

**Becoming known as
whole persons in clinical encounter**

A Hermeneutic Phenomenological Study

Janette Tolich

A thesis submitted to
Auckland University of Technology
in partial fulfilment for the degree of
Master of Health Science Mindbody Healthcare

2020

School of Public Health and Psychosocial Studies
Faculty of Health and Environmental Sciences

Abstract

This study sought to shed light on the unique essence of the clinical encounter in a biomedical context when whaiora (those seeking wellness) and healthcare students are invited to a whole person mindbody encounter (*wpmbe*). It used hermeneutic phenomenological methodology to explore the lived experience of clinical encounter when both clinician and whaiora are invited to be fully present as whole and experiencing persons. The whole persons approach is non-dualist; clinicians hold a unified ontological assumption that both subjectivity and physicality are relevant factors in the precipitation and perpetuation of illness. The experience of transformation and profound change to clinical practice for clinicians trained to work this way has been written about; but there are limited studies about the shared experience of the dyad from each person's perspective.

This *wpmbe* research occurred during an 8-week programme offered at a university health clinic. Whaiora were invited to attend the programme, advertised as a whole person approach to living with an ongoing illness or life changing event, run by an interprofessional group of university based clinical educators. Together, healthcare students and whaiora explored the experience of living with a life changing event or ongoing health condition through group and individual interactive sessions. The stories gathered during this research came from the clinical encounter between whaiora and tertiary healthcare students on clinical placement from two universities in Auckland, New Zealand. It was not particular to one healthcare discipline and was not illness specific.

Three major themes emerged from this study. Theme One, revealed the experience of the real struggle being allowed to surface. Theme Two, being deeply known and accompanied as a person in relationship was shown as particular to this experience. Theme Three uncovered immersion in an emergent organic space of genuine loving intention as a vital component. These themes created a platform to review the lived experience of illness and point to the ongoing challenge to understand the nature of suffering in illness and the role and responsibility healthcare has in attending to suffering.

This study concluded that whole person healthcare within a biomedical context significantly enhances positive outcomes for all parties. It points out that important matters are being overlooked in healthcare by continuing to pursue a narrow dualist

focus. The findings in this project demonstrated that whole person healthcare delivered with a mindbody clinical sensibility is remarkable and contributes to personal reintegration and wellness.

Acknowledgements

My first acknowledgment relates to why I undertook this thesis, it goes to the Mindbody Community, those who had the courage and determination to set up the post graduate Mindbody programme at AUT university.

The Mindbody community in Aotearoa New Zealand created a platform for me. They were my reason for conducting this research. Making a contribution to the work in this area, my task of gratitude. This is important because they have allowed a whole person mindbody approach to become part of my clinical education and practice and that of others and this has extended healthcare to many that is powerful and healing.

My gratitude extends on the home front to my family and my abiding friends who have always believed in me and continue to support me on a daily basis, firstly my husband who always thought I could do this, his belief in me and encouragement has spurred me on, and my children and their partners Sebastian & Ashleigh; Isabelle & Alex and Lucia & Scott who continue to bring joy to my life every day.

A deep and heartfelt thanks also and always to all my patients those past and present, some I have journeyed with for many years. Those who have passed on still walk with me, you are my inspiration and the wind in my sails.

My gratitude extends also to my interprofessional colleagues, support staff, healthcare students and whaiora in the living well programmes at AUT Integrated health, without your support, trust and respect there would have been no exploration into the possibilities of whole person encounter. My gratitude also extends specifically to those who participated in this study, whose stories ARE this study.

Last but not least, my primary supervisor Josie Goulding who has been there from the beginning and led the way with her loving generous intention. This would not have happened without you, Josie. Also, my secondary supervisor, Liz Smythe, you chose me and provided me with direction and certainty in the stormy waters.

“For now, we see in a mirror dimly, but then face to face; now I know in part, but then I will know fully just as I also have been fully known”¹ COR 13 New American Bible

Table of Contents

Abstract.....	i
Acknowledgements.....	iii
Table of Contents	iv
Attestation of Authorship	ix
CHAPTER ONE	1
Introduction	1
What brings me to this study?	1
Expanding my view towards whole person healthcare in practice	3
What is this whole person mindbody approach (<i>WPMBA</i>)?	5
Has this whole person mindbody approach (<i>WPMBA</i> in healthcare) been described?.	6
Why this study is important: Introducing the <i>wpmbe</i>	7
My aims for this study.....	10
Explanation of chosen words	12
Guide through the thesis.....	13
Reflection – Poems	15
Oscillating week 59	15
CHAPTER TWO	17
Literature Review.....	17
Introduction	17
Searching the literature	18
Clinical encounter in healthcare literature	19
Medical practice and its conceptual framework – integration of practice vs theory ..	20
Away from the Cartesian body towards the ‘lived body’	21
The whole person non-dualist approach in the <i>wpmbe</i> – a new 21 st century paradigm	22
The relational intersubjective dynamic in the <i>wpmbe</i>	22
Moving towards subjectivity in healthcare encounters	23
An encounter with the other vs a theoretical stance – both the challenge and the resource	24
Embracing a relational (affective) dynamic in healthcare	26
The <i>wpmbe</i> – inviting intersubjectivity towards a phenomenon of practice.....	27
The impact of phenomenology in literature and its links in the <i>wpmbe</i>	28
Summary	29
Reflection – Poems	31
CHAPTER THREE	34
Methodology and Methods	34

Methodology	34
Introduction	34
Why a phenomenological hermeneutic approach?	35
Underpinning philosophy	36
Heidegger's understandings – the meaning of being	38
My pre-understandings.....	40
Research design.....	42
Ethics.....	43
Social and cultural sensitivity	43
Methods.....	43
Identifying and inviting participants.....	43
Inclusion criteria and recruitment of participants	44
Informed and voluntary consent	44
Respect for rights of privacy and confidentiality	45
The participants	45
Engaging in research interviews	46
The interviews themselves	46
Gathering and analysing the data	47
Generating coherent stories.....	48
Crafting the stories	49
Introducing the findings	51
Reflection – Poems	51
CHAPTER FOUR.....	53
The Path of the Struggle.....	53
An introduction to the path of the struggle	53
The struggle.....	54
The struggle to be with the struggle.....	55
The struggle-stuck in the illness experience	56
Whaiora story.....	56
Permission for the most desperate thing to surface.....	58
Whaiora story.....	58
Student story	59
The struggle being at the forefront.....	61
Student story	61
Whaiora story.....	62
Whaiora story.....	63
The call to the vulnerable edge	65
Student story	65
Whaiora stories	66

The struggle to be with the horrible side of life	69
Whaiora story	69
Student story	71
The struggle –the <i>real</i> things that were worrying	72
Whaiora story	72
Putting sunshine in a dark place	74
Whaiora story	74
Student story	75
Becoming an integrated self in the <i>wpmbe</i>	76
Student story	78
Summary	79
Reflection	80
CHAPTER FIVE.....	81
Introduction	81
Being known – as being recognised.....	83
Being known - as a person with a life	86
Being known – as experiencing people.....	88
Being known – was being accompanied	88
Being known – was being listened to and remembered	89
Being known was being protected in relationship	91
Being known – as a shared vulnerability	93
Being known – as being enabled to authentically speak the truth	94
Being known – as personal surrender	97
Summary	98
Reflection – Poem	100
CHAPTER SIX	101
Arrival.....	101
Introduction - Framing the emergent landscape of the <i>wpmbe</i>	101
The marketplace a reciprocal arrangement	102
No longer a spectator	105
Co-witnessing a lived experience.....	106
The essence of the <i>wmpbe</i> – the creation of space	107
An organic space	108
Allowing this emergent space	112
Paying attention to the whole person	112
The environment	115
A changing landscape – environment having meaning.....	117
Reflection	118

Reflection – Poem	119
CHAPTER SEVEN.....	120
A Returning to Self (wholeness).....	120
Introduction	120
Emergent themes of the <i>wpmbe</i>	121
Part one - the appearance of the struggle as integral to the <i>wpmbe</i>	121
Naming the struggle – shining a light in the cave of suffering	122
Weaving the components of being with the struggle	124
The struggle in the <i>wpmbe</i> a reflection of itself.....	125
Truth emerging from the struggle	126
Part two - An experience of being known (in relationship) in the <i>wpmbe</i>	128
Being known in and through the presence of another.....	128
Being known as a passageway to wholeness and vitality	130
Being known through being accompanied.....	131
Being known in the <i>wpmbe</i> as being protected in relationship	132
Part three – the emergent landscape	132
The <i>wpmbe</i> an experience of my story being listened to – telling the real story	133
The <i>wpmbe</i> , the experience of a different intention.....	134
The <i>wpmbe</i> – a co-witnessing reciprocal arrangement; the marketplace – a contributing emergent landscape	135
Part four – a summarised integration - why does any of this matter.....	136
Linking the lived experiences of the <i>wpmbe</i>	137
In summary – the <i>wpmbe</i> – a way of returning.....	137
My personal reflection	138
Conclusions	138
Recommendations	139
References	142
Appendix A - Ethics Approval.....	149
Appendix B – Verification of Māori Consultation	150
Appendix C – Participant Information Sheet	153
Appendix D – Consent Form	159
Appendix E – Indicative Question Guide	160

Appendix F – Working Diagram

15/2/2018



Attestation of Authorship

I hereby declare that this submission is my own work and that, to the best of my knowledge and belief, it contains no material previously published or written by another person (except where explicitly defined in the acknowledgements), nor material which to a substantial extent has been submitted for the award of any other degree or diploma of a university or other institution of higher learning.

Janette Tolich

Date: 5th August 2019

CHAPTER ONE

Introduction

We ourselves are characters within a huge story that is visibly unfolding all around us, participants in the vast imagination or dreaming of the world; for narrated events always happen somewhere. (Abram, 1996, p. 163)

This introductory chapter charts the place of this qualitative hermeneutic phenomenological study as it seeks to uncover the lived experience of a whole person mindbody encounter for whaiora and healthcare students. Its place is found on the map of the vast human story of the experience of illness and of those seeking wellness. We all (as human persons) are the characters situated in this vast imagination of the dreaming world. Abram (1996) said, “Narrated events always happen somewhere” (p. 163). These particular narrated events come from healthcare situations in western biomedical practice in Aotearoa New Zealand. This chapter situates what is being researched—the lived experience of a whole person mindbody encounter, the *wpmbe*. My research and writing speak from the place of my personal experience over 30 years as a hospital-based allied health clinician, combined with clinical education in the BHSc at AUT University. It has been a long and winding road of caring for people with severe, life threatening illness and unrelenting progressive chronic disease. The *wpmbe* sits in this meeting place of the clinician and the ‘suffering’-other, the clinical encounter.

What brings me to this study?

The hearing and the calling to map out my view for others, by writing this thesis, comes about from seeing first-hand what possibilities arose for both whaiora (the Māori term for those seeking wellness) and healthcare students (HcS) when they were extended an invitation to take a wider view of personhood and illness, through taking a whole person approach mindbody in the *wpmbe*. After completing the Mindbody Healthcare Post Graduate Diploma in 2015 and creating an opportunity in a healthcare educational setting to work in a whole person mindbody way, I began to witness first-hand the effects of this *wpmbe*. It compelled me to make this whole person mindbody approach (*wpmbe*) visible and understood. A post graduate diploma in Mindbody healthcare has been offered at AUT University since the early 2000s. The experience of transformation

in clinical practice using a Mindbody approach has been written about (Broom, 2013), capturing stories from individual clinicians across the healthcare sector and demonstrating the effects of profound change in the clinical practice model. A noticeable factor in clinician transformation appears to be the contribution to its own sustainability, showing better health outcomes for both health care practitioners and their clients. (Goulding, 2013)

The story of this thesis is situated in the kingdom of the sick. The kingdom of the sick is described by Edwards (2013). Sontag (1990) was the first to pen the notion that we all hold dual citizenship in the kingdom of the sick and the kingdom of the well. At some time, or other, we each may identify as citizens of that other place. My own inherent sense of a mind–body-spirit connection in the experiences of illness, along with a growing awareness of the inter-connected nature of these experiences within our relationships, community, and culture, alerted me to the growing disconnection or disembodiment in the healthcare system. It now seems more essential than ever that new conversations be heard from both the kingdom of the sick and those who attend to them.

The hearing of the other voices of those who also work, live, and breathe these daily encounters (practising *wpmbe*) through their written word was validating and strengthening for me (Broom, 2013; Goulding, 2013). Through my own learning in the Mindbody Healthcare Post Graduate diploma, I found a way to express and integrate the whole person approach into my clinical and educator role. It began an illumination for me of what I had, in fact, already been experiencing in healthcare, in my own clinical work. These types of experiences I found were articulated in the writing of Griffith and Griffith (1994), and many others, who speak about the deeply human experiences of both patients and clinicians, and which provided for me a bridging language of the body with that of the mind and the spirit within the clinical domain. Their work, particularly expressed for me the connected nature of these situations (Griffith & Griffith).

