the possible risks and harms of participating in this study?

In any conversation about lived experiences of cancer it is likely that a variety of emotions will be experienced. These can include fear, grief, sadness, sorrow, hopefulness, comfort, loss. Distress can become more acutely felt and experienced, for some this can be helpful, others not. These experiences cannot be predicted and sometimes these feelings can be overwhelming. Separate individual support is given for those who experience heightened distress from discussing aspects of their diagnosis through either social work counselling or psychologist, depending on the issues that arise. Assessment and support for appropriate counselling services will be provided by a nurse, a physician, or social worker.

6. What are the possible benefits?

a) Personal potential benefits:

These supportive care groups have been offered 11 times since 2009. From these groups, the participants wrote of the following benefits in narrative evaluations.

- enhanced personal relationships
- better coping skills for difficult emotions of grief, loss, despair, spiritual distress
- less fear of dying
- more tools for handling moments of overwhelm, fear of recurrence
- greater hope for living each day with a sense of balance and peace
- more capacity for knowing how to set personal boundaries around well-being

b) Potential societal benefits

This study has potential to contribute greater insight into women's lived experiences of wisdom when living with ovarian cancer. This may contribute to the peer-reviewed journal literature guiding physicians and oncology programs caring for women with this diagnosis. As well, an educational workbook "Handbook of Soul-Medicine: Wisdom from women living with ovarian cancer" may be created to anonymously share the knowledge offered by participants with other women newly diagnosed with this disease. This workbook project and its dissemination is being discussed with the Ovarian Cancer Canada. You will receive a copy of this book on its completion and its publication will be non-for profit with any proceeds going to Ovarian Cancer Canada.

7. Voluntary participation and can participants leave the study?

Participation in this study is voluntary. You may refuse to participate, refuse to answer any questions or withdraw from the study at any time with no effect on your future health care. If you choose to withdraw from the study, your data from interviews, art-collages or poetry will be removed from the study also.

You do not waive any legal rights by signing this consent form.

8. How will participants' information be kept confidential?

Data protection

Every effort will be made to protect your confidentiality in the study. The following procedures will be in place to maintain confidentiality at all stages of the study.

The research data used for analysis, will include:

Transcriptions of the 2 interviews conducted after participation in the support group and Artwork from the group such as art-collages and poetry.

Your names will NOT be on any research items but rather an alias name and number code will be assigned to each participant's material.

Your research data will be stored in the following manner: paper records will be kept in a locked filing cabinet in LHSC in the Baines Cancer Research Unit; electronic files will be stored on the hospital secure network drives and on an encrypted memory stick for transferability if this becomes necessary at any time. These records will be kept for 15 years in compliance with the requirements of Lawson Research Institute, LHSC.

Representatives of Western University's Health Sciences Research Ethics Board and Lawson's Quality Assurance and Education Group may have access to your study-related records to monitor the conduct of the research.

9. Are participants compensated to be in this study?

There is no compensation for participation. If a book is successfully published, each participant will receive a copy at no charge.

We will give you new information that is learned during the study that might affect your decision to stay in the study.

10. Whom do participants contact for further information

If you have questions about this research study please contact:

Helen Butlin, [REDACTED]

Dr. Glenn Bauman, [REDACTED]

If you have any questions about your rights as a research participant or the conduct of this study, you may contact: The Office of Research Ethics.

11. Publication

Findings from the study may be presented at conferences or educational events, and published in clinical and academic journals, books, or within educational resources. No identifying information will be published at any time. If you would like to receive a copy of materials published as a result of this study please contact: Helen Butlin.

This letter is yours to keep for future reference.

CONSENT FORM

Project Title: Searching for wisdom: A phenomenological investigation of perspectives of participants' in an ovarian cancer supportive care group.

Principal Investigators:

Dr. Glenn Bauman, London Regional Cancer Program, Schulich School of Dentistry and Medicine, Western University, [REDACTED]

Researcher: Helen Butlin, PhD (Candidate), Doctoral Candidate, Health and Rehabilitation Sciences Graduate Program, [REDACTED]

I have read the Letter of Information, have had the nature of the study explained to me and I agree to participate. All questions have been answered to my satisfaction.

You do not waive your legal rights by signing the Consent Form.

I would like to receive a copy of the 'Research Summary Report' at the conclusion of the study. My email address is: _____

Print Study Participant's Name	Signature	Date (DD-MMM-YYYY)

Print Name of Person Obtaining Consent	Signature	Date (DD-MM-YYYY)

APPENDIX II. SOUL – MEDICINE GROUP

II.1 Program Curriculum

WEEK 1: DISSOLVING THE GRIP OF FEAR AND WORRY, SOURCING INNER BALANCE			
CHECK-IN	DIDACTIC	MEDITATION + EXERCISES	AT HOME PRACTICES
<ul style="list-style-type: none"> Opening introductions - Name, what drew you to this group, what are you hoping for. Introduction to the group process and the themes we will explore Week 1 Fear state and how it affects us in uncertainty Week 2 "PracticeCALM" & mindful, non-judgmental awareness of feeling states for coping with difficult feelings Week 3 Self-Compassion, principles and practices for tackling the inner 'critic' Week 4 Facing the unknown: Hope and uncertainty, the tension and the possibilities Week 5 Following your inner compass – 'wisdom within' Week 6 Claiming 'spiritual eldership' from one's struggles, "How the cancer has changed me" <p>Confidentiality and emotional safety:</p> <ul style="list-style-type: none"> share only what feels comfortable passing on sharing anything after an exercise is absolutely fine silence is also a contribution in a world with little space for silence tears are part of our humanity, grief has few spaces for expression, tears are welcome and don't need 'fixing' confidentiality, what is shared here stays in the circle you can share with loved ones what you are getting from the experience, not what others are saying. I as facilitator am totally open to feedback - you can use email or phone calls, or talk to an independent, neutral person who can relay it anonymously (Kim Crawford at extension: 53623) Anything participants add for a sense of safety in a group process? <p>PracticeCALM standard breathing/meditation practice – music:</p> <ul style="list-style-type: none"> Feet on Ground, imagine breathing through your feet, drawing breath up into heart. 	<p>Tracking and Transforming Fear which is also the root of worry and its impact of fear on mind, body, feeling states</p>	<p>Inquiry in pairs (5 mins each):</p> <ul style="list-style-type: none"> Finish the sentence with partner listening, without comment, receiving the sharing of personal experience: "When I feel fear and worry what happens to me is ..." <p>Group wisdom on fear:</p> <ul style="list-style-type: none"> Each pair shares insights from exercise; they are placed on a 'mind-map' to create a visual image of the 'fear state'. <p>Closing:</p> <ul style="list-style-type: none"> 2 mins of same PracticeCALM meditation. Notice the difference between that state and the talking about fear and its impact. Dissolving 'fear' is not impossible! 	<ul style="list-style-type: none"> 5 x 1 min a day of PracticeCALM exercise learned Readings, as participants wish. Track when you notice fear/worry has 'arrived' in your mind/body/feelings. Use the PracticeCALM to refocus mind on present moment, body in here and now and breathe of taking in and letting go with the stillpoint in between. Journal - observations of triggers for fear/worry.

<ul style="list-style-type: none"> - Stillpoint Focusing - focus on the 'pause', the stillpoint, between the breaths - Nature Place - visualizing a place in nature where one has enjoyed being or where you'd like to visit, but not one that brings grief or difficult/complicated emotions with it. - Visualize a tree in the nature place and focus on knowledge that it releases oxygen for you to breathe in and you release carbon-monoxide that it needs for sustaining life. Sharing 'breath' with nature. 			
WEEK 2: BASIC MINDFULNESS PRACTICES AND PRINCIPLES – WHY DOES IT HELP?			
CHECK-IN	DIDACTIC	MEDITATION + EXERCISES	AT HOME PRACTICES
<ul style="list-style-type: none"> Experiences of practice through week, readings, 'moments' of PracticeCALM? 	<ul style="list-style-type: none"> Physiology of Stress & Relaxation Response 	<ul style="list-style-type: none"> Standard mindfulness practice of following breath and body scan Pair inquiry (5 mins each): I feel alive when I ... Group sharing on exercise 	<ul style="list-style-type: none"> Continue PracticeCALM and/or mindfulness practices whichever are working better for each person Readings and poems as participants wish. Notice and journal moments when you feel 'alive' and in the here and now, study what enabled that.
WEEK 3: PRACTICE OF SELF-COMPASSION			
CHECK-IN	DIDACTIC	MEDITATION + EXERCISES	AT HOME PRACTICES
<ul style="list-style-type: none"> Observations from practicing at home exercises – mindful awareness, mindfulness practices, PracticeCALM practice, moments when they 'felt alive' and what had facilitated that. 	<ul style="list-style-type: none"> Self-Compassion research shows it helps with feelings of despair, self-blame, shame, guilt. If you find it difficult, then talk to yourself as if you were talking to a best friend. 	<ul style="list-style-type: none"> Loving Kindness to self-integrating body scan, watching thoughts, practicing compassionate statements to oneself quietly in response to what arises. Sharing about meditation experience Paired Exercise: 'From Judgement to Wisdom' Pick a shell from the basket Step 1: "Judge the Shell" – notice the shell's 'flaws', all the characteristics that if it is 'supposed to be perfect' mean it fails and can't be perfect. Share 'judgements' with group Step 2: "Affirm the unique" – notice what can be affirmed about these 'flaws', reframe the judgement with the question, "what might this 'flaw' contribute? What might be contributive, or unique, or appreciated about these apparent 'flaws'. Share with group. Step 3 – "Find the wisdom" – From an 	<ul style="list-style-type: none"> 'Walk Around the Clock', once a day when a negative line of thinking is noticed Meditation practices: daily choosing the practices that help the most from the ones learned so far: PracticeCALM, 'stillpoint breathing, mindful awareness, body scan, nature place. Journal self-compassion statements daily to affirm your efforts in daily life dealing with the struggles. Talk to yourself as you would to a 'best friend' Collecting pictures/photos/affirmations/words from magazines, personal collections etc for Art Collage. Readings: 2 chapters from Kristen Neff's book, Self-Compassion, outline practices and exercises.

	<p>indigenous perspective, everything in nature is a wisdom and a medicine with its own teaching. What might be the teaching of wisdom that this shell, with its unique aspects bring to your life for today? Share with group.</p> <p>Step 4 – “Sharing the teaching”. Place shell on table and offer the wisdom this shell has brought you as an offering to the whole group.</p> <p>Can we approach our own nature, our own being, in a given day, with this compassionate viewpoint, searching for ‘what might be wise’ about my apparent flaws, or imperfections. Watch for the judging mind that comes at our own way with ‘oughts’ and ‘shoulds’ and ‘judgement of our failings’. Turn these judgements around with compassionate eyes that ask, ‘what might be wise about this part of my nature/situation/perspective/experience? What is it trying to tell me?’</p> <p>Introduce Art Collage Exercise for at home over next 3 weeks:</p> <ul style="list-style-type: none"> • Hand out large Bristol board and glue stick to each participant • Handout possible themes to focus on • Any picture, photo, words that jump out when flipping through magazines, affirmations, etc. anything goes that your intuition grabs onto and you don’t need a ‘reason’ why. Create a pile of possibilities over the next week. • Emphasize the exercise is designed to be a process of learning to trust non-cognitive intuition about what pictures/photos/items need to be included. <p>This week’s focus: create your pile of possible things to include in your Art-Collage.</p>	
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WEEK 4: RELATING WITH HORIZONS OF UNCERTAINTY – CULTIVATING ‘DUAL-AWARENESS’			
CHECK-IN	DIDACTIC	MEDITATION + EXERCISES	AT HOME PRACTICES
<ul style="list-style-type: none"> Participants arrive to see a ‘bundle’ on the table. It is in a dark navy (not black) cloth, clearly has items in it but can’t be seen what they are. No comment is made about the bundle by the facilitator. (In at are ‘gifts’ selected by the facilitator that can include items such as pebbles, shells, candles (non-scented), flowers, manufactured style butterflies etc.) 	<ul style="list-style-type: none"> Self-Compassion research shows it helps with feelings of despair, self-blame, shame, guilt. If you find it difficult, then talk to yourself as if you were talking to a best friend. 	<ul style="list-style-type: none"> Mindful breathing PracticeCALM - Feet on Ground, breathe through feet Centering through Still-Point focusing 3 minute meditation on ‘the bundle’ - Open eyes and contemplate the bundle on the table. Notice feelings/ thoughts/body sensations Check in: Observations from meditation on the bundle. Observations from at home practices of self-compassion Group discussion: What is my relationship with the ‘bundle of the unknown’ in my life? What does radical uncertainty do to mind/body/feelings/images? What are helpful ‘antidotes’ to the fear stories about the future? What keeps you in the here and now? Gifting from the bundle: Each participant is invited to put their hand in the bundle and select, without seeing what is in there, an object. Reassuring participants that there are no bad surprises. <ul style="list-style-type: none"> Contemplate the gift chosen - what kinds of meaning(s) do you associate with this gift. 	<ul style="list-style-type: none"> Any questions about Art Collages: begin creating the collage, arranging the items selected intuitively allowing ‘inner compass’ to guide process. Non-rational process, they will be shared with one another in the last week. Opting out is an option. Meditation practices: selected from variety learned, a few moments if nothing else can be done, per day. Journal: note relationship with the unknown, when the ‘future’ or an actual experience, observe, using mindful awareness, thoughts/ feelings/body/images and sensations. Practice ‘dual-awareness’ and the movement between the thinking mind about the horizon of the ‘future’ and using mindful, self-compassionate awareness to bring attention to the present moment, what is in the here and now to source a different focus than the future. Move back and forth with skill noticing the challenges and benefits of being able to move between uncertain future and the here and now. Readings/poems:

WEEK 5: LISTENING TO ONE'S INNER COMPASS IN DAILY LIFE			
CHECK-IN	DIDACTIC	MEDITATION + EXERCISES	AT HOME PRACTICES
<ul style="list-style-type: none"> Any questions about Art Collages? Observations/experiences from meditation practices. Journaling moments when 'unknown' and 'uncertain' rose up and what happened in mind/body/feelings? What helped bring you back to the present moment and how did you ground yourself in the present moment awareness? What is hard? What is easeful? 		<ul style="list-style-type: none"> Meditation Practice: <ul style="list-style-type: none"> Using objects from nature to meditate with 'Stone' Meditation. Choose a stone from the selection placed in front of the group. Music is played. After breath awareness, mindful body scan and Still-Point focusing bring attention to the stone: <ul style="list-style-type: none"> The meditation focuses on the long story of the stone through its history in time tracing its journey, through using the imagination, back to its 'beginning'. Facilitator guides the process from the stone in their hand, here and now, back to possible stages in its journey to their hand, going back in time as far as possible into the unknown origins that can't be truly factually known. <ul style="list-style-type: none"> Group discussion on experiences in Stone Meditation. Observations in mind/body/feelings/images. Timed Writing individually 5 mins: <ul style="list-style-type: none"> Finish the sentence, and then repeat: <ul style="list-style-type: none"> "What I've come to learn about living life with my diagnosis is ..." Group discussion on timed writing: <ul style="list-style-type: none"> Facilitator creates a 'mind-map' of the learning(s) on a large piece of chart paper. Highlight at end, the array of 'wisdom' collected from their lived experience 	<ul style="list-style-type: none"> Meditation practices that you find most helpful, as often as you can/wish. Finding our daily rhythm can be grounding. Explore what works best for you. Journal <ul style="list-style-type: none"> Self-Compassion statements for things you can affirm yourself for each day. At least one. Readings/poems.

WEEK 6: REMEMBERING OUR WHOLENESS			
CHECK-IN	DIDACTIC	MEDITATION + EXERCISES	AT HOME PRACTICES
<ul style="list-style-type: none"> Experience in meditation on 'the wise one' – explain studies that show our wisdom generally increases about difficult situations if we imagine discussing it with one we consider wise. Group sharing of Art – Collages Those who created one, each share their collage and can explain or tell their story of creating it. <p>Participants are invited to offer:</p> <ul style="list-style-type: none"> What they feel/experience looking at it. How it speaks to them personally, in their life NOT offering judgments on its artistry, or value judgments on 'liking it' but rather, what it evokes in oneself. Individual timed writing (5 mins) 'How the cancer has changed me?': list ways the cancer has changed you. Group discussion: Share insights on timed writing. Facilitator creates a 'mind-map' on a large piece of chart paper of the insights. Group observes and discusses the collected insights from the group. Closing: Each participant shares one or two words or an image that capture one thing they are leaving the group process with. Play song – From Voices by Beth and Cindy CD. Participants are invited to reflect on their process through the group sessions. Make sure they know facilitator is available for debriefing any time and they can make an appointment. The contact information was given in their packages in week 1. 	<ul style="list-style-type: none"> Claiming wisdom from your life as a form of 'eldering'. Reading from Arnold Mindell's, "Sitting in the Fire" on the difference between elders & leaders. Suffering is the rite of initiation for eldership in many indigenous cultures. Diagnosis of ovarian cancer forces a process of searching for your own wise-way and personal wisdom. 	<ul style="list-style-type: none"> Meditation - "Asking the Wise Friend/Inner WiseOne/Living or historical Mentor" Mindful breathing PracticeCALM – feet on ground, breathe through feet. Bring to awareness an image of the 'inner wise one' who has either a) become within you through the experience with ovarian cancer or b) a mentor/guide that is not you, someone from history, a living mentor/friend, a loved one who may have passed on. Imagine: What does they look like? What is their preferred environment? What do they know that you may need right now. Ask a question about something that seems intractable or difficult. Imagine their response. 	

II.2 Bibliography of Readings, Handouts and Poems

	HANDOUTS	READINGS	POEMS
<p>WEEK 1</p> <p>Dissolving fear/worry, Living in the here and now</p>	<ol style="list-style-type: none"> 1. McMannus, Carolyn. "Mindful Awareness in Daily Life: 4 Potential Benefits and 4 Principles". From Wellness Program, Swedish Medical Centre, Seattle. Verbal permission given to use these readings in wellness groups of any nature in health care, in 2005 and materials sent by mail for me to do so. 2. Burfin, Helen. "Dissolving Fear... Drop by Drop". Practices for tackling fear in body, mind, heart. 3. Book bibliography of recommended readings on a variety of themes. 	<ol style="list-style-type: none"> 1. Kabat-Zinn. (2005). "Meditation not to be confused with positive thinking" <i>Wheeler You Go There You Are</i>. Hachette Books, (p. 88-93). 2. Whyte, David. (2015). "Beginning". <i>Consolations</i>. Many Rivers Press. 3. Golther, Jeff (2011). "The Power and Peculiarity of Fear". <i>Moving Through Fear</i>. Penguin Group. 4. Chenak-McElroy. (1999). "Messengers, Dreams and Visions". Chapter 5. <i>Animals as Guides for the Soul</i>. Ballantine Books, (p. 140-183). 	<ol style="list-style-type: none"> 1. Brown, Judy. (2016). "Trough". <i>The Sea Accepts All Rivers</i>. Trafford Publishing. 2. Woodman, Marion. (2000). "I trust there is a healing process...". <i>Coming Home to Myself: Reflections for nurturing a woman's body and soul</i>. Ed. Mellick, Jill.
<p>WEEK 2</p> <p>Basic Mindfulness practices and principles – why does it help?</p>	<ol style="list-style-type: none"> 1. McMannus, Carolyn. "The Challenge of Stress". From, The Wellness Program, Swedish Medical Centre, Seattle. Verbal permission given to use these readings in wellness groups of any nature in health care, in 2005 and materials sent by mail for me to do so. 2. McMannus, Carolyn. "Mindfulness Meditation". Ibid. 3. Healing and Recovery/Stress Cycle 	<ol style="list-style-type: none"> 1. Kabat-Zinn. (2005). "Stopping". <i>Wherever You Go There You Are</i>. Hachette Books, (p. 88-93). 2. Precco, Rob. "Learning to be with feelings". <i>Feeling Wisdom: Working with emotions using Buddhist teachings and western psychology</i>, chapter 8, p. 69-80 	<ol style="list-style-type: none"> 1. Whyte, David. (1997). "Sweet Darkness". <i>House of Belonging</i>. Many Rivers Press. 2. Oliver, Mary. (1994). "The Journey". <i>DreamWork</i>. Atlantic Monthly Press. 3. Rumi. The Guesthouse
<p>WEEK 3</p> <p>Practice of Self-Compassion</p>	<ol style="list-style-type: none"> 1. Definition of self-compassion from Dr. Kristen Neff's website. 	<ol style="list-style-type: none"> 1. Neff, Kristen. (2011). Chapter 1, "Why Self-Compassion?" <i>Self-Compassion: The Proven Power of Being Kind to Yourself</i>. New York, HarperCollins, p. 1-18. 1. Chenak-McElroy. (2002). "Elk Dreaming." <i>Heart in the Wild</i>. New York, Ballantine Books. 	<ol style="list-style-type: none"> 1. Walcott, Derek. (1987). "Love after Love". <i>Collected Poems – 1948-1984</i>. Farrar, Straus and Giroux, 1st edition. 2. Wagoner, David. "Lost". (1999). <i>Traveling Light: Collected and New Poem by David Wagoner</i>. Michigan, University of Illinois Press. 3. Fox, John. "Finding What You Didn't Lose".