I have become more acutely aware of the growing dissatisfaction and realisation that healthcare professionals and healthcare in general is becoming increasingly removed from this mindbody connection by a healthcare model which focuses on diagnosis and technological processes (Broom, 2017). Despite the fact that we are able to see more and more into the human body, past the confines of the skin, to a three-dimensional reality, it seems we are able to hear less and less of the human story. Our objective

insight has brought with it a lack of connection with subjectivity (Broom, 2017; Epstein, 2017; Nicholls, 2018).

I extended my physiotherapy practice to include clinical education, with a strong drive to educate, enhance, and promote better healthcare outcomes. Through my clinical work I began to witness a growing necessity to create a more sustainable system of healthcare for self and others. I began to realise that this could be possible through mindbody integration. For me, the foundation for better healthcare outcomes relies on a deep understanding of relational connections, one's sense of place in one's community, family, and culture; illness and healthcare an integral part of the trajectory of life itself. My hope is to promote a clearly defined acceptable culture where these multidimensional whole person (relational) connections are considered pivotal to future healthcare practice.

Working in healthcare, at the very seam of human experiencing, has been very affecting, bringing with it a personal awareness of the complexity and intricacies of human experiencing in the healthcare encounter. I have found that illness and health are not actually experienced as separate (from life) in the clinical room. Healthcare (therapies), however, are “derived from the systems they inhabit” (Nicholls, 2017; p. 216). Continuing to take a dispassionate, detached view in the interest of orthodoxy, safety, and legitimacy has an effect of “de-sensualising what is otherwise a highly sensual human encounter” (Nicholls, 2018, p. 206). My view or ‘take’ on sensual here, in the context of the *wpmbe*, is the inclusion of all layers of human experiencing as significant, and having meaning and connection as they appear in the clinical encounter. Nicholls (2017) talked of casual docility where “practitioners are taught to ignore all the other causes of health and illness and focus only on the body-as-machine” (p. 281). The effect of this disembodiment further separates illness and disease from its life world experience. Embracing a *wpmbe* in my work has moved me away from evidence-based population medicine to an acknowledgement in practice of the more particular in the experience of illness.

Expanding my view towards whole person healthcare in practice

Becoming a whole person mindbody clinician has been a journey of expanding my ‘clinical view’ from the predominant dualist practice of pattern recognition and focus on diseases to embrace a focus on the person/s within a relational framework, and *together* making meaning. Despite my yearning to practise as a whole person clinician, I was

constrained by the systems of healthcare that supported and legitimised my practice. These systems controlled my scope and limited boundaries providing safety through professional accountability based on patterns of known and defined outcomes. Illness and disease were viewed in a narrow dualistic separated model of physicality and subjectivity through a linear-causal lens. Clinical encounters did not include consideration of the lived experiencing subject-body in the experience, or seriously look at reasons for precipitation or perpetuation of illness. Nor did I, as a *medical* physiotherapist, have a language to describe any mindbody connections I was noticing. In my physiotherapy profession, clinical practice emphasised a *doing to* rather than a *doing with* in order to fix, with the emphasis on the building of skills and accumulation of specialised knowledge. Having no language to express any *experiencing* of subjectivity or to explore meanings connection in the *illness story*, these other non-physical precipitating and perpetuating factors of illness and suffering were ignored. Meanings connections to life and story (either mine or theirs) were dismissed as irrelevant and were lost to the whole picture. Tragically, meaning was unapproachable and became irretrievably lost. Integration of a mindbody sensibility changed my practice from a making *sense of* toward a making *sense with* (another). Permission to language *lived* experience allowed me to openly acknowledge what I was experiencing as a clinician in these encounters alongside the acknowledgement of lived experience of whaiora. I began to move away from an epistemological knowing towards an ontological knowing.

I had felt a growing daily discomfort, disconnection from colleagues, and disquiet in educating others to treat the body-as-machine when patients' stories and experience of illness held such personal and individual meaning. The stories I was hearing from patients of de-humanising experiences, the growing detachment of practitioners in order to survive, and the insistence on evidence-based medicine (only) made this situation no longer tolerable or tenable to me. I found others were writing about this disquiet (Broom, 2018; Epstein, 2017; Mayes, 2017; Sweet, 2017; Youngson, 2012). Becoming a whole person practitioner gave me a *licence*, a way to bring the person who had come to my door *into the room*, with their whole story. The encounter became a place where their physicality and subjectivity combined and became intact. Reading mindbody literature and the philosophy of Merleau Ponty, Heidegger, and Gadamer; and studying the views of existential philosophers Buber and Levinas, I found a language to connect perceptual and subjective awareness (Bolletino, 2001; Bredlau, 2019; Broom, 1997;

Buber & Smith, 2006; Coulter, 2001; Dahlberg, 2006; Eckersley, 2006; Griffith & Griffith, 1994; Groddeck, 1977; Harman, 2007; Kövecses, 2000; Lakoff & Johnson, 1999; Leder, 1990; McDougall, 1989; Merleau-Ponty, 2002).

This hermeneutic phenomenological research method which uncovers the essence of what is already present, then became the route to study the phenomena of the lived experience in the *wpmbe* (Van Manen, 1997). Intrinsic to the practice of medicine and encounter in medicine is its endless search to answer the age-old questions of why people become ill and finding the path to healing itself (Chiozza, 1999; Groddeck, 1977). The *wpmbe* sits in this realm of the lived experience of illness and healthcare and the alleviation of suffering. It sits in the relationship *between* the sick person and the one who professes to help, looking at the nature of what is already there as in a priori.

What is this whole person mindbody approach (WPMBA)?

Explaining a whole person approach is challenging; distinguishing it from other approaches even more complex. In the quote below, a student participant in the study attempts to describe what it is by saying what it is not. A *wpmbe* is experienced as the opposite to compartmentalising and disembodiment.

I think healthcare in many ways tries to divide people's lives into compartments. Or only see a certain part of a person. In actual fact that is not the way they experience themselves. It's not just let me look at your ankle and treat your ankle, it's like well that ankle injury is part of me! I experience my ankle injury as part of my person, to not actually see the person as part of the equation seems odd. Compartmentalising peoples experience by removing things or thinking it's not related to anything else that's part of you. It's kind of like this whole sense of disembodiment. In real life you experience it all as just one continuous line. Maybe the whole person approach is about an embodied experience? (Sarah, healthcare student)

This quote captures the experience of one's life being compartmentalised in the receiving of healthcare. It is as if in the healthcare experience of illness, one is separated from one's real life. What is happening is no longer part of you. In real life, you

experience illness in one continuous line; but in existing healthcare, this continuous (life) line seems broken.

Has this whole person mindbody approach (*WPMBA* in healthcare) been described?

A whole person mindbody unitary approach (*WPMBA*) has been described by Broom (2012). By its nature, a *WPMBA* invites and includes all facets of personhood in all its dimensions as integral to a healthcare encounter. When people become ill, they experience their illness within a multidimensional reality of social, cultural, personal, and relational domains. The *wpmbe* honours these domains by creating relational conditions that allow meaningful exploration of the illness in the context of one's whole life.

The whole person mindbody approach is described here by Broom (2018).

It entails a recognition that beside, alongside, within, triggering, perpetuating, or contributing to the physical side of illness or health with its characteristics, signs and symptoms there is a subjective story and much more, which is to be rendered visible. When this happens, it will yield data and avenues of care and healing. A *WPMBE* holds a belief that the person always exists within a larger whole, a community, a culture, and a family. Within this whole, they experience illness, not separately or even individualistically. (Broom, 2018)

The naming and describing of this *WPMBA* approach is extremely complex. Broom (2017) has written extensively about the challenges, as a *WPMBA* holds common elements with many legitimate and similar models of care. It does though, hold key, essential elements; the strongest and most particular being that it allows physicality and subjectivity in the same space. It is tempting to characterise it by calling it many things, holistic, person centred, integrative healthcare, narrative medicine or the biopsychosocial approach, non-dualistic healthcare or psychosomatic medicine. All these names for models of care do provide some insight as they delineate perspectives and practice models. As Broom (2016) stated, it is a challenge to gain a combined understood notion or explanation.

We appear to need a super word that combats dualism and reductionism. Is orientated towards wholes and focusses on relations within and between wholes. It needs to accommodate physicality and subjectivity, bodies and minds and whatever else constitutes human reality. It will easily extend to stories, meanings and symbols. It will

honour the role of diagnosis and biomedical treatments and utilise these wisely. It should endorse a multidimensional approach to the whole person and his or her story and relationships. This super-word does not in my view exist but whole person healthcare and story are definitely helpful. (p. 269)

Here, another participant (in this study), tries to explain where the whole person approach sits; it is not an alternative way, it is a way *where you come up the middle and embrace both within the biomedical model.*

I just loved this approach, there was a vibrancy and liveliness to it all. Just to think it was happening for 'new' health care professionals was just fantastic... There are people here who are going to embrace the whole person – you were a person at the end of the day... It was like there are different ways to know you and to get well.

It's hard to get someone who just comes up the middle and embraces both the purely medical and alternative in a good way while still getting a highly trained healthcare professional (HcP).

I was so pleased it was available because the health system needs to be more than someone just fronting up for a knee replacement. (Jill, whaiora)

There is a strong desire in the biomedical sphere to be seen as more than one's illness. To be seen as a whole person where one is able to “come to an understanding that one's own biographical story was (or is) inextricably linked to illness” (BarHava-Monteith, 2018, p. 13). For Barhava-Monterith (2018), the *WPMBA* was an “experience of the unification” of the dimensions of self (p. 13).

To conclude, the *WPMBA* is a non-dualist approach, encompassing the full reality of the human experience of illness. It utilises a biomedical paradigm without being consumed or limited by its reductionist framework.

Why this study is important: Introducing the *wpmbe*

As I grew in my own mindbody practice, I began experiencing the simple yet powerful effect that even the smallest tentative whole person mindbody approach had. As it became more apparent that allowing a *WPMBE* to blend with existing healthcare was having these outcomes, I decided to set up a programme in an interprofessional

healthcare setting in which students and those seeking wellness (whaiora) have an opportunity to more specifically explore meaning together in this way (in the *wpmbe*). In the programme, HcS and whaiora are exploring together the experience of living with a life-changing event or ongoing health condition.

Watching the effect of this programme has driven me to make *wpmbe* more visible, tangible, and understood. I needed a vehicle to articulate and translate the *wpmbe*'s simple yet complex nature, and uncover what is actually taking place, in a legitimate forum. I wanted to take a closer look at what actually happens in the whole person encounter itself when taking a whole person approach.

Thus, the *wpmbe* itself forms the essence of this study. The *wpmbe* with its focus on meaning making considers multi-dimensional personhood as integral to the experience of illness whilst contributing to recovery, healing, and restoration.

In other words, this study explores the lived experience or experiential world of a whole person encounter where the landscape is one of whole person viewing (BarHava-Monteith, 2018). This landscape differs from the current paradigms practised in healthcare. It is significant, as it is not offering an alternative to an existing model of care. It blends the predominant scientific, objectified stance of the bio-medical environment and integrates it within the dynamic of what happens person to person when whaiora are seen and heard as whole persons. It is an exploration into the lived experience of a clinical encounter when there is a marriage of 'sense and soul' (Wilbur, 1999), when a collective entwined view of objective science and subjective reality in the world of the experience of illness within a healthcare model is considered (Wilber, 1999).

The importance of therapeutic relationship and acknowledgment of the improved health outcomes from person centred care has been extensively studied and validated as having a place in better healthcare outcomes. This study goes further, integrating models of healthcare and philosophical ways of being—person centred care and whole person viewing (Bright, Boland, Rutherford, Kayes, & McPherson, 2012; Carruthers, 2013;

Pinto et al., 2012). Thus, the focus is on an experience of being seen as a whole person and *not secondary to a diagnosis*.

Each person, on both sides of the encounter is considered as whole, experiencing their life and illness together, multidimensionally. It is whole person viewing within healthcare, a view with a different focus.

Colquhoun (2012) a New Zealand doctor and poet, speaks about the clinical encounter “as a holy place, a source of communion and a science lab for the physics we have not yet described” (p. 143). Inviting human connection, which occurs between people as a science that embraces broken human fragility could provide clinicians with a means to move outside the confines they currently inhabit.

At the heart of medicine is compassion- not science, not politics, nor policy, not commerce- but the assorted wreckage of human beings, their fragility and the long slow unwinding of our bodies. It is a profession of skin and ache, and spiritual by its nature. The consultation is its holy place, a source of communion and a science lab for the physics we have not yet described that occurs between people. (Colquhoun, 2012, p. 143)

Encountering and embracing multidimensional personhood in the *wpmbe* becomes the way or clinical sensibility that underpins clinical practice, when perceptive and reflective clinicians consider and enact their philosophical way of being in the world as described by Orange (2010). It happens when clinicians are able to enter in as persons with other persons to the clinical encounter. It sits in the philosophical space which studies the ontological and epistemological themes that reveal what medicine actually is, a clinical practice (Svenaesus, 2000). Emphasis in research and healthcare practice has been given to the results of the meeting between patient and doctor, but not so much to the meeting itself—the clinical encounter. This study looks across each side of the dynamic and the in-between, intersubjective space of the clinical encounter as both *whaiora* and *HcS* experience it. It seeks to shed light on the mystery of what actually happens when *whaiora* and *HcS* are invited to be with each other in this whole person mindbody encounter (*wpmbe*).

Phenomenological enquiry has been chosen as it has the capacity to represent well the nature of this experiential reality of a lifeworld interrupted by illness. It is a study of an experience of an experience. The hermeneutic process deepens meaning by the capturing of participants’ stories in order to reveal the phenomena of this lived

experience. This methodology seeks to uncover the essence of the human experience (Van Manen, 1997).

Using hermeneutic phenomenology, I plan to go deeply into the human experience of the healthcare encounter itself, where illness is the pivotal reason that brings each person to the encounter. It will explore the creation of, and experience within, this non-reductionist healthcare space. This space exists where:

The art of healing is at its core ... and the task of the healer is to have loving intention, to create a space where a person can feel that intention, can feel safe with it and flourish inside it. None of which is incompatible with the inclusion of biomedical treatments. (Broom, 2017, p. 113)

My aims for this study

We exist in the company of others. The *wpmbe* sits in that vital and pivotal meeting place between those who become ill and seek help from trained healthcare professionals and those who offer this help. When people become ill, they experience illness within a multi-dimensional reality: social, cultural, personal, and relational domains. These life domains determine the choice of who, when, and how they seek help, and may bring them into an encounter within a healthcare provision along the path of their illness. Understanding help seeking and the experience of those who choose to attend to and alleviate suffering is one of the most daunting and far-reaching questions to face humankind. This thesis will make a small contribution, along with all that has gone before, in the search for understanding such an encounter. It is not an isolated task and I am certainly not alone. In the realm of healthcare, we rely upon the scores of others who have gone before laying the foundation, the study of which provides insight into our pre-understandings, healthcare and illness perceptions, and reasons for current practice. As healthcare professionals we exist in the company of others who work daily with the sick in order to alleviate suffering (Chiozza, 1999; Groddeck, 1977).

Colquhoun, talked about attending to ‘the ache’. To him, the ache is the seam or coalface where we encounter each other each day in medical practice. Being with others in this capacity and allowing ‘that voice inside that will not be quiet’ is what this thesis is exploring.

Ache is the knowledge that something fundamental to our existence will always be just out of our knowing..... This is what is found (often) in the face of death, love, failure and the unsaid. The pain the joy and that

voice inside that will not be quiet. It arrives when we are forced to consider the irreducible gap in human existence..... as humans beings we do not know where we are from, or why we are here or where we are going but despite all this we make small islands of meaning to stand on... when all else fails the ache can guide us to where that space is..... It is inherent in the act itself of creating place to stand and binds us together in the midst of our isolation. (Colquhoun, 2012, p. 143)

The multidimensional nature of personhood and its integral expression in the experience of illness is being overlooked. Ignoring this dimension is common practice in many healthcare sectors. It appears to be the default mode of delivery of the western healthcare model. Many say it is due to time and associated financial constraints within the systems themselves, driven by a reliance on fulfilling quotas, schedules, and producing measurable outputs. For whatever reason, the ignoring of the uniquely human experience in healthcare encounter for both the practitioner and the patient compelled me to document these stories of whaiora and students in order to give a voice to the very people themselves who are somewhat dis-empowered, and often cite being overwhelmed by the very sector that seeks to empower them.

There is growing concern across all healthcare sectors that the experience of healthcare is currently being experienced as impoverished by those consuming and those committed to its practice. Existing models of healthcare with their confining emphasis on lists; push to fulfil quotas; drives to maintain stakeholder endorsement; numerous deadlines, time constraints, and financial focus; and strong emphasis on measurements, diagnosis, and outcomes have lost their human connection (Epstein, 2017). The human experience of illness has become disconnected from a connection with real life and the experience of illness and suffering itself. The person and the relationships central to healthcare have become minimalised and people are feeling secondary to their diagnoses and illnesses. These concerns within healthcare are being voiced more and more as dissatisfaction accumulates, the increase of burnout is occurring, and chronic diseases proliferate. A large and growing group of healthcare professionals and consumers of healthcare no longer want to be constrained in this way and are finding a voice to express their dissatisfaction (Mayes, 2017).

My short-term goal for this thesis is to distinguish what comprises the essence of the lived experience of the *wpmbe*. The emphasis of my study is not to discover what is 'missing' from existing healthcare encounters. Neither is it an attempt in any way to negate the huge advances being made by many people all seeking the very best for their

patients through healthcare education, clinical practice, and research. Rather, it seeks to point out that there is something simple yet powerful that is being overlooked if healthcare continues with its narrow reductionist focus. Therefore this thesis aims to enable and encourage a healthcare practice that integrates what is already known in healthcare into wider whole person viewing.

There is hope held, as you will see expressed in my study, that healthcare can and will rise to the challenge of providing an integrated whole person model of care. Those that are delivering healthcare wish it to be different. Those receiving care hold a firm belief that the people in it do not want it to be so (Mayes, 2017).

Explanation of chosen words

Whaiora is a Māori word used to encompass the experience of one seeking wellness; patients in the *wpmbe* are referred to as whaiora and the use of this name became pivotal to the experience itself as it contributed to the nature of the *wpmbe*, a shared journey the participants describe taking together (Durie, 2001). Occasionally, the word patient¹ or client is used, and this would always mean the whaiora if it was a participant voice.

Healthcare is used to capture what whaiora and students might describe as any interaction which is based around a person; in this case whaiora seeking wellness and a clinician delivering *wpmbe*. Often though, it also refers to ‘other’ healthcare interactions and experiences that whaiora and students have had previously, such as assessments and interventions that are standard biomedical practice. I will try to make this clearly distinguishable as required when it alters the meaning of the script.

Healthcare students (HcS) are those who took part in a whole person mindbody approach with whaiora. HcS in this study came from multiple healthcare disciplines and include undergraduate and post-graduate students. They will not be specifically identified by their disciplines. It was not my intention to study the pedagogy of this learning experience; rather, to look at the experience of being invited to take a whole person view in a cross section of healthcare. The fact that they are students and not experienced practitioners may of course have influenced the dynamic of the *wpmbe* and

¹ Patient refers, in my mind, to Patior = Latin meaning “to suffer or to undergo”. Orange (2011) saw her patients as fellow sufferers, not clients with whom one would have a business relationship.

the ability to embrace the *WPMBE* but that dimension is not an essential feature of this particular study.

Healthcare practitioners² (HcP) is a term interchangeable with healthcare professionals and HcS, as I consider that HcS are essentially already socialised and culturally attuned to their professional healthcare role. The participants in this study several times refer to the HcS as professionals. The HcS are identifiable and recognisable by their professional behaviour and already operate within a boundary of professional practice where their scope is clearly defined, although still developing and not yet officially recognised by their professional bodies. Healthcare – when referring to healthcare in this study I am meaning a western biomedical meeting where those seeking wellness or experiencing distress seek the guidance and support of a legitimate HcP who is part of a registered body of professionals.

Encounter – I have chosen the word encounter purposefully, it is a loose enough and deep enough expression, which I think, creates possibility for exploration. It describes the meeting place or moment of happening. Encounter is what happens person to person in the intersubjective space when one is participating with another in seeking wellness.

Illness – is a place of dis-ease whether the body or the mind, relational, cultural, or spiritual. Any situation in life that produces discomfort or feels dis-ordered. It is a highly personalised experience and not necessarily determined by the identified disease or health event. In this study, I have-not distinguished illness as either physical or mental as I see these as each a part of the whole and the re- integration or return to wellness as a whole person experience. This does not mean that the participants will view their dis-ease in this way but highlights the re-integration of self as part of the experience of the *wpmbe* itself (Carel & Cooper, 2013).

Guide through the thesis

In this chapter I have introduced the context and the intention of the study. I have pointed towards the intention of the study to allow and invite whole person viewing into an already existing healthcare paradigm. I have explained the reason I feel compelled to illuminate the lived experience of the *wpmbe*. I also explained how and why I came to a

² HcP working with HcS in supervision are recognised by their respective registered bodies.

yearning to explore the phenomenon. The chapter briefly outlines my choice of methodology that is in keeping with its essence of an emergent experience.

In the findings and discussion chapters, I will weave quotes and stories and poems from the participants. Most chapters conclude with a reflection and, in some cases, a poem which captures the themes of that experience either for myself or the study participants.

In Chapter Two, I describe and discuss the literature that gives context to the lived experience as it is situated in the healthcare encounter between those receiving and those delivering healthcare and look at the direction and integration that these studies bring. Whole person care in the biomedical context is not commonplace and could be understood as many things but here I make it as explicit as possible. Chapter three outlines the methodology and methods undertaken in this study.

In my finding's chapters, Chapters Four, Five and Six, I look to the discoveries of this hermeneutic phenomenological exploration of the *wpmbe* captured in the stories of whaiora and students. These findings chapter take you on a journey entering deeply into an understanding of the landscape which illuminates an experience of 'being with the struggle' of illness itself. They explore this encounter, for both the whaiora and the healthcare students. These chapters hold the essential themes that emerged from the hermeneutic analysis I undertook. The *wpmbe* pathway shines a light on the mysterious and somewhat perceived intangible nature of the experience, finding a gentle and trusting way into the heart of the matter. The stories are a window into the experience of suffering and the experience of being with those who suffer.

Whilst the whaiora seek wellness, they experience being accompanied. Both the whaiora and the students describe a relationship that has the qualities of reciprocity, mutuality, and authenticity. As kaiairahi or fellow travellers (those on a shared pathway), the participants discover a shared understanding as they make meaning and sense together, as though on a shared journey.

The first findings chapter looks at where this experience takes each person in the encounter whilst on their shared journey. It goes to the place of the struggle. The second chapter throws light on the experience of being known and accompanied in the *wpmbe*, the invitation to be known. The third findings chapter looks at how this encounter came about. The creation of an emergent, organic space which allowed this *wpmbe* to happen.

Each chapter captures whaiora and students' endeavours to make sense of this occurrence. This making sense seemed to matter.

And so it is a simple outline:

- The Pathway of the Struggle – experiencing of going deeper
- The Invitation – experiencing the invitation to be known
- The Arrival – experiencing an emergent landscape

In Chapter Seven, the last and concluding chapter, I bring together and discuss what has been elucidated from the study as a whole. It is where I interpret and make sense of the nature of this lived experience of the *wpmbe*, situated it in its context of the healthcare encounter.

The stories themselves, and the people that tell them, interlink the three findings chapters and make up the substance and constituent elements that illuminate this whole study. Each story and each person, by their very own distinct experience, become part of the woven tapestry of the study as a whole, as they each reflect a view from their own perspective or lens. By the gathering of all these stories in one place, the parts begin to form the whole as in a hermeneutic circle (Thomson, Dykes, & Downe, 2012). The essence of the lived experience now here tasted and seen mirroring the hermeneutic phenomenological methodology of this study.

Reflection – Poems

In order to grasp the essence of this lived experience as a growing hermeneutic explorer and as a way of identifying my own presuppositions and perspectives, I have written a poem. It describes the yearning, longing, and caution that I feel in undertaking this research. It reflects the intimacy of this *wpmbe*, that place where healing occurs, and the courage it takes to be there.

Oscillating week 59

Oscillating

Between

Something I am trying to recognise

Calling it a calling

Calling it a compulsion

But not wanting it revealed

Precious yet mysterious

Doesn't everyone already know?

Maybe I don't want 'them' to know, to know the hidden secrets, the path I walk down
 The tears I witness
 The calm
 The waiting
 The healing
 The moving
 The rush of awakening with another
 Only for that time and place
 Contingent
 Remote
 Complex
 Simple
 Intangible generosity-could it just be love?