	HANDOUTS	READINGS	POEMS
WEEK 4 Dealing with a 'horizon of uncertainty'	No Handouts.	1. Levine, Stephen. (1997). "Broken Glass". <i>A Year To Live: As if it were your last.</i> ; New York, BellTower .	1. Berry, Wendell. (1999). "The Peace of Wild Things". <i>Selected Poems of Wendell Berry</i> . New York, Counterpoint. 2. Markove , Donna. (2000). "I will not die an un-lived life". <i>I will not die an un-lived life: Reclaiming purpose and passion</i> . NewburyPort, MA, Copsey Press. 3. Piercy, Marge. (2003). <i>In Praise of Fertile Land</i> . Ed. Mauro, Claude. Seattle, WA, Whit Press. 4. Oliver, Mary. (2004). "Peonies". <i>New and Selected Poems</i> . Boston, Beacon Press.
WEEK 5 Listening to one's inner compass in daily life	No Handouts	2. Chernak , McElroy, Susan. (2002). "Turning Poison Into Good", Chapter 5, <i>Heart in the Wild</i> . New York, Ballantine Books.	1. Avot , William. (2003). "Anyone Can Sing". <i>Small Things that Matter</i> . Imprint Unknown. ISBN-10: 0954603303. 2. Niebbuhr , Reinhold. (2010). "Nothing that is worth doing....". <i>The Irony of American History</i> . Chicago, University of Chicago Press. 3. Eliot, T.S. (1968). Excerpt, "At the still point....". <i>The Four Quartets</i> . London, U.K., Faber and Faber Ltd. 4. Excerpt, "With the drawing of this Love....". London, U.K., Faber and Faber Ltd.
WEEK 6 Remembering our wholeness	No Handouts.	1. Mindell, Arnold. (1995). Chapter 13. "The MetaSkills of Elders", <i>Sitting in the Fire</i> . Portland, Oregon, Lao Tse Press.	1. O'Donohue , John. (2008). "For the Traveller." <i>To Bless the Space Between Us: A Book of Blessings</i> . New York, Doubleday. 2. Milosz, Czeslaw . "Hope". In a Collection of twenty poems post World War II, titled "The World" but there is no citation to be found on the internet that I can see. 3. Rea, Rashbati . (2009). "The Unbroken" in <i>Beyond Brokenness</i> . Xlibris Publishing. 4. Fox, John. "Finding What You Didn't Lose." <i>Finding What You Didn't Lose: Expressing Your Truth and Creativity Through Poem-Making</i> . New York, TarcherPerigee Press.

APPENDIX III. BLOG: THE MATERIALITY OF RESEARCH

 blogs.lse.ac.uk

<http://blogs.lse.ac.uk/lseviewofbooks/2016/03/24/the-materiality-of-research-the-materiality-of-motherhood-in-academic-research-notes-on-workflow-from-a-mid-life-doctoral-mother-by-helen-butlin/>

The Materiality of Research: ‘The Materiality of Motherhood in Academic Research: Notes on “Workflow” from a Mid-Life Doctoral Mother’ by Helen Butlin

In this feature essay, Helen Butlin reflects on the process of rethinking the notion of ‘workflow’ as a mid-life doctoral mother concurrently working in front-line healthcare. She describes how this has meant apprenticing to writing as a craft, redefining one’s understanding of ‘the good PhD student’ and accepting the inevitable messiness of both life and academic research.

This essay is part of a series examining the material cultures of academic research, reading and writing. If you would like to contribute to the series, please contact the Managing Editor of LSE Review of Books at lseviewofbooks@lse.ac.uk.

The Materiality of Motherhood in Academic Research: Notes on ‘Workflow’ from a Mid-Life Doctoral Mother

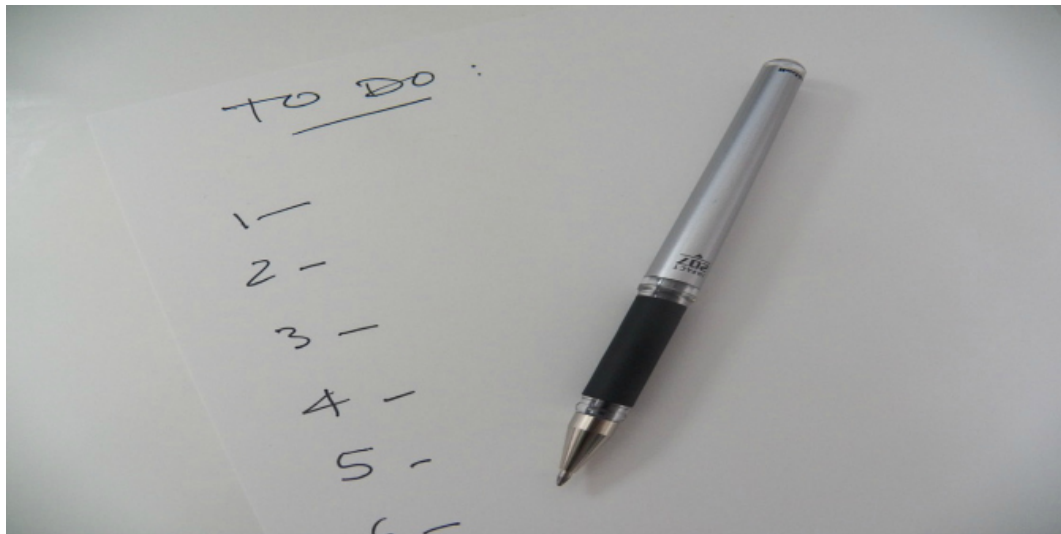


Image Credit: ([inspireexpressmiami](#))

6 Dec 2013 Thought Paper for the Health and Rehabilitation Sciences Seminar

Assignment: For this thought paper, I would like you to consider (and describe) the workflow that you use when writing. Do you write outlines before starting a paper? How do you keep track of where your ideas come from? How do you keep track of information that you have read? And finally, how might you make this more efficient?

‘Flow?’, I ask myself, the self that was still in shock that I had started this thing called a PhD. ‘And efficient?Is he kidding?’

I am a 47-year-old mother of two working in front-line healthcare, who was offered the chance to do doctoral research on a 'Pilot Study' I had developed in my hospital. The PhD seemed like A Good Idea At The Time. The above assignment was a monthly Thought Reflection Paper for the mandatory first-year course, 'How to be a Successful Graduate Student'. This came just before the end of my first academic term, which was an initiation by fire on the glories and diversity of Qualitative Research (QR). Having neither conducted any formal research nor ever once considered myself to be a Researcher, it was nothing short of revelatory.

The assignment was a timely question, having just handed in my first academic essay in fifteen years. It offered a chance to reflect on this experience. However, 'flow' was definitely not the first word that came to mind, while 'work' was an excellent description.

The fact is, the 'workflow' that ensued in writing the essay was a profoundly disheartening process of realising I am no longer twenty-something. It was a case of trying to remember what my workflow *used* to be, back in the days of my pre-children brain and all-the-time-in-the-world schedule. I had to figure out whether any of that former process worked after fifteen years of child-induced sleep deprivation while working mostly full-time.

I had the demoralising realisation that an entirely new workflow was going to have to be designed for this 'new normal', which included confronting barriers unimagined in the years before – interruptions galore involving snacks, homework and 'Mom I have to get to volleyball and no one can take me...', as well as attempts to import articles with new digital technologies that did not formerly exist. ('What's Reference Management Software?' was my first class question in the 'How to be a Successful Graduate Student' seminar. Heads turned ... all of them under 30.) Slowly, and painfully, my essay was produced, but 'flow' is not a word I'd use to describe the process.

I'm not sure that 'flow' exists for any academic over forty. It's more a process of accepting the limits of life and oneself and getting on with it in fits and starts around the demands of a busy household, worklife, relationships, research projects, writing projects, committees, weddings, births and funerals; of somehow still getting the creative process sparked whilst knowing that perfection belongs to the gods and definitely not to mere mortals and most definitely not to those humbled on a daily basis by our children.

It is realising that one's thought flow now has no periods in it. So many thoughts jostle in one's mind and compete for attention. They can range from the ridiculous – 'I might be a poststructuralist with a dash of the postmodern tendency to never fully take hold of any standpoint, but with a critical social theorist adamancy that there must be a "real" if one is going to aim for change in a really messed up world' – to the sublime – such as 'cripes-dear-god-its-6pm-and-I have-nothing-for-the-kids-for-supper-and-THANK-ALL-the-goddesses-that-came-up-with-pizza-delivery'.

Academic writing became a zen practice of remembering to put full stops between my thoughts, pausing to figure out what on earth I was actually trying to think, let alone write, and then re-writing all the run-on sentences into intelligible paragraphs. It also became a blessed reason to tell everyone to go away for long periods of time so I can finally, after all these years, reclaim some semblance of a brain and start *thinking* again. Years on the front-line of healthcare as a busy allied health practitioner have meant a very difficult realisation that one's thoughts, creative or otherwise, are far less valuable than how many people we can push through our practices to ward off the effects of the Reduced-Budget-For-Next-Year hovering over our heads.

At mid-life, the academic writing process can also be a lifesaving practice to counter the particular kind of demoralisation that I call 'healthcare despair'. It can put years of *clinical prhonesis* – practice-based wisdom – into existence beyond snatched hallway conversations with colleagues that evaporate the minute we walk away on to our next patient. Academic writing for the front-line clinician can be a form of *'poetic resistance'* to (re)claim our professional knowledge from dying with us, which truly inspired me to continue with my Health and Rehabilitation Science PhD.

'Flow' in academic writing over 40 is not the world of the twenty-something student involving herculean hours in the library finding all those thousand articles to secure the magnificent 'A' grade one is so determined to acquire. Flow

in academic writing for this mid-life doctoral mother became more like a river attempting to get to the ocean with the path of least resistance so that one has a shred of sanity by the end of the day. 'Flow' is the prayer that one finds what one needs in the hour and a half one has before the rugrats get home from school, technology glitches notwithstanding. This may be that original thought that burned long enough to get one to sign up for doctoral studies and that can only come to those seasoned by losses, travails and drudgery to hone one's own being into something original. Digging out the gem of originality from pages and pages of run-on sentences is the challenge.

'Flow' is also the prayer that help comes at the midnight hour for editing the epic borne of fifteen years of pent-up front-line knowledge. After a 3am magical writing surge, the edits can happen, but likely without the magic. In the end, writing is a craft and one must apprentice to this regardless of one's talent. This means hours of editing, and honing others' big ideas into half of an original one of one's own. It's always a movement from more to less. Just like mothering. Who I thought I'd be as a mother is a ratio of about 100 million to the power of 10 million to the mother I actually am. The doctoral study I thought I'd set out to do has borne out to have the same ratio.

'Flow' in my first doctoral course paper involved writing an outline a month before life happened. I had tried very hard to do what I believed all good PhD students should do. I planned the outline mid-term. I read the readings and sources, make good notes, gathered all the bones and expected that I would then write. Unfortunately, my flow means I write as [a method of inquiry](#). I never know what I want to say until I write. Hard as I tried to change this for my first course's final essay, it was not to be.

My process is therefore counter to notions of 'the good PhD student' in my mind's eye and the one described in all the writing workshops offered by my university. Every single paper I've written since has happened in pretty much the same way. I should have been on to this. Trying to be 'the good mother' by looking around me at all the high-functioning supermoms in the playground brought me to despair. Being 'the mother I am' was a long and painful process towards some semblance of self-acceptance and self-respect. Why I thought it would be any different in a PhD programme, I have no idea. After beating myself up for being a 'woman of many words', I sat down on this first essay to the task of editing. 'Flow' then meant a wrestling match with a story that seemed to refuse to fit in the box it was destined for: a Qualitative Methodology paper of fifteen pages.