So when I need courage to tread into the unknown, to keep walking in the undergrowth
 'alone and 'together'
 What I say to my followers
 Those I respect
 Those who grew Me
 This is a small contribution
 It is growing a gardenia in a dark corner, its tiny glossy leaves, it's once a year tender
 flower

It smells like human suffering pregnant with healing
 The gaze between two lovers
 Its touch elusive like the wind as it passes
 Tasting like the heavy wait for the rain
 The sound of evocative silence, broken by the footfall of the tramper
 The harnessing of a life-force

It is space and only space
 This oscillation.

Janette Tolich

CHAPTER TWO

Literature Review

Introduction

The mindbody approach involves a scrutiny of the healthcare philosophies and assumptions that are largely implicit in modern practice (medical) and goes on to challenge and greatly expand them. (Goulding, 2013, p. 275)

This chapter seeks to put the study of the lived experience of *wpmbe* into context by gaining an understanding of current and past healthcare literature on whole persons, mindbody, and clinical practice encounter. This chapter is about discovering the implicit understandings, assumptions, and healthcare philosophies which influence our expectations and aspirations. These influences determine our behaviour as HcP and, therefore, have implications for the studying of a *wpmbe*.

I will include healthcare literature which explores how a mindbody non-dualist approach is conceived in relation to personhood, and how clinical encounter is experienced, understood, and practised. By elucidating the particular nature and essence of a *wpmbe*, in further chapters, my hope is to provide insight into possible *missing* links and identify the particular challenges to practising in this way.

The journey towards becoming a whole person mindbody practitioner for HcP has been identified as a transformative and radical integration (Broom, 2013). Broom (2013) stated that, “it is a kind of transformation that ripples through established systems, potentially involving all players and all structures” (p. 1). Whole person practice places an emphasis on the inclusion of human subjectivity alongside physicality *within* the experience of illness/disease and *within* the clinical encounter. It is a radically different approach. This radical whole person mindbody integration has been made explicit through the recounting of transformative stories of a change in practice in a book from a group of multi-disciplinary HcP. The collection in this book of individual and unique experiences of growth stands as testament to these ground-breaking new *ways of relating* in the clinical encounter which have brought about profound change in the healing trajectory for both clinicians and patients alike (Broom, 2013). In the recounting of these experiences, practitioners explore the background philosophy they turn to in order to explain the phenomena they now experience in these *wpmbes*. These whole person mindbody connections are *between* persons and *within* clinical encounter. In line

with these experiences of others, and my own, I will look at how philosophical understanding is woven into the philosophy of medicine as influenced by phenomenological thought, and how this relates to the *wpmbe*.

I will explore the directions current healthcare literature is taking in trying to *explain* whole person care in the biomedical paradigm through a search of healthcare data bases. Further, I will look at how healthcare literature expanded my view and enabled me, as a clinician, to securely locate whole person (non-dualist) viewing in my own practice. Then I will look at the healthcare literature that supports a relational dynamic and therapeutic alliance as pivotal to encounter. I will discuss the contribution of the phenomenological traditions in medicine, meaning making, and clinical philosophy that underpin the *wpmbe*.

This review of the literature may appear slightly different as it has been done congruently with the hermeneutic methodology of this research, “presented as an essential dialogic partner... in order to provide context and provoke thinking” (Smythe & Spence, 2012, p. 12). At times, inclining towards a particular text; and at others, reviewing as moving, thinking, revealing literature that may extend to a new horizon inviting one to read more widely. This way of reviewing, whilst engaging in the hermeneutic art of interpretation, sits within its own contextual nature of understanding. All in order to more deeply understand the meeting place of clinical encounter.

Searching the literature

With my focus on the whole person mindbody encounter in illness and healthcare, I searched in a variety of multidisciplinary healthcare databases as this study was not limited to one particular field of clinical practice but looks across disciplines. I included literature from the ‘mind’ disciplines and the ‘body’ disciplines. For the purposes of this study, I did not choose to include alternative or complimentary health practice. The healthcare databases included Ebsco, JSTOR, Cinahl, Scopus, Sage, and MEDline in order to get a full overview of whole person healthcare within biomedical practice. My search terms included: whole person*OR mindbody AND illness OR disease*AND healthcare AND lived experience OR phenomenology AND clinical encounter*.

In addition to searching within these databases, I manually searched references from the lists of articles and books for relevant titles; particularly those on illness and disease, self and personhood, phenomenology of medicine, lifeworld phenomenology,

phenomenological research approaches and whole person care. Alongside, I was reading current theses written about the whole person mindbody approach and searching the literature they were referring to. I included reading literature about researching lived experience, the lived body, embodiment, subjectivity and intersubjectivity, ontology in medical practice, relational healing, psychotherapeutic and psychological literature, neuroscience and affect regulation, and therapeutic relationship.

Clinical encounter in healthcare literature

When reading the healthcare literature that speaks of the clinical encounter, I became overwhelmed by the exhaustive discussion on competing ways of explaining the reasons and nature of this encounter, and noticed that healthcare itself is somewhat entangled in its search to explain and situate the purpose and nature of encounter. This entanglement has led to the proliferation of theories and models of practice which remain difficult to integrate into practice. For example, it is very surprising that the Te Whare Tapa Wha model of health, which is indigenous to Aotearoa New Zealand, and takes a whole person view, is still largely underutilised in quite prominent sectors of healthcare in New Zealand (Durie, 2001; Glasgow & Nicholls, 2018). This evokes questions about how and why we are so reluctant to integrate philosophy, sociology, and our understanding of what it means to be human into modern healthcare. Nicholls (2018) asked, “Why is it that we have shown an abiding passion for complex anatomical and pathological ideas but turn our professional nose up at philosophy and sociology” (p. 243)? Healthcare literature that studies practice implications in the valued clinical encounter, shows a tendency to look at how we can be more *inclusive* in order to become more holistic, and most theoretical critiques of models of care promote the inclusion of *more*—more quality of life measures, more subjective questionnaires, more biopsychosocial measurements (Hansen, Walters, & Howes, 2016). In addition, in the literature it is apparent that there have been two competing forces at work; the key prevailing paradigm of evidence based medicine (EBM), which relies on a hierarchy of evidence, versus person-centered care (PCC), which seeks to have the person as pivotal. This competition has brought about a drive to make EBM more person-centred in order to remove the detachment that is experienced by the continued focus on a mechanistic body-as-machine model (Glasgow & Nicholls, 2018; Goldenberg, 2010; Miles, 2015).

There is even growing debate as to whether embodiment and disembodied healthcare and illness experiences even include the inside of the body or are they only focused on

the outer ‘sensual’ experiences. The visceral or ‘inside’ body a separated notion seen as more machine like than the *outside* perceptual body.

How we view the experiencing whole mindbody is a minefield of differing debates, including social, cultural constructivist ways of viewing. It does appear though, that the biomedical literature is at the door of the ‘*let’s get re-embodied stage*’, despite healthcare still wondering how to do this (Glasgow, 2018; Nicholls & Gibson, 2010). An extensive systematic review looking across definitions of whole person care (WPC) as seen in general medical practice in 2018 is useful in locating the components that HcP believe make up this model of care. Practitioners in general are still seeking to define a WPC model *rather than* a biomedical reductionist model. This review found that a WPC model should emphasise that the persons themselves, who need to be viewed in an integrated fashion. Thomas, Mitchell, Rich, and Best (2018) emphasised that WPC requires an understanding of the inter-connectedness of various illness aspects, as opposed to the notion of WPC becoming merely the addition of biopsychosocial elements. Of note, is that the humanness and ability to sustain a therapeutic human relatedness highlights a two-sided awareness. What was often a one-sided monologue now, in a WPC framework, becomes a dialogue as the relationship is considered part of the healing trajectory (Thomas et al., 2018).

Medical practice and its conceptual framework – integration of practice vs theory

It is not difficult to find literature in healthcare and the popular domain about how the technological focus and specialisation in scientific medicine has contributed to depersonalisation and dehumanising experiences divorcing lived experience from making meaning. Abram (1996) attributed this as blindly overrunning the experiential world, “the sciences have become frightfully estranged from our direct human experience, with their specialised and technical discourses and have lost relevance to the human experience” (p. 41). It is now causing increasing dissatisfaction with biomedicine and its uni-dimensionality, demonstrated by the increased use worldwide of complementary and alternative medicine, which is knocking at the door of traditional, more legitimate practice (Hansen, Walters, & Howes, 2016). It is openly acknowledged that those seeking an alternative approach are seeking human connection. This, of course, is not always necessarily what happens as some alternative therapies are experienced as just another modality. Along with this growing dissatisfaction is a welcome realisation that we, as people, are more than the sum of our parts. Taking a

whole person approach is a move away from a body as machine mentality seen as proliferated by technological advancements. Separation of mind and body has been worsened also by the development of psychological, body mind neglecting vs mind neglecting therapies.

According to Broom et al. (2012) there is ongoing general resistance to a combined mindbody approach and symbolic relationships between disease and meaning in mainstream healthcare sectors despite the new understandings across disciplines.

A general cultural movement away from positivist notions of meaning to post-modern narrative making and general resistance to ideas of relationship between disease and meaning is engendered by the enduring general and medical acceptance of dualist concepts of mind and body. (Broom et al., 2012, p. 170)

The mindbody split pulls in both directions, mind privileging over body, with psychological approaches giving ascendance to the mind over bodied experiences and body privileging over mind; physical approaches ignoring meaning of subjective relevance to recognisable illness.

Away from the Cartesian body towards the ‘lived body’

As far back as 1984, philosophers of medical practice were beginning to criticise the Cartesian notion of dualist practice that had dominated society in both scientific and philosophical spheres for over 300 years. According to Leder (1990), “these flaws isolated the body from its essential self and its life-context and divided it further into isolable parts and functions”; in contrast, he believed, “the paradigm of the lived body effects are-unification” and by implication, “could help to re-orientate healthcare” (p. 29-37).

Groups of philosophers were turning their attention to the experience of the lived body in the experience of illness. It was the start of a move away from the separate notions of mind and body towards an acknowledgement of a need to consider the subjective experience in illness (Leder, 1990). It had suited the advancement of medicine to see the body as a machine, its parts could be repaired, surgically removed, and technologically supplemented in relative isolation without too many prohibitions; the body had become seen as extrinsic to the essential self. Discussions about paradigms that move away from Cartesian thinking are now happening more broadly across healthcare as it seeks to be inclusive of subjective dimensions. BarHava-Monteith (2018), in her critique of current healthcare, found that the impact of adherence to this ‘body-as-machine’ paradigm is

still dominant. Cartesian dualism still underpins much of how western medicine views illness and disease by privileging the observable. This dominant prevailing paradigm continues to remain this way because “mental and physical domains of healthcare are not just separated in how they are taught but they are (still) prioritised differently” (BarHava-Monteith, 2018, p. 21).

The whole person non-dualist approach in the *wpmbe* – a new 21st century paradigm

Integrating a practice that includes the view of multidimensional personhood into everyday therapeutic encounters, remains an ongoing challenge for medicine. It is strongly acknowledged that an explanation or definition is needed with no real idea about what a practice model looks like. A thirst remains for a whole person approach to be explained.

Hutchinson (2011) who placed palliative care distinctly in a whole person care context called WPC the new paradigm for the 21st century, which can no longer be ignored. The study of palliative care has revealed the healing power of WPC. The call to practice in a whole person way is a call to an ancient part of the healthcare mandate that is relevant to all stages of illness. The role that palliative care takes in alleviating the deepest suffering to man’s integrity and its role in assisting ‘living with mortality’ provokes the most vital living amidst the deepest suffering in man’s search for meaning (Hotchies & Hudson, 2013; Hutchinson, 2017). Palliative care’s unique role in assisting people to move from ultimate loss to a sense of integrity and wholeness, often independent of objective improvement, gives it a profound place in understanding the experience of suffering and WPC. In our thrownness towards death, we are able to become whole people towards each other; everything can come together in one place. For instance, family is considered, meaning and purpose are considered. In a palliative care setting the healthcare system suddenly *expands its gaze*, as it changes from curing to caring. In chronic illness, the person is overlooked in the pursuit of change, and the emphasis is still on problem solving with a focus on the disease and its difficulties (Frankl, 2006; Hotchies & Hudson, 2013).

The relational intersubjective dynamic in the *wpmbe*

The *wpmbe* is grounded in relationship; therefore, the literature pertaining to encountering the other in meeting is relevant (Buber, 2006). Therapeutic relationship has been extensively explored, described, and analysed in current healthcare literature

across the expanse of the healthcare spectrum, from patient and provider perspective, as a health determinant. Much research is focussed on establishing its component parts and measurement of the same; and how the inclusion or exclusion of these can determine patient outcomes. Despite the breadth of knowledge of the benefits and significance of the therapeutic alliance, keeping professional distance and maintaining a certain detachment are still seen as necessary safeguards. Having these safeguards in place could be effective in preventing meaningful intersubjective engagement.

Moving towards subjectivity in healthcare encounters

Healthcare training and practice still promotes curricula which privileges compliance, uniformity, and predictability over creativity, individuality, and subjectivity (Nicholls, 2018). Including subjectivity allows for a broader more embodied way of thinking. According to Nicholls (2018), healthcare practice is still marginalising through normalisation by teaching healthcare students to ignore all the other causes of health and illness as they focus on the body as machine. By taking a dispassionate detached view in the interests of orthodoxy, safety, and legitimacy, Nicholls believed that we *are* de-sensualising what is otherwise a highly sensual human encounter. He pointed out that healthcare students, “must juggle empathy and detachment, proximity and separation constantly seeking to elevate their practice beyond common sense to demonstrate diagnostic insights and technical skills” (Nicholls, 2018, p. 217).

Emerging literature about the patient/PCC model is growing in awareness that something important is happening in the in-between relationship. Through a deeper understanding of the value of the interpersonal therapeutic space there is a move towards encouraging a ‘being-with’ rather than a ‘doing-to’ (Bright et al., 2012). This promotion of a present and relational space may have been further heightened by the growth in understanding of the therapeutic effects of mindfulness practice which support therapeutic engagement, sensitivity, and attending to (Elfred, 2013; Epstein, 2017).

Goulding (2013) clearly outlined this *intersubjective focus* in her discussion of the route of transformation towards becoming a mindbody whole person practitioner. Expanding

and understanding healthcare in this way is like taking a phenomenological turn towards a relational knowing. Here the *relationship between becomes* the clinical ground.

It is a shift...this **change in focus** from a dualistic philosophical position towards a whole person approach stresses the importance of returning to the phenomena of clinical presentation and practice (a phenomena of practice)...It is here in this open stance of a non-understanding, not pre-judging relating that attention to the patient and the relationship between...can become the clinical ground. Where the patients can emerge as persons before the practitioner (Goulding, 2013, p. 276).

Goulding talks about this shift in focus as being “able to attend to our own experiences as a primary source of information for our practice rather than using theory as our immediate reference point” (2013, p.280). This then opens up the space between which becomes the clinical ground. Including this space generated in between the practitioner and the patient and in addition attending to the experience of the practitioner while in relationship is a challenging dimension for many (Goulding, 2013, p. 280; Orange, 2010).

This use of the emergent intersubjectivity is a change towards understanding the individual’s experience of their illness origins and meaning as particular to the individual. It involves “not just descriptively looking for a formulaic match with what we know about disease already.” (Goulding, 2013, p. 279)

Additionally, HcP do not readily consider their ontology or state of being as a necessary framework for therapeutic practice in relation to others. If we accept that therapeutic encounter is vital in our therapeutic work, we need to closely consider “our theories of being, or ontology in relation to the client” (Driver, Crawford, & Stewart, 2013, p. 4). HcP do not readily consider their ontology in the framework of their practice as a person, most likely as they are not trained to consider this as a component of the experience of a clinical encounter let alone a vital component.

An encounter with the other vs a theoretical stance – both the challenge and the resource

Psychotherapists are becoming more intent on making the centrality of relationship matter, despite the differences in theoretical perspectives that have developed over the past hundred years or more. What remains as both the challenge and a resource for our

therapeutic encounters, are the “emotional states that they present us with and what this evokes in us” (Driver et al., 2013, p. 1).

This tension between theories, models and interventions is played out across all the psychological therapies. What seems to be important for clients though is the value of a real relationship. “How this relationship is defined, however and how ‘real it can be allowed to be, is much more complex and experientially affected by the practitioner’s theoretical position as well as their person preferences, style, maturity and self-awareness” (Clarkson, 2003, p. 153).

Defining the therapeutic relationship remains challenging. It appears to be inextricably linked with the practitioner’s theoretical position. Existing and established notions of this relationship are being challenged by those who promote deeper connections and personal intersubjectivity and endorse the healing potentiality of human relationships as vital in the clinical encounter (Broom, 2007). Mindbody dualist separation is slowly being outed by what is becoming more and more widely known of our neurobiological connections and their role in disease and illness. Our relating and our experience of illness are entwined in both the physical and subjective realms. A large body of basic research in clinical psychology on the therapeutic alliance is (now) also supporting a shift from a purely intra psychic one-person psychology to a relational two-person psychology (Schore, 2016).

It is now known and commonly accepted through the weight of evidence from neuroscience that our early relating is pivotal and profoundly affects the kind of relationships we have in later life. Healing requires a creative relational space, under threat the whole person needs a creative space in order to heal (Schore, 2016).

Winnicott is famous for describing the mother and baby dyad in which the ‘good enough mother’ establishes a creative space where the baby can learn to play. Likewise, this provision of this creative space in therapeutic encounter facilitates recovery by offering a place where holding occurs. Through the experience of being held safely (in relationship) the individual is able to recover, function again, and regain the capacity to

be alone again, able to love and to work (Frankl, 2004; Stolorow, Atwood, & Orange, 2002).

Embracing a relational (affective) dynamic in healthcare

An enormous amount of current experimental and clinical data supports the psychological organising principles that emotional processes are essential to organismic survival. Emotion is central to a deeper understanding of the human condition.

Unconscious processes lie at the core of the self, throughout the life span. The decade of the brain, 1995-2005, has now taken a paradigm shift from the dominance of the cognitive left-brain paradigm to a deeper understanding of right brain and bodily based emotions.

The cognitive revolution put the emotions out of sight and out of mind, cognitive science now has to re-learn about embodied systems ... they have a power that is independent of neo-cortical processes. It is now the age of both right and left brain studies identifying the need for integration. (Schore, 2016, p. 54)

Schore (2016) has identified the model of human development as a psychobiological inclusive experience. He is adamant we need to apply these newfound compelling insights from neuroscientific knowledge into all areas of social work and psychotherapeutic techniques. Emotional regulation theory and, thereby, relational experience is not only a new paradigm for the psychological theories but demands an integration with the biological disciplines.

In order to accommodate the growing deeper understanding of the fundamental questions of science, the links of early (childhood) developmental processes, their role in short term and long term survival, and the influence of both the biological and psychological, an integration of various disciplines has now become essential. In other words, these insights and new discoveries and their applicability to healthcare practice in general will not come about from a single discipline perspective (Schore, 2016). Both biological and psychological fields is essential to whole person integration. The experience of intersubjectivity in relationship profoundly impacts all areas of mindbrain and mindbody interconnectivity. Emotional regulation and resonance in relationship

expands and promotes self-understanding, emotional health and physical well-being of the whole person

Clinical practice has, for its own reasons, remained a separated modality; unembodied and bio mechanistic. As there is growth towards more reflective practice which scrutinises and seeks to understand philosophical underpinnings, there is growing awareness that adherence to current models and practices does not allow whole person practice approaches. Glasgow and Nicholls (2018) demonstrated in their quite recent study of the physiotherapy profession, a growing awareness of the incompatibility that healthcare frameworks provide and point to a fundamental philosophical contradiction between the traditional healthcare frameworks of theories, models and approaches and more inclusive practice. In themselves, they restrict a more expansive inclusive view, despite practitioners wish for a more inclusive approach (Glasgow & Nicholls, 2018).

Goldenberg (2010) referred to the distance between patient and professional created by philosophical contradictions as a conceptual schism with “The literature emphasises*(ing) a conceptual schism between the distanced objectivity of science and the lived experience of a particular patient that helps explain the problem of actualising an integrated medicine” (p. 49). The belief that the lived experience of the patient is not relevant nor indeed included as part the objectified science of the interaction creates this gulf, a conceptual schism between patient and practitioners, which inhibits the actualising of integrated medicine (Epstein, 2017).

The *wpmbe* – inviting intersubjectivity towards a phenomenon of practice

It can become concerning for practitioners when it starts appearing that objectivity is getting overtaken by subjectivity or vice versa, it becomes difficult to make sense of this in a dualist paradigm. The information can start to feel more subjective than objective. What we need to do is find new ways of understanding this separation and thinking about this objective versus subjective division. Here, attention to a phenomenological approach can assist (Goulding, 2013).

Goulding (2013) provided a pathway towards understanding taking a phenomenological stance. By moving away from how we have always done it, comfortable in known

expected outcomes, a whole person practitioner places the phenomena central and allows an emergent intersubjective space, gives it meaning and pays attention.

Meaning and interpretation are always secondary to experience or the phenomena. However, meaning is always constitutive of experience... in practical terms the meaning of the patient's illness is both part of the pre-reflective phenomena and available for emergence. (This) play in the interpersonal space becomes a relational space that facilitates meaning. (Goulding, 2013, p. 281)

What Goulding (2013) is referring to, is that this unknown, uncertain and more subjective (than objective) space that opens up in clinical encounter when we make ourselves available and present to what is happening *between* in this intersubjective awareness points to the stumbling block in clinical practice. Once we put aside our search for linear causality differential diagnosis and pattern matching, we start to see the person within the experience. Most practitioners, because of their training and associated belief systems, do not see the power and potentiality that is available for healing here.

The impact of phenomenology in literature and its links in the *wpmbe*

The story of oppositional stances, one for sciences and one for humanism (i.e., scientific knowledge vs clinical practice), and the negotiation between the two goes back as far as the 1970s when it was becoming more evident that biomedicine's inhumanity was increasing in force. At that point, creation of the fledgling study of medical phenomenology began to be invoked as an antidote to overcome those challenges. The lifespan of the phenomenological effort to unite art and science of medicine was brief vigorous efforts ended in the 1990s when related fields, like narrative ethics and embodiment studies, took off instead (Goldenberg, 2010).

Phenomenology can shed light on the blind spots of modern medicine and thus help it better understand itself as a human activity and practice. Finally, I think that phenomenology and its extension hermeneutics, can also be a tool in understanding medical practice itself as an interpretive meeting...medicine rests on a meeting between two persons. Persons are indeed embodied, vulnerable, suffering and mortal and that is why we need something like medicine in the first place. (Svenaeous, 2013, p. 111)

Health should put the stress neither solely on meeting nor the application of medical knowledge. It needs to be both for maximum benefit. These two notions of health

should not exclude each other. Including both in dialogue makes use of the potential that is present creating possibility for better healthcare.

Phenomenology provides extraordinary insights into many issues... within the world of medicine. Such issues include the nature of medicine itself, The distinction between the immediate experience and scientific conceptualisation, the nature of the body- and the relationship between body, consciousness, world and self; the structure of emotions, the meaning of health, illness, disease, the problem of intersubjectivity, the complexity of decision making in the clinical context, the possibility of empathic understanding, the theory and models of clinical practice and the essential characteristics of the therapeutic relationship i.e the relationship between the sick person and the one who professes to help. (Toombs, 2001, p. 1)

This phenomenological research of lived experience of the *wpmbe* clinical encounter explores what happens when both clinician and patient are invited to be present in a relational space. By both being-in-the world and considering all the multi-dimensions of life as having meaning in the experience of illness, brings with it the *problem* of intersubjectivity. A phenomenological study can provide extraordinary insights into the *essential* characteristics of the therapeutic relationship as it is experienced. The relating and relationship is caught up in this hugely complex matrix including a multiple of domains, including consciousness, world, self, identity, and structure of emotions. Context of theories and models strongly influence how we behave but, most often, in healthcare these influences are poorly understood. Revealing the nature and essence of clinical encounter when invited to be whole persons may also conversely explain that which may inhibit a 'relational' whole person encounter.

Summary

It is notable that there is a paucity of literature detailing what comprises a whole person mindbody encounter in biomedicine. Biomedical healthcare literature still sits very snugly in its two dualist camps—the physical and the subjective. There are growing signs of connections being made but essentially taking a whole person view is still not the mainstream. Exploring of subjectivity, together within the physico-materialist domains, is a growing field in psychobiological discovery. Even so clinicians (from the psychological, social, or physical disciplines) are not trained to integrate this into practice. Exploration of self, identity, self-capacity, and personhood are not viewed as having meaning in illness story. This is definitely not the norm across multiple healthcare disciplines. Including a mindbody person connection is challenging as

practitioners feel they do not have the ‘know how’. The main hurdles cited by Broom (2007) concern emotion, self-belief, and styles of intimate relating. The importance of self-identity and its disruption when a person becomes ill has been more recently uncovered through neurobiological advancement, but it is still not the predominant consideration in the return to health through meaning making in the physical domain.