Adding to this natural inability to Write-With-A-Plan, life came along and 'happened', upsetting the whole notion anyway. My father was diagnosed with cancer. My creative inner muse refused like a mule to follow any outline. I sat with it in hand, empty-hearted, and started writing something completely different. Since the topic of my essay was an autoethnography of creating a support group in an oncology programme, my father's diagnosis brought my worklife close to home. It meant the outline evacuated its content in a hollowing-out of everything that had felt important about the paper. My father was dying. The paper didn't seem to matter. Now a different story was being lived and the story intending to be written evaporated, because 'flow' in life means one writes in the real time of the now, not in the future or the past. 'Flow' means letting go of what one thinks one *should* write and surrendering to what heart and soul is actually asking to be written. Sleepless one night, I got up and wrote from the middle, from where I was in that moment. Ten hours later, I hadn't stopped writing. My first paper was born.

Through a different lens, one could perhaps see that a hugely wise thing had happened with that paper given that, in the coming months, my father would die and I had to interrupt my doctoral studies 'flow' to head over to England for palliation and his funeral. 'Flow' meant I may have instinctively, through some bone wisdom beyond my ken, have gotten myself ahead, so that I didn't get too far behind with the vagaries of what had arrived in the present.

Stories have their own life. So does research; it just gets made to look less messy than it really is. Life has never *not* been messy; we just try to live as if it isn't and create intellectual worlds that try very hard to smooth out the edges. I could do nothing but surrender to the process and trust it since it clearly had a life of its own, much in the same way that many who have come through my door in the cancer programme have had to learn how to live with the big non-negotiable in their life called 'mortality'.

'Flow' in all this meant that, despite the chaotic appearance of this whole process, I wrote what subsequently

became my comprehensive exam paper awarding me the title of PhD Candidate in one year. This has also become the first chapter of my thesis. It turned out I had laid down the major philosophical and theoretical underpinnings for my research. The paper also became a much-edited book chapter (in press) and garnered an invited article in a journal.

So 'flow' can mean that sometimes while it looks like the river is insanely wasteful, meandering its way to the ocean, it actually uses the least amount of energy of all modes of transport created to get there. The mind might think it has the 'right' path mapped out, but the organic wisdom of life, residing in our creative bones, might have a different way, which may just, in fact, be truly one's own unique way. This may be situated right in the heart of the flow of things and get us there much more easefully and carefully than we 'think'. And when we stop thinking, sometimes that's when our most original thoughts might well dare to be born.

Helen Butlin is a Registered Psychotherapist in Ontario, Canada, specialising in oncology care at the London Regional Cancer Program, ON, Canada and a private practice focusing on supporting individuals to integrate personal wisdom in leadership, clinical professions and daily life in general. She is also doctoral candidate in Health Professional Education at Western University, Ontario, focusing on excluded knowledges in cancer care from women's perspectives when living with ovarian cancer. She is a co-author of *Just Stay: A Couple's Last Journey Together* (2012) and has a particular interest in qualitative research that integrates poetics and embodiment. More information about Helen's work can be found at www.helenbutlin.com.

This article gives the views of the author, and not the position of the LSE Review of Books blog as an entity, or of the London School of Economics.

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APPENDIX IV. ETHICS: THIRD-PARTY SCRIPT FOR RECRUITMENT

Project Title: Searching for wisdom: A phenomenological investigation of perspectives of participants' in an ovarian cancer supportive care group.

You are invited to volunteer for a study that involves two interviews with Helen Butlin who is an investigator with this study. This research is investigating women's personal experiences of 'wisdom' while living with a diagnosis of stages 2 – 4 ovarian cancer. You are being invited because you are currently undergoing treatment for ovarian carcinoma, or are in follow up after treatment, at the London Regional Cancer Program, Ontario, Canada and have just finished participating in a 'Soul-Medicine' supportive care group.

This study will investigate your experiences and insights about wisdom and the research is being guided by the following questions:

- a) How 'wisdom' might be experienced as meaningful?
- b) What might constitute 'wisdom' in lived experiences?
- c) What ways might 'wisdom' be experienced as a process for finding a 'wise-way' through the challenges of ovarian cancer?

The two interviews will be approximately 60-90 minutes long each, and will be scheduled over the next 6 weeks at a time and location convenient for you. The interviews will be 'semi-structured', which means that Helen Butlin will ask a variety of open-ended questions related to your insights, reflections and thoughts on your experiences of wisdom. The interviews will be audio recorded and transcribed for analysis. Also, you are invited to share replications of your art-collage and poems from the group process, if you are comfortable doing so. These are helpful in considering alternate ways of considering 'wisdom'.

Your participation is entirely voluntary and you can withdraw from this study at any time without affecting, in any way, your oncology care, or your access to counselling and support in Supportive Care. You can stop the interview at any time should you decide you do not wish to continue answering questions, and you can decide not to answer any question at any time if you so choose.

All of the information collected will be anonymized and assigned an alias name. All identifying information will be removed from any information you share. A Master list of your identifying information will be kept in a locked filing cabinet in a filing cabinet in a lab at the office of Helen Butlin, in the London Regional Cancer Program in a separate locked cabinet from the information you share in your interview.

The findings of this study on the phenomenon of wisdom will be used to give voice to your insights in the development of educational materials for other people newly diagnosed with cancer; in the development of educational materials for health and social care practitioners; and in academic journals for clinicians

and researchers to consider in their program design and future research. As well, it is hoped that a Workbook that supports women Living With Ovarian Cancer will be published, which will include the anonymous insights that participants share about their wisdom for living with this diagnosis.

The aim of this study is to gain insight into the phenomenon of wisdom in order to create more focus on wisdom in oncology care with people living with cancer diagnoses.

This Recruitment Package contains a Letter of Information and a Consent form for you to sign should you be interested in participating in this study. This study has been approved by the Review Ethics Board of Western University and London Health Sciences Centre.

If you wish to participate please contact Helen Butlin, whose phone number is on the Letter of Information, to indicate your interest and an interview will be scheduled at your convenience either here at LRCP, and your parking will be covered, or Helen can visit you in your home if that is more convenient for you, or the interview can be conducted on Skype or by phone. You may also contact Helen Butlin if you have any further questions about volunteering for this study. You may also request at this time that Helen Butlin contact you to provide you with more information about the study; in this instance your contact information will be passed along to her, and she will follow up with you directly by telephone. Do you have any questions about this study and/or how to participate?

APPENDIX V. SEMI-STRUCTURED INTERVIEW GUIDE

Study Title: Searching for wisdom: A phenomenological investigation of perspectives of participants' in an ovarian cancer supportive care group.

The interview will be conducted over two sessions of 60-90 minutes each. It is divided below into approximately two parts. However, in phenomenological interviewing the conversation follows the narrative of the interviewee and may go deeper into certain questions than others or other insights and lines of inquiry may emerge from the dialogue where the interviewer invites deepened reflection on a particular statement to elicit further insights from the interviewee.

Interview Guide:

Part 1:

When you hear the word 'wisdom', what comes to mind for you?

About the soul-medicine group sessions

Were there insights about wisdom that you gained as you took part in the 'Soul-Medicine' group?

Probes:

Do you have any examples of how this has shaped your experience with ovarian cancer? With daily life?

Were there insights about wisdom that you gained through creating the art-collage and/or poetry exercise?

Probes:

Do you have any examples of how this has shaped your experience with ovarian cancer?

With daily life

Where do you turn for sources of wisdom for living with your diagnosis?

Probes:

Can you tell a story giving an example of 'finding wisdom' in these sources?

What was this like for you? What were your feelings in this experience?

Are there other sources of wisdom you've discovered?

Can you say more about these?

Tell me about a time when you were struggling and didn't know how you'd get through, but somehow found a way through anyway?

Probes:

What did you notice within yourself as you found a way?

What wisdom has come from this experience for you?
 Can you think of another example of finding a way through when you didn't think you could?

Is there an image of 'finding a way through' that comes to mind to describe this experience?

Probes:

How do you feel about this image?

What does it mean to you?

Why have you chosen this image?

Have you experienced a 'knowing' of something, without having a rational explanation for it either before or after your diagnosis? Examples?

Probes:

Have you experienced this kind of 'knowing' in relation to your diagnosis? Example?

Have you experienced this 'knowing' in daily life about other things? Example?

Can you give another example/story?

Do you have examples of experiencing wisdom from beyond your own knowledge or experience?

Probes:

What was this like?

Can you say more?

Where do you think this wisdom came from?

Did it make a difference in your own life in that moment?

Have you experienced a 'gut feeling' or 'intuition' that has guided you in some way? Examples?

Probes:

Can you describe what this was like?

Can you give examples?

How did it feel?

What did you do with this?

Would you see this as wisdom?

What do you notice about the way you are living now versus the way you were living before the diagnosis?

Probes:

Can you describe what this is like?

Can you give another example?

In what ways, if any, has spirituality or spiritual wisdom been a part of your life through this experience?

Probes:

Can you give an example?
How has this helped or supported you, if it has?

Are there ways you feel wiser as a result of your experience with ovarian cancer?
What have you learned?
How is this manifest in your life?

What wisdom would you share with another woman about living with the uncertainty of a recurrence of ovarian cancer?

Probes:

How did you come to this wisdom yourself?

Can you give an example of a moment when this became real for you?

What other wisdom, in general, would you share with another woman, facing ovarian cancer?

Probes:

What are ways you'd offer this?

Are there unhelpful ways you've been offered 'wisdom'?

Part 2 – Second Interview

What was the first interview about your experiences of wisdom like for you?

Are there any further insights that you'd like to share about wisdom that have come up for you over the past days/weeks since our conversation?

This interview will explore further your views and experiences relating to wisdom and will focus a little more on the experiences in your relationships, including being a patient in oncology treatment.

For mothers

Are there sources of wisdom that have helped you with being a mother in this experience?

Probes:

Can you give an example?

In what ways do they help you?

How did you discover these sources?

Are there any that have been the most helpful for you?

What do you notice about the way you are mothering now versus the way you were mothering before the diagnosis?

Probe:

Can you give any examples?

What wisdom, if any, has helped in supporting your children through this?

Probes:

Can you describe more about how this was valuable?

Any other examples?

Have you experienced 'wise' support of your children and family from others?

Examples?

Probes:

Can you tell me what this looked like?

What made this 'wise' for you?

Any other examples?

Have you experienced wisdom coming from your children through this time?

Examples?

Probes:

Can you give another example? Say more?

What ways have your children found to offer support to you? Examples?

Probes:

What was this like?

Do you see these ways as 'wise'?

Any other examples?

If you were to share your wisdom about being a mother with another mother with ovarian cancer, what would you say to her?

About your partner/extended family

Are there wise ways that your family has supported you?

Probes:

What makes these ways 'wise' from your perspective?

Are there other examples?

Do you have a partner? Are there wise ways that your partner has supported you?

Probes:

What makes these ways 'wise' from your perspective?

Are there other examples?

If you have a partner, what do you notice about the way you are partners now versus the way you were partners before the diagnosis?

Probe:

What wisdom are you gaining about 'being together' in this experience and what you most need as a couple?

Can you give any more examples?

What wisdom would you share with a woman with a partner about coping as a couple with this diagnosis?

Probe:

Can you give an example?

What makes this particularly valuable, in your experience?

Are there wise ways that your partner/family has been supported by others?

Probes:

What makes these ways 'wise' from your perspective?

Are there other examples?

What would 'wise support' of your partner look like from your community around you?

What wisdom would you share with another woman about the impact of this diagnosis on your extended family and best ways to cope with this impact?

Probe:

Can you give examples?

Oncology Care

Have you met a clinician you would call 'wise'?

Probes:

What did they do?

Why do you describe them as wise?

How did you feel?

To what extent was this important to your care?

Other examples?

Have had experiences of a difference between 'wise care' and 'unwise care'?

Probes:

Can you provide examples?

What did these feel like for you?

If you were to share the wisdom generated from your experience to gynecological-oncology physician trainees about the most crucial wise-ways of working with women with ovarian cancer, what would you say?

Probes:

Is there anything else?

Why is this important?

Final Questions:

Is there an image of 'wisdom' that comes to mind after this conversation that best captures your sense of what wisdom means for you?

Is there anything else you'd like to share or discuss related to wisdom for living with ovarian cancer?

Thank you very much for offering your reflections on wisdom for this study.

APPENDIX VI. PERMISSION TO USE COPYRIGHTED MATERIALS**VI.1 Palliative and Supportive Care**

On Jun 27, 2017, at 9:28 AM, Anna Hofvander [REDACTED] wrote:
Hello Helen,

Congratulations on having articles accepted into *Palliative and Supportive Care*. Please cite your articles properly within your thesis and I believe you should be all set! Thank you for checking with us.

Best Wishes,

Anna

Anna Hofvander
Publishing Editor, STM Journals
Cambridge University Press
[REDACTED]

<image001.png>

From: Helen Butlin [REDACTED]
Sent: Monday, June 19, 2017 1:56 PM
To: Kelly Loftus [REDACTED]
Cc: [REDACTED]
Subject: Permissions request for reprinting articles in doctoral thesis manuscript

Hi Kelly,

I am writing to request permission to re-print two articles that were published by Cambridge Press in the Journal of Palliative and Supportive Care.

The purpose is to include them in my doctoral thesis with Western University, Ontario. The thesis is being submitted in the style of a four chapter integrated thesis that includes 4 peer-reviewed published articles. This obviously necessitates their being re-printed for this purpose, and this purpose only, in order that the examining committee may read them as part of my thesis submission.

Appropriate citations will naturally be included to the journal and Cambridge Press in a footnote with each re-printed article.

The articles requested are:

Butlin, H. (2015). "Psycho-oncology: Searching for practical wisdom?" *Journal of Palliative and Supportive Care*, 13(5), 1495–1500.

Butlin, H., Kinsella, E. A., Garcia, C, Bauman, G. [2016]. "Searching for wisdom in oncology care: A scoping literature review". *Journal of Palliative and Supportive Care* (e-pub. ahead of print).

I appreciate your consideration of this request,

Sincerely,

Helen Butlin

Keep some room in your heart for the unimaginable
~ Mary Oliver ~ (Evidence)

Helen Butlin, MDiv, PhD (Candidate)
Registered Psychotherapist (CRPO)

Cambridge University Press is the publishing business of the University of Cambridge with VAT registered number GB 823 8476 09. Our principal office is at University Printing House, Shaftesbury Road, Cambridge, CB2 8BS, United Kingdom.

VI.2 Poem, *From the Heart of Health Care*

Poem is posted on professional website associated with the book

Dear Helen

About the poem – all is fine. I am confirming

- a) The poem is published on this website:
<http://www.practicefutures.com.au/journalists-views>. The website will exist at least until mid next year.
- b) You regain full copyright and have permission from me (the website publisher) to re-publish it as you wish including in your poetry book
- c) The reference would be: Butlin, H., (2017), *From the heart of healthcare*, <http://www.practicefutures.com.au/journalists-views>

All the very best

Joy

Professor Joy Higgs AM PFHEA PhD Professor in Higher Education, Charles Sturt University

Mail address Professor Joy Higgs, Division of Learning and Teaching, Charles Sturt University – Sydney, Locked Bag 450, SILVERWATER NSW 2128, Australia Street Address: Charles Sturt University – Sydney, Suite 1.01, Quad 3, 102 Bennelong Parkway, Sydney Olympic Park NSW 2127 (W) [REDACTED]

Email: [REDACTED]

Joy Higgs Website: www.epen.edu.au/JoyHiggs Member - Australian Learning and Teaching Fellows Network <http://www.altf.org/> Principal Fellow Higher Education Academy, UK

VI.3 Soul-Medicine: An Autoethnography

Hi Helen,

Thanks for inquiring about this. If the doctoral thesis is only intended to be used for academic (non-commercial) distribution then we have no objection to you re-using the chapter there. Please do make appropriate acknowledgment if it is used. Thanks!

Best,

John

John C. Bennett

Acquisitions Editor, Education

BRILL USA, Inc. | 2 Liberty Square, 11th Floor | Boston, MA 02109 | USA

| Web <http://www.brill.com>

From: Helen Butlin <[REDACTED]> Monday, July 30, 2018 5:51 PM **To:** John Bennett <[REDACTED]> **Subject:** Butlin - Chapter republishing permission for doctoral thesis request

Hi John,

Your name was offered by Jolanda Karada for this request to reprint a book chapter in a book Sense Publishers has published. Jolanda did direct me to the website form for requesting republication of Sense Publisher's copyrighted material but the website republishing form seems to require an "invoice number" which seems to not fit this context? I'm uncertain as to how to submit the request without this. I am requesting permission to reprint a book chapter in my doctoral thesis being submitted Aug 31, 2018.

The chapter is published in:

Tasker, D., Higgs, J, Loftus, S, 2017 Community-based healthcare: The search for mindful dialogues, Rotterdam, The Netherlands, Sense Publishers.

The book chapter is titled, "Soul-Medicine: An Autoethnography and the author's name, mine, is Helen Butlin.

Appropriate citations will be included in the reprint in the thesis and in the permissions acknowledgements.

I look forward to hearing from you at your earliest convenience.

Please let me know what the correct step for this might be.

Sincerely,

Helen Butlin

Helen Butlin, MDiv, PhD (Candidate)

VI.4 The Materiality of Research: *The Materiality of Motherhood in Academic Research: Notes on "Workflow: from Mid-Life Doctoral Mother (Blog)*

Hi Helen

Great to hear from you.

Of course, that's no problem to reprint your blog post as part of your thesis. I'm really pleased to hear that it proved of use to your eventual dissertation! All that we would require is a footnote (or whatever fits with your referencing system) that acknowledges that it was originally posted on the blog. I can advise about the best referencing style for this if that would be helpful.

Do let me know if you have any further questions.

Best wishes,
Rosemary

Dr Rosemary Deller Managing Editor, LSE Review of Books

London School of Economics and Political Science

Ground Floor, Queen's House,

55-56 Lincoln's Inn Fields

London

WC2A 2AE

Tel: [REDACTED]

<http://blogs.lse.ac.uk/lsereviewofbooks/>



Hi Rosemary,

I hope this finds you well. I am approaching the end of my doctoral studies with thesis submission approaching August 31 this month.

I am therefore, writing to request permission to re-print this blog in my doctoral thesis being submitted at Western University, Ontario, Canada, on August 31, 2018. It is part of my "reflexive writing" section on the researcher's reflexive inquiries during the conduct of the study. I apologize for the late notice having just made a structural decision to include reflexive writings in between thesis chapters to 'out' the researcher's reflexive process and this piece captures a great deal of that in one place. The piece reference is:

The Materiality of Research: 'The Materiality of Motherhood in Academic Research: Notes on "Workflow" from a Mid-Life Doctoral Mother' by Helen Butlin

<http://blogs.lse.ac.uk/lseviewofbooks/2016/03/24/the-materiality-of-research-the-materiality-of-motherhood-in-academic-researchnotes-on-workflow-from-a-mid-life-doctoral-mother-by-helen-butlin/>

I look forward to hearing from you.

Sincerely,

Helen Butlin

APPENDIX VII. REFLEXIVE JOURNAL FOR INTERVIEW PHASE**Jan 22, 2016 – Day before first interview.**

As I read and prepare for this interview using Linda Finlay's book *Phenomenology for Therapists* chapter on Data Gathering I read, "For the therapist, the most challenging thing for you will be to ensure you stay focused on the research project and hold back from making therapeutic interpretations or interventions." I ponder this. Having practiced with two colleagues, one in Spiritual Care with similar training and work as my own and one an Occupational Therapist and doctoral student I reflect on whether this was true at all in those interviews. I cannot find any moment of impulse to explore anything said therapeutically even when emotions were stirred. I am aware though that the reality of what the women I will be interviewing are facing - which is an almost certain end of life process in the nearer future than they want - forms a radically different back drop to a conversation about their lived experiences of wisdom. I notice a deepened awareness of this interview being similar to Chochinov's 'legacy document', their repository of wisdom. I am regretting not building in a step, discussed but set aside to have their interview formally given back to them as a gift from their contribution as their own repository of wisdom for them to keep, share with loved ones. One of the collatorals from the need to streamline research projects of this nature to their simplest forms in order to focus scope, manage REB processes and so on. Something I doubt mine will manage anyway. Simple is never my way it seems.

I also notice that thus far, both women who have consented participation have chosen for me to come to their home. Neither of these met with me in my office but rather inquired about the groups by phone and their screening assessment for the group was done over the phone. It will be curious to see what the women who do come to my office and experience that space choose. If they haven't seen it, the imagining of my office will be strongly associated with the cancer treatment areas and therefore the current women are demarking this research interview, instinctively as NOT associated with treatment, their health care team etc. I wonder if it is a helpful way the research process allows for them to restore some of the power differential encountered with their cancer care by having this take place in their own familiar surroundings and where agency might be better held onto.

For me, it is a very curious shift in my years of experience as a practitioner. On occasion, I have followed my patients into their end of life processes at home and met with them and their families there. Yet still I am coming as therapist, spiritual counsellor, support in role. Here, I come as someone seeking something FROM the individuals, they are GIVING something, voluntarily to me. I am receiving a gift, they the giver. It's a curious shift energetically in the relationship and emotionally. I wonder how they feel?

I feel excited and ...hard to put a word on it, humble. Humble in the sense that this is really a pure gift they are giving me. They are not forced into this

relationship in any way, with 'Helen the researcher'. They have chosen it. In my role, often, it is out of great distress and the word, or persuasion out of a belief that support is really needed, from of a front line clinician that compels them through my door. After that, they choose to return or not but nevertheless, something about the disquiet and emotional strain they are going through is a driving force behind the initial conversation. Here, it is curious to wonder what compels this 'yes' from them to contribute their 'wisdom' to the study. I wish I had added that question to the interview guide...."What drew you to the study?" I suspect it would hold a clue into the phenomenon under scrutiny.

I anticipate a bit of awkwardness as the person who ran the group show up in their home, in me too. Shifting roles creating uncertainty for navigation. Fortunately, the group process itself was full of that and we are both well-prepared for that dance having done it already in the group, particularly in week 1.

It is a marker moment to be 'here'. 3 years of preparation, milestones, hoops, mettle testing challenges, personal, professional and doctoral. A descent far more than an ascent....as only a core concept such as 'wisdom' could provoke!

It feels very, very good to finally be meeting and preparing for an encounter in the interview process with a brave and generous participant. A woman with shortened life, reaching for hope and meaning as best she can and somehow, for

own likely inarticulate reasons, saying 'yes' to this study on wisdom in women living with ovarian cancer.