Some overarching main themes emerged from this literature review, the clearest discussion about whole person practice in healthcare literature in a biomedical setting sits within the domain of palliative care. In palliative care, a more vital living comes with living with mortality. Here, it is more humanely vital to not exclude all aspects of personhood, culture, and family relationships as having an impact.

Healthcare literature shows that practitioners yearn and lean towards ways to enact a more whole person ‘holistic’ approach. The ‘definition’ of WPC is somewhat caught up in PCC model. The PCC movement has grown from an entirely different perspective than whole person healthcare, with an emphasis on ethical relating alongside unpacking and the sharing of empowerment. It’s tendency being to add more dimensions to practice domains, including more quality of life measures and proliferation of more biopsychosocial models of health. These ‘combined’ models of healthcare have had their own challenges embedding firmly into the domain of practice. My belief is that they still maintain ongoing subtle biomedical separation. Broom and other Mindbody clinicians have been speaking about illness and disease as having a co-emergent mindbody integration. Their voices are refreshing and now seen as visionary, particularly as more and more neuroscientific and integrated systems of mindbody connection are being discovered (Broom, 2000; Coulter, 2001).

The place of the *wpmbe* is not established in current healthcare literature but the value of its component parts are surely debated and considered as having a high degree of importance in the therapeutic alliance and clinical outcomes. These component parts of the *wpmbe*, include persons having a multidimensional lived experience in illness; persons experiencing *persons in encounter* in healthcare and noticing a relational effect; persons actually experiencing a non-dualist mindbody lived body life story connection as whole persons in illness. Efforts are being made to integrate these components in models of care as it is agreed that these components strongly influence healthcare, but their influence is contested (Toombs, 2001). It also begs the question, why has medicine

advanced further and further down a dualist corridor, basing its pivotal encounter on a mechanistic reductionist 17th century notion?

The relational and multidimensional components of a person experiencing illness continue to be further disintegrated across disciplines operating explicitly in mind and body silos. Medical phenomenology has sought to bring an answer and does provide insight into acknowledging lived experience, but dualist practice continues to limit our understanding of illness and a meanings connection. “If we see humans as interacting beings rooted within a meanings context, we need to see them in illness this way as well” (Carel, 2008, p. 20). A new language is needed, and a change in perception for biomedical healthcare in order to reconnect a whole and wholly experiencing person to themselves in illness.

Reflection – Poems

Included in this reflection is a practice poem I wrote about the experience I have had when a person arrives at my door (of clinical encounter) in their search to be put back together as a person.

Name me

Name me why don't you

Is it I that am here?

I come

Creeping to your door in what capacity I do not know

Can you please reveal me to me?

I wait

Why does this world wait?

This forever waiting in this healthcare system

The waiting world, growing bigger

Waiting to be heard and still, I crouch

Could it be it is not my place?

This world yours not mine?

Name me why don't you as the person
One who came to the name on your door
Seeking wellness

Let me in your door
Let us look around together
Put the pieces back together

No more cowering in the darkness
Let's shed light to the dark distant corners
Those sad and happy corners

Then let us walk out together

Janette Tolich

This second poem is about the confusion in the search to find the self; it arose from the search in this chapter to capture the reality of therapeutic encounter in healthcare literature.

Self - a clinical philosophy

Confusion reigns
Our search for meanings to explain ourselves
Fragmented my separated mind and body, diminishing me
My-unhomelike-being -in-the-world
Where I don't feel like myself anymore

I sit here beside myself
With anxiety
Could it be that this is my becoming?
Like myself again.

I am and only exist in my object relation to you
You have become my capacity, while I wait to become myself again

I wait for the world of literature to catch up
To fall into step with my real experiencing self
Healing awaits where this wholeness becomes

Janette Tolich

CHAPTER THREE

Methodology and Methods

Methodology

Introduction

Phenomenological research is important because many professions such as pedagogy, nursing, healing, counselling seem to require not only trainable skills and specialised bodies of knowledge but also abilities that have to do with discretionary, intuitive, pathic and tactful capacities. It seems that in these directions lie the relevant and continuing contributions of hermeneutic phenomenology for the epistemology of professional practice. (van Manen, 1997, p. xviii)

The methodology guiding my qualitative study is hermeneutic phenomenology. As in the quote above, I see this underpinning methodology and method of research as a ‘natural fit’ to ascribe meaning and relevance to this clinically based work. A study of this nature can further promote and contribute to deeper insights into the epistemology of professional practice. I value the contribution that hermeneutic phenomenology has made to the direction of healthcare. I also ‘know’ and have experienced in my own personal study and practice how a phenomenological attitude awakens and opens up an existential pathway uncovering a ‘new’ way of being in healthcare encounters. A phenomenological ‘way of being’ promotes practice that is able to deeply explore human experience in suffering, illness and ‘disease’ and re-integrates it with its inherent multidimensional life-in-the world experience.

Through exploring, matching, and experiencing resonance within this philosophical paradigm I am seeking to uncover the essence of the *wpmbe*. Over the last three decades, there has been a turn towards re-connecting philosophy with the practice of medicine and health as “it has become more widespread acceptance that the success of medical science by itself will never provide us with answers to all the problems of medical science” (Svenaesus, 2000, p. 63). Formulating a theory of health practice combining philosophical reflection is becoming a necessary and indispensable tool to the practice of medicine. The practice of medicine has become detached from its connection with philosophy (Nicholls, 2018; Svenaesus, 2000).

By using this research methodology, the thesis will add to the already existing distinct literature that supports phenomenology in practice as endorsed by van Manen (2016).

Linking and promoting phenomenology in practice is a platform which invites, encourages, and endorses whole person viewing and mindbody healthcare as I will further elucidate in this chapter.

Why a phenomenological hermeneutic approach?

Having worked in healthcare for over 30 years and having the opportunity to grow and develop as a mindbody practitioner, encouraging others to take an open wider gaze has increased my awareness of the disconnection with the lived context in illness and healthcare experience and how this affects recovery and rehabilitation. Both HcP and HcS, and whaiora appear separated from experiencing their illness within (the context) their lifeworld in western biomedical dualist practice. I am seeking to uncover the phenomena of what happens when HcS and whaiora are invited to consider all aspects of their life as having meaning in their experience of illness.

The essential nature of the *wpmbe* is intimately entwined and underpinned by a line-up of many infamous phenomenologists; each with their varied perspectives inform this whole person mindbody approach. These include Merleau Ponty's embodied intersubjectivity, his famous works on the phenomenology of perception and the visible and invisible; also the existential philosophies of Martin Buber and his dialogic we, our relationships with one another becoming an I-thou intersubjective reality rather than an I- you; and Levinas's ethical grounding of the experience of suffering within ethical responsibility in relation to other. For the purpose of this study, Heidegger's (phenomenology), being-in-the-world and Gadamer's (hermeneutic) interpretive understanding (through language) will be the main methodology which guides the study and its design (Buber & Smith, 2006; Kramer & Gawlick, 2003).

This philosophical approach deeply appealed to me, as a mindbody clinician, as it invites a two-sided perspective, a fusion of horizons. Including my own pre-understandings as being essential to the process is an acknowledgement that what I hold to be true is that my understanding (of the *wpmbe*) is that it is deeply embedded in its emergent nature. For this reason, in order to uncover the phenomena of this lived experience and throw light on the truth of this experience, I needed to have a way of getting myself 'out of the way' in order to overcome the particularities of both parties

present “to arrive at a new understanding that transcends both parties horizons” (Dorrestein, 2015, p. 41) captured in the presence of both.

Underpinning philosophy

Heidegger [1889-1976] and Gadamer [1900-2002] are the two key philosophers who inform my chosen style of phenomenology. Phenomenology seeks to uncover multiple layers of perceptual reality which may be hidden in any act of consciousness (intentionality) by seeking a deeper understanding of an experience of an identified phenomenon. Intentionality, what you are conscious of—all our thinking, feeling, and acting—are always orientated to or with things in world we inhabit. They have a relationship with the ways we are attached to the world and things in the world. When we hear, see, or touch someone or something it is always as it appears to us, rather than in its entirety or wholeness. In other words, intentionality takes a conscious experience and analyses it in light of what it presupposes (Gadamer & Bernasconi, 1986; Harman, 2007; Heidegger & Stambaugh, 1996). What we ‘see’ is only always as a piece of the whole (picture). In phenomenological research, we seek to make a distinction between the object and our own lived experience. As I interpret each of the stories from whaiora and students, the themes I notice are only ever, and always, a glimpse of the whole.

Phenomenological research looks for answers to the question “how do we know what we know?” The phenomena is never completely on show but already there as in a priori (Heidegger, 2005). By exposing phenomena in this way, it evokes a new discovery of the unknown in another’s experience. This approach is not seeking to problem solve, ask why, or to control. It seeks to hear personal story of lived experience while not limiting subjectivity or imposing power or control (Thompson Dykes & Downe, 2011). By remaining true to the phenomena, it helps uncover “the taken for granted assumption” (Smythe, 2011, p. 39).

King & Llewellyn, 2001 identify these multidimensional layers of meaning as mysteriously covered over due to their familiarity.

Covered over, half-hidden, disguised or forgotten, going unnoticed in our everydayness. This is the taken for granted nature of our everyday experience, in our human experiencing. We tend to not see or ponder the complexity and mysterious of our

everyday mode of existence due to its nearness and familiarity. (King & Llewellyn, 2001, p.42)

Uncovering this familiarity is part of the process of a phenomenological study.

Hans George Gadamer is more closely accredited with developing what we know as phenomenological hermeneutics. To describe the difference between a purely phenomenological stance and the phenomenological hermeneutics is complex. Phenomenology on its own, or in pure form, as described by Husserl, is standing outside one's historicity. Phenomenological hermeneutics, as guided by Heidegger, is staying embedded in it. A purely phenomenological approach may start with a process of bracketing one's own experiences (taking away your pre-suppositions) to expose the phenomena; whereas in a hermeneutical approach the researcher uses a more 'Heideggerian' perspective of self-reflection in a hermeneutic circle (Smythe, 2012).

Hermeneutic phenomenology tries to be attentive to both aspects of its methodology. It is descriptive (phenomenological) because it wants to be attentive to how things appear, and it wants to let things speak for themselves. It is interpretive (hermeneutic) because it claims there are no such things as uninterpreted phenomena.

For me, what matters is that the voices (of those who have a lived experience of the *wpmbe*) can speak and be heard. The interpretations are to be 'heard' only ever in context, as a contribution through what has now become a shared horizon of understanding. It is as if this uncluttered phenomenological freedom to be heard allows the voice of the other to be heard by the other. Van Manen (1997) stated that

the implied contradiction may be resolved if one acknowledges that the facts of lived experience are always meaningfully (hermeneutically) experienced. And even the 'facts' of human experience need to be captured in language, and this is inevitably an interpretive process. (p. 181)

Gadamerian hermeneutics pays particular attention to the interpretation of text and language itself, through making sense of the meaning of the personal story and writing and re-writing processes. Interpretation within this study is always my own, coloured by

my historical context. I need to be open to my inevitable prejudices while at the same time respectful of opinions that differ (Gadamer, 2013).

Heidegger's understandings – the meaning of being

Heidegger explored the meaning of being-in the world; this being-in-the-world, he called *Dasein*. When we experience something, we also have a response to it. He described our being in the world as a thrown projection.

Heidegger's quest was to understand the forgotten question of being through an analysis of human existence. Heidegger is considered as awakening the need for this question in our age. He brought the "great question of ancient Greek philosophy back to connection with our real life" (Harman, 2007, p. 78). He strove to bring actual life of human beings back into philosophy, rather than excluding them. This is not viewing humans from the outside, as their outside appearance tells us nothing about what it is to live the life of *Dasein* (Harman, 2007).

How can we reach this understanding of *Dasein*? How can we use this understanding to inform our understandings in phenomenological research? When I view healthcare practice, I notice it is commonplace in our current biomedical practice to 'use' the world to 'know' the world. In understanding *Dasein*, this 'known' world is scattered and destroyed or, in Heidegger's phrase, destructed. The vessel (in our case our body in the world), no longer being that which holds us, disappears in its everydayness and shows itself only when it no longer serves its purpose. We constantly look to re-purpose it, to redefine our way of being-in-the world. Never entirely visible from the outside, "we are not even entirely visible even to our own selves" (Harman, 2007, p. 56).

Dasein has a special relationship to its possibilities. *Dasein*, is not a "sterilised thinking machine gazing calmly at the world" (Harman, 2007, p. 60). Its essence is nothing but existence. In its temporality (or position) is not something clearly and lucidly present. The opposite of presence is its temporality, "it stands outside of itself, simultaneously swinging towards the past and the future" (Harman, 2011, p. 59). It is a here and now that transcends time but is within time. *Dasein* is always a 'who' and not a 'what', its mine-ness is its key feature and it has a specific relationship to its own possibilities. *Dasein* "It is its possibilities" (Harman, 2007, p. 60).