May it honour her 'yes' and bring something of her own hard won wisdom to fruit.

Jan 23, 2017 – 1st interview

I arrive after not finding it easily and needing to call for help on directions. The usual challenge of my outer world inadequacies, the part of my nature I have navigated around my whole life. She has prepared tea and cookies, I'm very touched. Hospitality extended and a levelling of the playing field has been marked from the relationship of group facilitator, counsellor at the cancer centre. I am now guest with gifts being offered, tea, cookies and the interview. I feel a sense of relief that this simple gesture and age old ritual between women in their homes for a guest takes charge of our new relationship and marks its beginning. I say 'yes, thank you so very much, that is very kind". Agency given, acknowledgement of the new footing we are now on. I am now a recipient, she, the giver, in control of her home. She asks if we should sit at the table if I need to take notes. Answering my first conundrum...how to ask to sit at the table so the Dictaphone can work best without it seeming intrusive and that I am taking control. We have some preliminary warm up conversation, weather, her upcoming trip to the sun. I am feeling my way into this new role, now finally embodied, prepared for over 3 years and thousands of hours of reading and

writing. Researcher. Oddly, it feels laced with some other dynamics, hard to put my finger on. Confessional? Not really yet a confessional of a person's story is about to take place. Testimony? She may not be alive by the time this study is published, her story seen in print. A woman's reflections of her wisdom experiences, finding it, knowing it, what is it for this diagnosis. Not sure but there is a sense of stepping into something and the rituals have all set the tone. I am guest, not therapist, she host, a gift giver in charge of the gift. It feels very relieving to be honest. And I don't have to write a chart note or perform a hundred bean counting data entry points for the conversation. The writing after and analysis is 100% welcome....it has purpose beyond dollars being saved and counted for the hospital. I note the absence of that underlying tension and foundation to everything I do in my therapeutic healing, soul-medicine work. This aligns congruently with what is ahead, it is not carved out against a paradigm, it is aligned with it. That feels wonderful.

She asks if I mind if she takes off her head covering. I say not at all. She comments that some people are uncomfortable with her short, growing in, wiry grey hair. I say that I'm more than used to it. Given that it simply looks like short hair I am surprised this makes others uncomfortable and comment as much and she states that she can just tell from their body, their look they feel the discomfort. I think again how the individual is stigmatized with others fears, what our patients carry...for others and have to deal with. Her turban coming off creates a sense of comfortableness, I feel I've been invited into a closer intimacy,

she is taking control of her story in another new way, 'this is me', my embodied self carries the story, my hair tells and I am letting you see it. It feels like a signal of acceptance both of me and of our purpose, the interview, offering her wisdom about her own experiences of finding it. I realize that signing up at all is a signal that a woman feels some sense of contribution. I wonder too if the group plays into that and whether she would have signed up without participating. I somehow doubt it. Who claims themselves as 'having wisdom'. A pang of worry about having 'outed' the concept so much. What does that do in this conversation? While, Joan of Arc in me....remembers thinking this through and laid it down, as invitation, and a gauntlet perhaps. I didn't want to spend an hour of 90 minutes trying to therapeutically support someone to believe they could 'claim' wisdom to offer insights on. Stepping in, knowing fully what was being studied, in itself, a sort of selection process to aid in eliciting wisdom since, it wasn't a study on how women find courage to believe they HAVE wisdom. That's what the groups aim is. 6 weeks were hopefully enough for these women to believe that had something to offer. Others in the group valued their contributions – I hope that was realized. Do you study wisdom 'head on'? Something to think about.

I explain the recorder, how the interview is protected by the ethics protocols, what it will be used for as in the Letter of Intent but now, a conversation and me saying thank you, most sincerely for her willingness to contribute. I remind her too that at any time she can stop, withdraw from contribution, pause, resume another time. Process consent as therapeutic, a skill set that comes naturally

since it is the same in any therapy session. She comments that I am probably doing this in her 'best moment' as she is "more well and ok than she has been since the chemotherapy – all 18 treatments and I'm feeling really quite good". I comment that this might be a great moment then to pause and reflect on the journey she has undertaken to get here and what has given this inner strength to feel this ok, even well, after what she has gone through. Inwardly I hope and wonder if in fact, this interview will inflict something less needed right now...does she need to stay away from the story and just enjoy feeling more normal and well?

We begin, deep breath.

There is an ease 1 on 1 with her and I'm glad I got to know her in the group because I was used to her more introverted way with longer pauses than the others, thoughts brought forth from thinking inwardly before they are spoken. I was better prepared for not filling the pauses to alleviate mine or perceived anxiety. Therapeutic rapport, with trust, respect and connection being already established it felt the interview fell into a very easeful process of dialogue and exploration.

First ethical tension. 'The therapist me' knows the living story of this person's grief from a significant loss just prior to her diagnosis. 'The researcher knows I need the story tied to the phenomenon in ov.ca. as the context'. The loss story is

more present and raw and the questions turn to that time, lived now and not ending, around the question. But, I worry that this doesn't give me content for 'ovarian cancer' and 'wisdom', the frame of the study. Research imposes on human realities that are not neatly separate. 'The therapist me' would simply follow exactly where her feeling world is, be there, see what might come from the 'being there' together. The 'researcher me' knows I have a number of questions and areas about wisdom in her life I'm hoping to elicit. A small breathe inwardly, feet on ground, breathe from feet, trust the process, as I've done a thousand times in sessions for inner guidance and 'flow'. I gently allow time for the tears, affirm her story and then invite a reflection on how that digging deep experience connected with the times she had to with ov.ca. It seemed pretty smooth and unobtrusive, it felt ok to invite that reflection, not simply because I needed it for the interview but because in fact, therapeutically, it invited her to go closer to her own living experience not defined by her relationship with her husband, the one she is living now and the place within where wisdom will be needed for what lies ahead, which is perhaps less about her bereavement in the present moment. She responded with some rich reflections. I feel some relief. First tension of roles moment passed through safely it seems. I notice the pull of the story of the bereavement in subsequent questions and her responses. I note, with my therapist mind that this is an interesting phenomenon and that clearly, the bereavement has been a different kind of hard for her, it still has living content that is more powerful than her own life. They did that together, she is doing this alone. This comes into her narrative later.

I notice I am working much harder to communicate empathy and understanding without words because I have to constrain my more usual way of adding words, thoughts as a catalytic for the conversation and for her to claim her own. It does something to robust relationality that I'd consider a skill in my work that is very 'insight emergent' for both. It introduces a new way of being, for me.

Jan 24 Interviewee #2

This interviewee is a very different personality than #1. I already know this will be a very different conversation from the group process shared together. There is a strong pragmatism, perhaps practical wisdom that I've heard in her story already. I am prepared to work on how to tease out the ephemeral, the reflective as this does not come as naturally to her as to others. This is not a judgement. I often wonder if the emotionally reflective personalities suffer more, emotionally and psychologically too sensitized to emotional pain and the need to express it that seems to make a world training minds, not hearts, so very uncomfortable. This individual has a remarkable resilience, does not dwell on fear or anxiety. Gets on with things.

She is prepared for me and has thought through the details of my perhaps needing a table to sit at for note taking. Touching.

I explain the process, the confidentiality again and we begin. I notice the pragmatism streaking through every story. To ask of feelings seems awkward, they are not a focus of the narrative or experience. Often a thought is the response, yet images and metaphors emerge.

I notice a tension between the need to not put words into the interviewees mouth and the process I use a great deal in therapy which is to offer catalytic thoughts for the person to either jump off from, or say 'no its not that but it IS this...', trying to stay purely with "can you say more?", "what did it feel like?" and the other probes feels stilted, even somewhat intrusive as it keeps the focus and 'work' on the interviewee rather than it being a reciprocal exchange and flow of conversation that sparks the new and emergent insights, both ways. It is an interesting tension to hold.

I am really intrigued by this individual's seeming absence of strong emotions or focus on the very difficult knowledge of outcomes with this diagnosis. She seems to have really integrated 'a way' through that for herself. I wonder about my own perception that this construes 'wisdom' and how much I'm imposing on this study by making that my core concept. In a way, this is a finding of many years of therapy already investigated into identifying this as phenomenon from soul-searching and psychological resiliency by individuals. I worry a little about the tension between the lived stories and thoughts she is sharing and the way the questions seem, sometimes to impose 'wisdom' on them. While in fact, I know

from reading the extensive studies on wisdom, that in fact her stories do indeed exemplify many of the characteristics described in the literature, I also feel a tension that she, herself, may not call it wisdom. I weave that question in here and there to try to get her own perspective on this. In fact, outing my own recognition of the 'gap' and whether she would join a dot between her experience and wisdom...or not. We laugh...a lot. She is an exemplar of humour as resilience. I feel some envy, while I have a strong sense of irony, good British style humour, storytelling humorously, less my strong point but I so appreciate it in others.

Jan 31 – Interviewee #2 – second interview

I notice a concern in me that she will get tired of talking about her experience. It is clear she is focusing on her day to day, living now, I consider that these interviews ask the women to go places they have worked hard to not focus on, put behind them. The conversation weaves fairly naturally to the questions this interview brings – about roles, family, parenting through it. Again I notice the stark difference between genders and rarely do I hear the number of different roles being talked about, the people that need taking care of by the patient, with males.

There was an intriguing moment when she herself brought in the difference in care experiences from oncologists and in patient nursing. I notice how much her

stories describe her as advocate while this was not a word she used much. I could hear how much strategy she thought through, worked with in her medical consults. From all my reading on feminist bioethics and the play of paternalism in medicine I am deeply struck in a way different than in therapy sessions by how hard this person...and many others before her...have had to work to get their needs heard and met. In therapy sessions it becomes more about coaching for ways to navigate the situation and if they're good at it, as this individual is, it doesn't get focused on as much. Here we can explore these experiences in more detail and compare the focus on 'wise care' versus 'unwise' care. This unfolds a really interesting discussion that sparks my curiosity and already I can see this section of the interview could almost be its own 'mini-research' study, separate from the rest of it. Her analysis of what makes a medical person 'wise' fits with the literature on wisdom characteristics, she names 'breadth' and gestures wide with her arms as a key in two of the doctor's she's dealt with in her medical care. She names 'kindness' as another.

I notice too as she talks about her full and rich life with a family that I feel an old familiar pang of this not being my story in Canada as an immigrant without my family here and a divorce putting me on a path of being a single parent. Often have I wondered what and who will be my 'village' helping me if I got a life threatening illness. Her main coping has been focusing on family and a broad range of friends and sisters being solidly there for her, with their husbands helping in practical ways for her and her husband as needed. The 'social capital',

to quote Habermas, that I simply haven't had since my divorce. It is a frightening feeling and one I am well used to cradling, not repressing, and digging deep into a place of faith so it does not contaminate the moment as an avoidance or a consuming feeling that clouds my ability to be present to the other.

On leaving I noticed I felt a twinge of embarrassment that this study does not have built into it anything for a 'thank you' for her participation. My nature is always to honour people's 'giving', even when, perhaps especially, they give in intangible ways. I am aware of what a huge 'give' participating in this study is, asking the women to walk through emotions they have put to rest, at least temporarily, or think about aspects of their diagnosis they may not want to reflect on at the moment. Also, it may stir up things they haven't looked at yet or gone into. I want so much to give this individual something for a way to bring closure. In my sessions there is always something creative, marking the moment, to bring a process to an end. I don't have my office with me and the array of poems or simple objects like a shell or stone that often leave with a patient, invited to choose something, small tiny objects of their own found 'soul-medicine'. The gifts themselves circulating patient to patient through my office, when they've completed their journey with our sessions and are on their way to 'new normal'...or becoming sicker and moving into palliation in the community which are harder goodbyes for us both. The practice of the 'give-away'.

This feels very unreciprocal. Again I think about how the strict ethics we adhere to are very constrained with the paternalism that creates the problem of power differentials. When one's therapy practice is grounded in a feminist ethic, seeking always to level the differential to the best degree one can, give agency, not take it, show a 'self' (safely and effectively as is a core competency laid out by CRPO) rather than hide a self, it has been a very counter-intuitive process to have to erase much of that process in the set up and conduct of the research interviews. I am very aware that unless she comes to see me in my therapy role, I may never see this individual again. I'm regretful that we didn't state we'd give the women a copy of the book in the ethics application as a give-back, just a summary of findings. I am also aware, that if we had, many of them may not be with us by the time it is published...a good 2 years away minimum, knowing how long these things can take, for me anyway.

Instead, I ask if I can give her a hug. She says, "oh yes, of course, I really appreciate hugs." It feels poor but it's all I have. I express gratitude for the gift she has given of her time, her reflections and insights. She expresses that she hopes they're 'good enough'. I worry about this aspect of discussing wisdom...the struggle to think we have any, especially as women, it has been so erased as a currency through our lives. I try to reassure her, with a different round of encouragement and appreciation that it has been immensely valuable. It truly has. She exemplifies 'practical wisdom' in a way that makes her quite rare for having this as her preferred coping strength.

I leave with a feeling of deep gratitude. I have enjoyed the researcher role in these interviews because it feels much more 'level' than the counsellor/therapist role in the cancer centre where they meet with doctors and are subjected to treatments that can compromise a deep sense of dignity and provoke great vulnerability, my office being 'one more clinic room' with 'one more practitioner' to assess them, despite all the ways I neutralize this differential while holding a highly professional, strong container for the vulnerabilities that emerge in their sessions. I notice this difference and it highlights how lop-sided the power differentials are in the medical system...and my role being one the most innocuous in regards to power for most and yet also, subtly, so subtly still skewed in my favour since I am not expected to be vulnerable and indeed, would be questionable if I was. For this research interview I have been the receiver, a guest, not a host, the one not being sought out for support, wisdom, guidance or help but the one being given to and the centre of their story of agency and power finding a way through and I simply a questioner, listening, teasing out the layers and levels of experiences. It was energizing and really filling to engage with people about their stories but from a whole different footing and purpose. My instincts that focusing on the people's wisdom from their perspectives would position this research in a rather unique way of assuming the patient actually has something of tremendous value...feels affirmed. They do. A sense of privilege for both my roles left with me.

APPENDIX VIII. TABLE SUMMARIES OF FINDINGS

Table VIII.1 Summary of Theoretical Lens Findings

Theoretical Lens #1: EMBODIMENT			
	Beth	Carrie	Denise
Wisdom	<i>“different from knowledge”</i>		
Embodied knowing	<i>“If you feel something’s wrong in your gut, there’s something wrong”</i>	<i>“I knew there was something significantly off”</i>	<i>“It’s made me question my gut feelings”</i>
The ‘colonized’ body	Refusing pain medication: <i>“I weaned myself off”</i>	<i>“I put my lipstick on!”</i>	Taking control: <i>“I can control <u>when</u> I do things for it [treatment]”</i>
The colonized ‘self’	<i>“overriding my guilt”</i>		<i>“to lie down and not feel guilty”</i>
Gynaecological oncology: “Silent whisperer?”	<i>“I had those symptoms twenty years ago...I just didn’t see it coming”</i>	<i>“Houston, it’s a big problem!”</i>	<i>“symptoms....I’m afraid that I’m going to miss the boat”</i>
Wisdom and self-compassion	<i>“the one talking to myself is more optimistic”</i>	<i>“you can help yourself, protect yourself”</i>	<i>“not being so hard on myself”</i>
Wisdom and embodied relationality		<i>“I found a lot of strength is being around other people”</i>	<i>“in a wisdom conversation they might be understanding”</i>
(a) with people	<i>“reaching out to other people”</i>		
(b) with nature		<i>“some people get soft in the city”</i>	

Table VIII.1 Summary of Theoretical Lens Findings – con't

Theoretical Lens #2: IMAGINATION			
	Beth	Carrie	Denise
Horizons of hope	<i>“planning gives me an idea....I have a future”</i>	<i>“I see myself winning actually!”</i>	<i>“I’m going to work on relationship building ...connect in different ways”</i>
Reverie	<i>“enjoy the moment with my grandchildren”</i>	<i>“a little art work... I can go away and be gone”</i>	<i>“you get to notice trees, flowers, birds singing... it’s for the experience”</i>
Image-centred knowledge	<i>“I have to push through it”</i>	<i>“I’ve clung to my glimmer of hope”</i>	<i>“I’m afraid I’m going to miss the boat”</i>
Material imagination	<i>“too many moments of self-reflection can get you in a dark place”</i>	<i>“think about bright things so you wouldn’t see grey”</i>	<i>“give yourself some breathing space”</i>

Table VIII.1 Summary of Theoretical Lens Findings – con't

Theoretical Lens #3: FEMINIST BIOETHICS			
	Beth	Carrie	Denise
Productive agency	<i>"I tell my daughters... you have to push"</i>	<i>"you just have to navigate yourself"</i>	<i>"waiting, you just wait...you had to wait, I had a plan"</i>
(Re)claiming subjectivity and agency	<i>"I had those symptoms...why didn't I push?"</i>	<i>"You definitely need to be wise and in charge".</i>	<i>"I started crying...a nurse saw me...and you know, it worked out"</i>
Embodied and empathic knowledge	<i>"If you feel something's wrong in your gut"</i>	<i>"intuitively I knew I had a very significant situation"</i>	<i>"intuitively I knew I had a very significant situation"</i>
(Re)claiming epistemic power	<i>"taking myself off medication"</i>	<i>"you definitely need to be wise and in charge"</i>	<i>"take control of some of that"</i>
Medicalization	<i>"After menopause...it's like, you're done"</i>	<i>"respect is huge...even the way they get involved in your body"</i>	no specific quotes
Socio-political globalized contexts of medicine	<i>"everything is in dollars and cents like a lot of women.... how do you know?"</i>	N/A	N/A

Table VIII.2 Integrated Summary of Phenomenological Portraits and Theoretical Lens Findings.

	PHENOMENOLOGICAL	THEORETICAL LENS		
		Embodiment	Imagination	Feminist Bioethics
Beth	<p>'Wisdom-compass': <i>"be in the present moment"</i></p> <p>meta' perspective on wisdom: <i>"wisdom is an accumulation of life experience"</i></p> <p>wisdom as a relationship with 'time': <i>"be in the present moment"</i></p> <p>Time's 'dual nature': Past: <i>"memories became a way"</i> Present: <i>"pushing through"</i> Future: <i>"creating that feeling of hope"</i></p> <p>Wisdom is <i>"Be here in the present"</i> doing: <i>"schedule things, plan ahead"</i> taking control: <i>"be in charge"</i> mortality awareness as catalyst to <i>"be here now"</i>: <i>"I'm going to die"</i> spiritual wisdom to cope and hope: <i>"I cast my cares on the Lord"</i> meeting life's limits: <i>"accept acceptance"</i> relationships: <i>"I talk about it"</i></p> <p><i>As mother to daughter: "she's my guru"</i> <i>Mother-guilt: "Children always come first".</i></p> <p>Wisdom as an embodied 'knowing': <i>"I knew for a while"</i></p>	<p>wisdom: <i>"different from knowledge"</i></p> <p>Embodied knowing: <i>"If you feel something's wrong in your gut, there's something wrong"</i></p> <p>The 'colonized' body: Refusing pain medication: <i>"I weaned myself off"</i></p> <p>The colonized 'self': <i>"overriding my guilt"</i></p> <p>In gynaecological oncology: <i>"Silent whisperer?"</i> <i>"I had those symptoms twenty years ago...I just didn't see it coming"</i></p> <p>Wisdom and self-compassion: <i>"the one talking to myself is more optimistic"</i></p> <p>Wisdom and embodied relationality: <i>"reaching out to other people"</i></p>	<p>Horizons of hope: <i>"planning gives me an idea...I have a future"</i></p> <p>Reverie: <i>"enjoy the moment with my grandchildren"</i></p> <p>Image-centred knowledge: <i>"I have to push through it"</i></p> <p>Material imagination: <i>"too many moments of self-reflection can get you in a dark place"</i></p>	<p>Productive agency: <i>"I tell my daughters... you have to push"</i></p> <p>(Re)claiming subjectivity and agency: <i>"I had those symptoms... why didn't I push?"</i></p> <p>Embodied and empathic knowledge: <i>"If you feel something's wrong in your gut"</i></p> <p>(Re)claiming epistemic power: <i>"taking myself off medication"</i></p> <p>Medicalization: <i>"After menopause... it's like, you're done"</i></p> <p>Socio-political and globalized contexts of medicine: <i>"everything is in dollars and cents like a lot of women how do you know?"</i></p>

Table VIII.2 Integrated Summary of Phenomenological Portraits and Theoretical Lens Findings – con't

	PHENOMENOLOGICAL	THEORETICAL LENS		
		Embodiment	Imagination	Feminist Bioethics
Carrie	<p>'Wisdom-compass': <i>"wisdom as navigating"</i></p> <p>Navigating as internal: <i>"Going inward to come out strong"</i></p> <p>Navigating as body/mind process: <i>"Your brain's got to go somewhere"</i></p> <p>Navigating as active: <i>"pushing your body through"</i></p> <p>Navigating as continuum towards a future: <i>"I can't conquer this... I go forward"</i></p> <p>Navigating as relational: <i>"finding the sweet spot"</i></p> <p>Navigating role changes: <i>"taking a passenger seat"</i> As 'daughter': <i>"trying to make sure she's not terribly upset"</i> As 'sister': <i>"just now some have had to step up a little more"</i> As friend: <i>"I'd come back feeling great I'd helped her"</i> As 'mother': <i>"like a tightrope...their needs and your own"</i> As 'couple': <i>"we had a team approach"</i></p> <p>Navigating daily life: <i>"Doing things! Makings plans!"</i></p>	<p>The 'colonized' body: <i>"I put my lipstick on!"</i></p> <p>Embodiment in gynaecological-oncology: "the silent whisperer?" <i>"Houston, it's a big problem!"</i></p> <p>Wisdom and 'self-compassion': <i>"you can help yourself, protect yourself"</i></p> <p>Embodiment and relationality: <i>"I found a lot of strength is being around other people"</i></p>	<p>Horizons of hope: <i>"I see myself winning actually!"</i></p> <p>Reverie: <i>"a little art work... I can go away and be gone"</i></p> <p>Image-centred knowledge: <i>"I've clung to my glimmer of hope"</i></p> <p>Material imagination: <i>"think about bright things so you wouldn't see grey"</i></p>	<p>Productive agency: <i>"you just have to navigate yourself"</i></p> <p>(Re)claiming subjectivity and agency: <i>"You definitely need to be wise and in charge".</i></p> <p>Embodied and empathic knowledge: <i>"intuitively I knew I had a very significant situation"</i></p> <p>(Re)claiming epistemic power: <i>"you definitely need to be wise and in charge"</i></p> <p>Medicalization: <i>"respect is huge...even the way they get involved in your body"</i></p> <p>Socio-political and globalized contexts of medicine – N/A</p>