In a Heideggerian stance, we create (or are the creation) of the possibilities we have for experiencing our world, through our own pre-reflection and pre-interpretive

understanding. Our fore-understandings become (or already are) our way of 'being-in-the world' (Heidegger & Stambaugh, 1996). Heidegger rejected the notion that human beings are spectators espousing that subject and object were inseparable. Our human existence is an embedded, entwined, and integrated (knowing) of our being-in-the-world.

Heidegger's *Dasein*, his way of 'seeing' our being in the world, "does not create the truth, but finds it in the world as soon as it is born" (Harman, 2007, p. 70). This is the 'kind' of phenomena I am seeking to uncover using this methodology, that truth as it only and already exists (in human existence).

Gadamer's emphasis on understanding and language is pivotal to a study where language has meaning and where meaning is conveyed through language and story. Language is the messenger or Hermes. Gadamer's pursuit of truth is found in the conversation of question and answer. He espoused a theory of truth emergent from conversational interplay. Deeply interested in the manner of conversation, "a type of genuine conversation, never the one we want to conduct that creates genuine unstable and open moments" (Orange, 2011, p. 107).

As clinicians and hermeneutic researchers, we need to 'learn' the patient's language, knowing it is different from ours and "we must both grapple moment by moment with the troubles generated by our cultural incompetence, and keep on trying to understand" (Orange, 2011, p. 107). This is the nature of the work, the openness required in the semi-interviews and the drafting and crafting of stories, using the language of the other, constantly realising the place and importance of not (yet) knowing.

A new relationship of understanding forms which Gadamer called a fusion of horizons. The meaning of language is mediated and co-created by both the listener and the speaker (the spoken or text). "This forms the hermeneutic circle where there is a constant movement of interpretation from the whole to the part and back to the whole until a harmony of understanding has occurred forms" (Dorrestein, 2015, p. 41). Deeper meanings can be contemplated as the 'taken for granted surface meaning appears to suddenly fall away' (van Manen, 2014). Then we (as the researcher or interpreter) begin to see the truth understood from another's perspective, aware always of the 'places' within which we have formed our views.

Gadamer's hermeneutics equips the mindbody clinician to hold a stance of readiness to listen and learn from the voice of the other as a clinical philosophy (Orange, 2011). This

stance is intrinsic to the *wpmbe*. It is a way of engaging in dialogue with another, with an expectation that creates an opportunity to learn from the other in a spirit of curiosity and wonder “expecting to be surprised” (Orange, 2011, p. 16).

Gadamerian hermeneutics for clinicians “means never presuming that we have a perspective free view of our patient, or of what occurs between us, or even of our own participation in the clinical dialogue” (Orange, 2011, p. 16). This stand is integral to this study as it is my stance. One cannot stand outside one’s historicity to explore meaning with this method. Gadamer’s philosophical hermeneutics “frees us from our enslavement to a natural-science model of understanding in the human sciences...thus, showing us an alternative to tempting reductionisms” (Orange, 2011, p. 15). I am surrounded by tempting reductionism, but it no longer confines or defines me.

My pre-understandings

It is important in this particular type of research to be mindful of one’s own pre-understandings and assumptions. Through an original interview with my supervisors and ongoing reflection on my practice I understood my desire to tend to the ‘suffering other’. This desire was very much grounded in my own early personal experiences of seeking healthcare for my family. I had witnessed a strong connection between the meaning and experience of suffering and illness. I was deeply affected by what I noticed as the overlooking of other influences in health and well-being. My close association with hospice care in New Zealand, working in the South Auckland community of practice with hospice care in particular, and my personal family experience of ongoing illness in my early teenage and adult years influenced my perception and how I experience healthcare encounters. As a clinician, I see the hospice care, the ‘cloaking’ of family and whanau, as a blueprint for a holistic, family inclusive, relational, whole person, whole life (and death) care. There is an awareness in the healthcare sector that palliative care is truly at the forefront of WPC and PCC (Coulehan, 2009; Hutchinson, 2011).

By looking at our own stories, we see how deeply embedded we are within our own life experience ‘being the way we are’ and that our past experience and acculturation has shaped and continues to shape the way we understand and experience the world (Carel & Cooper, 2013; Smythe, 2012). Because “we find it hardest to see that which is closest” (Smythe, 2012, p. 39) we tell our own stories first, before we listen to those of others, in order to make a clear path for a new understanding of the phenomena we are

attempting to uncover in this type of research. The findings of this study and the way, or method through which the ‘real’ truth (of the lived experience) was unveiled, resonates profoundly with my experience as a clinician. I have noticed numerous occasions in healthcare when ‘assumed’ understanding dominates in clinical practice. I have seen and felt with my own ‘eyes’ how safety and best practice in healthcare (for the person/s and family/s) can be compromised by a closed view. My firm belief is that a spirit of open enquiry which explores life experience allowing meaning and story to be made apparent enhances safe practice and whole person viewing.

This pondering curiosity, where possibility is opened up is very much a key attitude for a mindbody practitioner. To become a mindbody practitioner, one needs to metaphorically blink to clear the clinical eye and vision in order to “look again at the data floating to the surface in the clinician /patient encounter” (Broom, 2017, p. 98). Allowing a space where subjectivity and objectivity are viewed in the same space means changing from this clinical analytic scientific field. An orthodox medical ‘natural attitude’ would mean that most of the data would not have surfaced. The usual style of medical questioning would not “engender such emergence” (Broom, 2007, p. 99). Having a phenomenological attitude means exploring the phenomena as they surface in the interview “in the spirit of the meaning of being of things” (Broom, 2007, p. 100). By suspending judgement and moving away from diagnostic labels, the real life world (lived in the world) or experienced-world becomes apparent. Here, in this encounter, there is no disconnection between the science world and the life world. Subjective meaning not ‘visible’ to science awaits our ‘knowing’. Merleau Ponty’s philosophical concepts of the lived body, or the subject body, describes this human capacity for subjectivity as a chasm or a crossing-over place that combines both subjective experience and objective experience giving us a window to viewing this way. It really depends what “we as clinicians (choose) to make visible or invisible” (Broom, 2007, p. 108).

A hermeneutic clinical sensibility has become my default position as I have explored my own natural attitude. Having a hermeneutic attitude takes one away from one’s own prejudices as it allows those who participate in this study to share their own stories and also allows those who read this to engage with their own experience. By its nature, this

research paradigm will invite more questions, never actually coming to a definitive answer.

Here, I tell a story from one of my own patients that influenced me greatly when I was beginning this research project. Though it is anecdotal and does not make up the data, its meaning had an impact on my wish to uncover the mystery of what happens person to person in a *wpmbe*, and my desire to make it discoverable for others. My client described her experience in the *wpmbe* as though she was walking down a path together with her HcS. They were both looking at everything together, expecting and seeing the ‘same’ things, aware that that this would lead them to a shared space but, in this case, in the *wpmbe*, they had the freedom to end up somewhere else. This *wpmbe* pathway allowed something to emerge that was unexpected. She said “It was if in this experience you could have an entirely unpredictable and uncontrolled outcome, it was not prescribed. The *wpmbe* allowed for surprise”. Here, in this *wpmbe*, conversation and listening were prioritised. This was a dialogue where the routes remained unpredictable.

Research design

The research question and its hermeneutic phenomenological methodology exploring the lived experience of a mindbody encounter for whaiora and healthcare students informs the nature and design of this study, which is emergent over time. The gathering of data from hermeneutic interviewing and analysis begin to throw reflections off each other, allowing the reality of the lived experience to slowly reveal the phenomena. Understanding of the phenomena then begins to grow. Intentionality, language, and meaning fit well with this exploration of the lived experience of the *wpmbe*, as the encounter itself is a lived experience of meaning making. Similar reflections, or models of this method, are enacted in healthcare itself. Carel (2012) has “developed a toolkit which uses phenomenological concepts such a thematization and being in the world to assist patients in making sense of their illness and providing a method for describing and making sense of it” (p. xx).

This methodology is making use of subjective reality through hermeneutic analysis as it pays attention to human experience by interviewing, outer-viewing, and inner-viewing (Broom, Booth, & Schubert, 2010). There is an inward and an outward flow, as in a

hermeneutic circle, as each component part (story) points toward the whole and the whole towards the parts (Smythe, 2011).

Ethics

Ethics approval was sought from the Auckland University of Technology Ethics Committee (AUTEC) at AUT University. This hermeneutic phenomenological project draws its information from interviews with human participants; so at all times ethical consideration was paramount. Recommendations as per the document were adhered to (see Appendix A).

Social and cultural sensitivity

I outlined in my ethics approval the significance of the Treaty of Waitangi in this research and I sought consultation with the Māori advisory group, Matauranga Māori committee at AUT University to consider the research importance and possible implications for Māori during and post study. Whakapapa – relationships, Tika – validity of research, Manaatikanga – responsibility and respect, and Mana Tangata – power and authority, were all discussed and specific implications for this study for Māori were commented on. The feedback formed an integral component of the study (see Appendix B).

This study was identified as being extremely compatible with the Māori (whole person) view of the experience of illness and noted as being congruent with the Te Whare Tapa Wha model of Māori health (Durie, 1998). It was also identified as possibly making a significant contribution to future healthcare in Aotearoa New Zealand on its completion and implementation as an accepted model of health.

There was no participant in this study who identified specifically as Māori.

Methods

Identifying and inviting participants

Invitation was made via a separate invitation to each group, both HcS and whaiora, who, as per the information sheet, were informed that participation was entirely voluntary. Recruitment was on a first come first served basis. I had no issue with excessive numbers. Nine participants came forward who were part of a much larger group of 50 people. It was decided that a mixed sampling of both groups would provide rich (but not comparative) data. This decision to include both groups was made in consultation with my supervisors as it would add richness and diversity and enhance the

likelihood of different perspectives emerging from data. It would also be a more representative cohort of the whole person mindbody experience.

Inclusion criteria and recruitment of participants

Recruitment: 9 participants were recruited from students and whaiora who had completed the 8-week Living Well programme held at Akoranga Integrated Health (AIH) Clinic. The students had completed their placement in this area and all assessment requirements associated with the learning situation had been signed off by the exam board. Participants were given an information sheet asking for consent through an independent person, the clinic receptionist at the AIH clinic.

Exclusion criteria: Students who were under my clinical supervision and non-consenting parties were excluded.

Data gathering method: Individual in-depth conversational interviews were conducted at venues suitable to participants, such as their home or at the AIH Clinic at the North Shore AUT campus. Conversations were audio recorded (with consent) and transcribed verbatim.

Informed and voluntary consent

I provided interested people from both the whaiora and HcS groups with a detailed participant information sheet (see Appendix C) in order for them to be able to make an informed and independent choice about participation. Students and whaiora were given a letter in a reply-paid envelope by a non-involved staff member in the final week of the programme inviting them to be contacted about the research. To minimise risk to participants, it was important that they were not involved in the research until their formal involvement with the programme was completed. The letter included an information sheet and a consent form with a request to make contact with myself or my supervisor if they wished to participate or have any questions answered.

The information sheet outlined the specific reason for the research, information about the interviews to be conducted, and where and how the findings would be published. It also outlined how participants could access the research after it was published. It stated that participation was entirely voluntary and that the recorded interviews would be

safely recorded and stored. Participants returned a signed consent form approved by AUTECH (see Appendix D) after they had adequate time to consider the invitation.

Respect for rights of privacy and confidentiality

There is a need to acknowledge and uphold the right of participants to privacy and confidentiality. Participants' identity was protected using fictitious names; each participant was given a new name. In particular cases, where significant identifying features (health events or disability) became apparent in the stories themselves, it was discussed with my supervisor. Editing was done to minimise the potential for the story to be recognised. The richness and power generated by these (particular) stories was seen as integral to the experience and as validating to their own experience and that of others. In each of these cases, I sought additional verbal post interview consent from the participants in question.

All consent forms and digital recordings were stored securely in separate locations. The place of the research has been identified as this seemed important that it was located, but the individuals identifying information was altered. Students and whaiora were identified separately in the stories, as this added to further dimension richness of the data.