Table VIII.2 Integrated Summary of Phenomenological Portraits and Theoretical Lens Findings – con't

	PHENOMENOLOGICAL	THEORETICAL LENS		
		Embodiment	Imagination	Feminist Bioethics
Denise	'Wisdom-compass': <i>"Do a fresh take"</i>	The colonized body-Taking control: <i>"I can control when I do things for it [treatment]"</i>	Horizons of hope: <i>"I'm going to work on relationship building...connect in different ways"</i>	Productive agency: <i>"waiting, you just wait...you had to wait, I had a plan"</i>
	Reflecting on wisdom culls personal wisdom: <i>"I guess I've been wise"</i>			
	Wisdom and time: <i>"I think time is a factor in developing wisdom"</i>	The colonized 'self': <i>"to lie down and not feel guilty"</i>	'Reverie': <i>"you get to notice trees, flowers, birds singing... it's for the experience"</i>	(Re)claiming subjectivity, agency and epistemic power: <i>"I started crying... a nurse saw me... and you know, it worked out"</i>
	Wisdom-as-"do a fresh take" in relationships: <i>"I needed their support"</i>	In gynaecological-oncology: <i>"I'm afraid that I'm going to miss the boat"</i>	"Image-centred knowledge": <i>"I'm afraid I'm going to miss the boat"</i>	
	Wisdom in spiritual community: <i>"there are times when you need others to step in..."</i>			Embodied and empathic knowledge: <i>"doctors are wise...they can't know all the answers"</i>
	Wisdom as 'do a fresh take on faith': <i>"there are times when you need others to step in..."</i>	Wisdom and 'self-compassion': <i>"not being so hard on myself"</i>	Material imagination: <i>"give yourself some breathing space"</i>	
	Wisdom versus advice: <i>"wisdom comes from understanding"</i>			
	Wisdom as self-compassion: <i>"I'm being forced to be kinder to my body"</i>	Embodiment and relationality: <i>"in a wisdom conversation they might be understanding"</i>		(Re)claiming epistemic power: <i>"I can control when I do things for it"</i>
	Wisdom as "Do a fresh take" on 'work': <i>"what are people going to remember?"</i>			Medicalization: <i>no specific quotes</i>
	Wisdom as process: <i>"reflect", "realize", "recognize", "apply"</i>	Embodied knowing: <i>"it's made me question my gut feelings"</i>		Socio-political and globalized contexts of medicine: N/A
	Wisdom as accepting limitations: <i>"I have to start small"</i>			
	Wisdom as 'invisible' to oneself: <i>"I think you're so close...you don't see it"</i>			
	"Do a fresh take" on wisdom: <i>"wisdom comes in many different forms"</i>			

**APPENDIX IX. 'EMBODIED KNOWING' AND SOCIO-POLITICS IN EARLY
SCREENING FOR OVARIAN CANCER**

From the contributions of Beth, Carrie, and Denise's experiences of their embodied knowing it is worth considering how this can be somehow harnessed specifically for women's attunement to their womb and ovary health. Investigating this embodied knowledge in a woman's sense of her body as a legitimized line of inquiry in the clinical process of diagnosis might open spaces for voice and expression of things dwelling in a tentative unknowing but niggling. It may, at the least, attune women to pay attention with a sense of permission from the physicians to book a consultation to express nagging worries about diffuse symptoms specifically in relation to the subtlety that ovarian can present itself with that maps so closely to perimenopause symptoms or bowel symptoms.

It is important to place emphasis on embodied forms of knowing into a socio-political context of ovarian cancer early screening measures compared to breast cancer. The latter has come an enormous way in the past twenty years such that early screening is standard of care for women over fifty in Ontario and detection capacity of technology, radiology and surgical, medical and radiation oncology clinical expertise has grown immensely. Lives are being saved daily from these strides. This is less true for women arriving to hear news of ovarian cancer as it still tends to be diagnosed at a far later stage, while changes are well underway with advocacy groups such as Ovarian Cancer Canada (OCC) (2018). Epistemic power can be experienced as imbalanced due to unequal distribution of power, money, resources, and social status contribute to health inequalities

between the affluent and the impoverished classes in Western society (Crawshaw, Scott-Samuel, & Stanistreet, 2010). One key difference, not subtle to those diagnosed with ovarian cancer, and observed by participants in this study, is a significant imbalance of resources for support, information and research in cancer care funding drivers. We are cautioned by feminist bioethicists to keep an eye on the interests circulating through health care policies, research funding allocation and industry interests into the matrices that define how women are given time, costly detection screening and medical health care.

With this in mind, this discussion draws attention to the following statistics published on Ovarian Cancer Canada's (OCC) website in March 2018. OCC is a non-for profit advocacy and supportive care resource group for women with ovarian cancer. They report Canada's 2018 federal budget announced provision of, "the single largest investment in fundamental research in Canadian history of \$354.7 million. However, it is left to the Canadian Institutes of Health Research, the (CIHR) to allocate their funds. Their website shows a graph of CIHR funding between 2010 and 2014. Breast cancer researchers received \$81.3 million, prostate cancer researchers, \$39.8 million, and ovarian cancer researchers, \$16.9 million. OCC's (2018) website states, "With substantial financial backing, both breast cancer and prostate cancer have seen marked advances in treatment and survival. In contrast, little has changed in screening or treatment for ovarian cancer." Furthermore, the website report that CIHR's 2015 – 2019 strategic plan, "sets its sights on high mortality cancers and other funders and are to address rare cancers. But ovarian cancer fits neither of these categories."

For Beth, Carrie, and Denise leaving daughters and nieces behind after their deaths, this would not likely foster much hope that their own experiences of 'embodied knowing' yet not having physicians clue into their symptom maps to think 'ovarian cancer' and mobilize detection processes to catch it earlier, will change much for the girls and women left behind. Beth "knew" something was wrong, for years, but kept 'not knowing' chalking it up to worry and hypochondria. It is highly likely her cancer was not growing through those years but somehow, Beth wonders what conditions had been created earlier in life and whether robust screening flagged by the array of symptoms she had lived with, may have caught an earlier diagnosis.

Embodied knowing was a life preserving knowledge for more than patient in my office, even with one individual with stage 1 ovarian cancer diagnosis. Carrie had blocked bowels and still struggled to secure a diagnosis described in her clamour "Houston, we have a problem!" to her G.P. that finally secured her, at her insistence the screening required to mobilize a surgical oncology consultation and even then, found herself still in the position of "pushing ...and pushing harder" to get rapid surgical intervention. Some of that may have been perception of having to push on the system as it may well, through the physicians, have been pushing as hard as it could within the socio-political constraints described in the clinical phronesis section. Early detection and differential diagnosis is a socio-political matrix of discourses that constrain and handcuff physicians as much as patients and these glimpses into those discourses through Beth and Carrie's eyes reveal this saliently.

Perhaps in decades to come, similar strides for ovarian cancer might be made as in breast and prostate cancer. But, until that happens, embodied knowledge in what I term “the knowing” would be worth exploring as a wisdom-resource and researching empirically, through qualitative methodologies and I’d argue the best, being phenomenology for its capacity to preserve the dynamism of the phenomenon because this dynamism will be a necessary aspect of engaging ‘the knowing’ phenomenon in clinical discourses between doctors and patients. It can apply Wykretowicz and Saraga’s (2018) phenomenological approach to medical diagnostic consultations that keeps the whole in view, deeply attending to the person with a phenomenological attitude.

From Lorentzen’s (2008) study “I know my own body” and women’s accounts of power and resistance in medical interactions we can see how ‘performance’, embodied action of identity/self is critical in relation to agency, subjectivity and epistimetic power. That women with any symptoms feel a need to “push” on a “medical system” because their embodied gendered identity is a perceived as a critical reason for propelling a need to do such ‘pushing’ because they feel they must compensate for a skewed medicalized gaze on them as women, is extremely troubling. Layering onto these narratives from three educated, Caucasian, well-spoken, English speaking women, we are left wondering what women experience in clinical discourses where they have an embodied knowing of ‘something is wrong’ and try to appeal to their physicians with this knowledge, or stay silent because they cannot find a way to claim agency to do so and who are also constrained in embodied in ways into

additional stigmatized incarcerations of their power to 'speak' their knowledge, such as culture, colour, second language barriers, and mental health portfolios that arrive to the oncologist ahead of her first consult.

If there is no obvious diagnosis for diffuse symptoms, asking a patient for their intuitive wisdom, asking them what their own 'knowing', gut intuitions feels like, exploring how its differentiated from fear, anxiety, is a knowledge that can be explored in a clinical dialogue. It has formed the content of many a discussion in my counseling office as patients wrestle with whether to accept a treatment with a less-than-enough percent to make them certain they want to endure it. It does not need to be discerned in one shot either. It is possible to guide ourselves and others to differentiate perseveration, rumination, anxiety, existential distress, spiritual distress, gut 'knowings', with time, skill, and attunement. One thing is certain, gut 'knowing' does not 'out' itself on demand, under pressure. Opening the conversation, led by a clinical practitioner, especially physicians with diagnostic power and treatment giving agency, may go a long way to begin to release this subjugated, excluded knowledge from its silences. Making it more comfortable to discuss in clinical cultures, would aid a circulating form of knowledge that will expand its presence, phenomenologically in the culture of care. Empirical knowledge of the phenomenon harnessed by empirical research through phenomenology in its various methodologies now emerging in clinical research will assist with this galvanization of what is already 'known' but not legitimized.

In mentoring younger learners, wise physicians have a critical role to play in lending legitimacy by talking about this phenomenon in clinical practice with their students, showing its 'phenomenological map' within their own practices. Wise mentors in clinical praxis can add 'embodied knowing' to their repertoire of experiential knowledge to impart and achieve a great deal, one student at a time, one reflective practice group or portfolio course group at a time. They can begin today by initiating their own research projects, studying themselves with phenomenological investigations of 'embodied knowing' in their daily clinical practice. It may form a living, organic 'hermeneutic circle' in clinical practice, generating voice for lost and excluded knowledges.

This type of study on subjugated knowledge in clinician's life might also potentially, bring a deeply nourishing source of well-being mitigating burn-out and fatigue (Granek, 2013) partly influenced by the exclusion of aspects of their humanity in the legitimized discourses that make the human difficult to attend to, in self and other. This type of research process might even be extremely timely as the last generation of physicians reaches their mature years who learned the art of medicine in less technologically driven, industry driven times, when medicine was still closer to its ethics of care without the terrible constraints and socio-political complexities and pace infusing clinical life today (Talbot & Dean, 2018). Their wisdom is needed and mobilizing it to be passed on might be a much-needed remedy to the medical education for the physicians of our future care needs.

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