The participants

The participants were gathered from those who had completed an 8-week programme in an interprofessional student run university clinic in which they experienced a healthcare engagement involving a *wpmb*. The HcS, both undergraduate and postgraduate, came from two universities in the Auckland area, AUT University and Massey University. They comprised diverse healthcare disciplines including, but not exclusive to, nursing, physiotherapy, occupational therapy, psychology, psychotherapy, dietetics, and osteopathy. They volunteered to participate; that is, they were not invited to the study due to their specific discipline or orientations. In the programme, HcS and whaiora had explored together the experience of living with a life changing event or ongoing health condition. Whaiora had been invited to attend the programme advertised as a whole person approach to living with ongoing illness or a life changing event for those seeking wellness. This 8-week programme is run by an interprofessional group of clinical educators. The structure of the programme involves 2-hour contact time between HcS and whaiora on a weekly basis; 1-hour individual and 1 hour group interactive sessions exploring wellness in the context of a whole person mindbody approach. In addition,

and integral to the programme learning, group reflection and teaching takes place outlining a whole person mindbody approach.

Engaging in research interviews

To prepare myself to gather stories from whaiora and students, I read and re-read van Manen's (2016) *Meaning giving methods in phenomenological writing*. The interviews were held in a private and calm setting familiar (known to the whaiora and students) but not the actual rooms in the clinic where they had had their *wpmbe* encounters. One participant chose to have the interview in her own home as she had a severe physical disability and at that time was unable to travel. Each interview was face-to-face semi-structured with a short list of indicative questions. They were recorded verbatim and later transcribed word for word and held in a secure hard drive folder by myself. Four interviews were conducted in quite close proximity, 1-2 weeks apart, and were shared with my supervisor for feedback on the process itself. Discussion was had on how to focus on capturing the story of the lived experience itself by the nature of the questions. The original list of questions (five in total) had been discussed before beginning this process as the style of questioning was an important component in eliciting a story from a lived experience. In order for this form of hermeneutic questioning to evolve, I went back to my supervisor after the initial four interviews and we looked to together at what 'stories' if any were emerging and re-worded the indicative questions to be more open and less pre-assumptive and prescriptive (see Appendix E).

I chose to adopt an open and hermeneutic stance which acknowledges that language and silences themselves holds meaning. I thus allowed the interviews to flow, becoming a more emergent space for story whilst search for meaning. Each interview was allowed as much time as was needed, in some cases 60 minutes hour others required 60-90 minutes to give greater time to the experience of the interview itself.

Returning for a second interview was a consideration if a deeper exploration of a certain experience would have been useful. After eight interviews were conducted and after discussions with my primary supervisor, we decided this was not necessary. The data was indeed rich.

The interviews themselves

In the interviews we paused often as interviewees began feeling the very experience itself, at times re-visiting the powerful transformative effects of the *wpmbe*. We wondered together and were curious about how this could come about. There was a

perceived knowing one had had a life changing experience or, in one case as the whaiora expressed, a literal speeding up of the rehabilitative process. There were tears at times from both myself and the interviewees and long moments of shared silence as we both became aware of the ‘real depth’ of the experience of the *wpmbe*. This was a close relational encounter as we co-shared the experience. The quote below from a whaiora (within the interview itself) captures almost perfectly this experience in the interview.

By getting to know each other like we did, your origins and your history it established a relationship. Unbeknown to them (HcS) they enabled me to shed some of the skins to get down deeper, similar to the experience of this research interview itself. (Brian, whaiora)

Gathering and analysing the data

In hermeneutic phenomenology, enquiry gathering and analysing data are not separate. They occur simultaneously from the first moments of pre-reflection, starting before and then continuing within the interview process. There is further flowing backwards and forwards using pre and post reflection and self-reflection processes. Through this multi-layered process of noticing and contemplation the essence of the lived experience is revealed.

To feel you have adequately described the experience of another is extremely complex, as van Manen (1997) so aptly said: “Experience is always more immediate, more enigmatic, more complex and more ambiguous than any description can do justice to” (p. xvii). It became apparent for me, whilst writing these stories, how challenging it is to remain true to the data. As in the quote below we become the creator within the relationship of language and experience in human enquiry.

How do we capture and interpret the possible meanings of a (human) experience. The things we are trying to describe are not things at all – our actual experiences are literally “no-thing”. And yet we seem to create some-thing when we use language in human inquiry. What is the relation between language and experience? It seems that with words we create something (concepts, insights, feelings) out of no-thing (lived experience) yet these words will forever fall short of our aims. Perhaps

because language tends to intellectualise our awareness – language is a cognitive apparatus. (van Manen, 1997, p. xviii)

Acknowledging to myself that words will “forever fall short of our aims,” assisted me in the writing and crafting of the stories themselves. Capturing the meanings or significance of the text was challenge for me. I needed to allow myself poetic license whilst remaining true to the participants themselves. At times the stories were of a deeply felt human experience that was disturbing. Van Manen (2016) described the phenomenological text succeeding when it lets us see that which shines through, that which tends to hide itself. The writing itself is revealing something from the stories which point to the experience.

The words are not the thing itself. And neither is the language fully able to deliver its true meaning, as language itself is a limited capacity. So in our human science study we write as if we are responding to the text as if reading poetry. We need to be attentive to what has been said in and through the words. (van Manen, 1997, p. 93)

In this way of responding to the text as if reading poetry, the stories of the lived experience began to be able to speak for themselves. They became tangible and real. Essence began appearing. The essence was heightened and enriched again and again by a new experience created by what happened between me, the reader, and the text.

Generating coherent stories

The watermark of phenomenology is when a story read from the data holds the audience in almost a sacred silence. They are captured by a felt knowing that stays with them in a story that becomes their own. (Smythe, 2011, p. 49)

Crafting the stories from the transcripts took considerable time. I wanted to use the language, words and text, and notably each person’s idiosyncratic way of expressing themselves as this placed them, and not me, in the story. I wanted to capture their story so that there became a felt knowing that remained long after reading this work. For me, each participant’s way of speaking and use of words, their pauses and gaps in the story that met up later, reflected for me *their* way of being in the world. I needed to keep my research question, what is the lived experience of this *wpmbe* firmly in my mind as I tried to “pay attention to what grabbed me” (Smythe, 2011, p. 48) knowing that this experience was always and only ever experienced in the context of the lived experience

(so far) of the participants lives. Because the *wpmbe* was so interconnected with health and peoples view of illness I found this challenging at times (to stay on task) as the pain experienced in other healthcare situations (which they often referred to) was at times raw and vivid and came to the forefront. I did not want to explicate what was ‘different’ in this (*wpmbe*) encounter, from other healthcare encounters. My task was to go deeper into the experience itself.

Crafting the stories

Crafting stories from verbatim transcripts is integral to the interpretive process, at this stage as a hermeneutic researcher with my understandings I became closely entwined in the project. “a well-crafted phenomenological story is able to reveal ways of being, thinking and acting in the world that shed light on what is known but covered over” (Crowther, Ironside, Spence, & Smythe, 2017, p. 827). These story only ever provide glimpses, as the actual truth is never the goal. With this methodology multiple meanings always remain to reveal new possibilities. This appealed to me immensely (although was distinctly challenging) as it is as though the stories themselves always tell another story. It meant for me that I could put away any presumption whilst still acknowledging it, and whatever was glimpsed was only ever a part of the truth. How I actually did this is explained in the next paragraphs.

Analysis – interpreting the stories – challenges for a hermeneutic explorer

The words of the famous Persian poet Rumi express very well how I felt about this stage of the research: “Observe the wonders as they occur around you. Don’t claim them. Feel the artistry moving through, and be silent” (Banks, 1995, p. 153). Writing to capture the stories from the transcript became a challenging prospect as I sought to display as honestly and clearly as I could what was the essence of this lived experience. How could I claim another’s story? How could I re-write their actual words, so it represented their experience? A depth of ‘feeling’ was rising up from this deeply human experience of illness, the hurt and the pain of feeling separated from oneself was very strong and, as a mindbody practitioner, this was a deeply felt lived experience that resonated with mine. I needed to find the silence in me for these words to speak. Representing others in their truth became paramount and the sense of this ethical responsibility sat heavily with me.

Over a whole year of deeply dwelling, embedding myself in the stories, I had come up with the essential themes but they were not the essence as I found out. I have recorded

these themes in writings and a diagram (see Appendices F & G). I met again with my supervisors to reconsider my own experience in finding rather than crafting the stories. My vision had become clouded. It appeared to me that the stories of the experience were the thing itself, there was so much meaning in there, and surely the themes were obvious. Surely this was the phenomena showing itself? These had been difficult first months where I felt quite isolated and alone. I could see these emerging themes and outcomes and I had no idea how to stay with the story itself. After all, it was no wonder, had I not been trained in outcomes?

So what comprises this hermeneutic (researcher) plus clinician that I am? A hermeneutic clinical sensibility includes:

A strong sense of one's own situation- a knowing that this shapes and limits one's own capacity to understand, a sense of the experiential world or system, one's own that of the patients and that formed with the patient, a strong sense of complexity that resists all forms of reductionism, a sensitivity to the languages of personal experiences, including non-verbal contexts, a strong sense that understanding it's application ...in a rich sense is curative, a sense of vocation and devotion. (Orange, 2011, p. 26)

I had experienced a strong sense of my own understandings in this situation and needed to jump this obstacle of my own system. I had to be re-trained in order to be with and be sensitive to what was now formed between us as a new understanding in the re-crafting of these stories. I needed to resist my own reductionism.

My secondary supervisor wondered aloud with me whether I wanted to change my methodology to a descriptive phenomenology which would have fitted this style that I had used. No, I did not want to change my methodology; I wanted to find a way to do this phenomenologically, hermeneutically. So, I began again, a re-dwelling with the data. I had to keep with the data and write a story that kept to the truth. My supervisor said I had been 'picking out the eyes' of the story and not the 'experience'. I could now see this for myself. At this stage, I re-worked my whole writing of the participants' stories.

I sat for hours in a state of reflection and meditation, re-writing and reading and re-writing. An iterative process seeking to capture the true essence of what was said. Fifty-three stories in all—all so entirely unique, descriptive and riveting. I was looking to what was behind the words, between the lines and contained in the language itself. All the while, I was noticing and honouring idiosyncrasies with nuanced understandings coming to light. In all, I wanted to find the 'naked' truth. By sitting with the whole of

each transcript, re-crafting, the stories reading and then re-crafting again the stories I began to feel and ‘know’ in my being that it was becoming a new and trustworthy truth. It was not ‘something “done in the mind in a logical, systemic manner” (Smythe, 2011, p. 44). Smythe (2011) talked about looking and looking again and in the pondering of meaning the philosophy itself becomes alive; it is then that the resonance draws us in again and again, fresh each time bringing to a new understanding. What happened next is that the stories became stories and they did become alive (Smythe, 2011). They became their own stories of the lived experience, to name just a few: the weta’s in the cave dwelling story, the cat story, of opening the heart, the pillow story – caring lost in healthcare, the making of the sheath dress – honouring simplicity. They became the stories of what happened in the *wpmbe*. In the findings chapters, the stories have names. These stories became the background to the experience and then the foreground came to light.

This story writing became a “lived experience of dwelling with the possibilities of what something could mean” (Thomson, Dykes, & Downe, 2011, p. 44). I had re-traced my steps. I was starting to see the link between the stories and merging understandings.

Once the stories were alive they started to stand alone and together, as if they were pointing towards each other, each making a unique contribution to the whole. I started to see how they were linked and the findings emerged. I was able to group the stories and put them together into three findings chapters: the what, the experience itself; the where; and the landscape of the how, the emergence of the *wpmbe* (described in Chapters 4-6).

In order to understand and make sense of the data, one first understands the parts in relation to the whole. The parts each reflect their own meaning, whilst also having something in common. Each is a unique reflection of that theme, a contribution to the whole. The end product, which is the meaning, is more than the sum of the parts.

Introducing the findings

At this point, naming the phenomena becomes a keystone for thinking, questioning, listening, reading and writing (Smythe, 2012; Thomson et al., 2011).

Reflection – Poems

I have written a poem as way of reflection. It captures components of my experience of learning to use this methodology to uncover the lived experience of the *wpmbe*. It

recognises the twists, turns, challenge's and fun with writing true accounts
encapsulating a growing intimate closeness I found with the lived experience of the
participants, the fusion of horizons and the forming of a new understanding.

Somedays

Some days it's easier
I am alive in the 'knowing'
Some of that reaches the paper on a good day
And what of the others?
Others I am caught up, caught up in all the questions & answers
Doubting myself immensely
The task too long
The task too huge
The task not where it is at
The task too long and winding.....too many twists and turns
The task not within my grasp
But then,
I take it slow
I honour myself
I honour my time
I deeply know my small part in the world
I let grace visit
I feel her gently delight & become my companion once again
I fall in to contentment with the suffering other
I no longer resist, life comes in for them and for me.

Janette Tolich

CHAPTER FOUR

The Path of the Struggle

The Healing Time

Finally, on my way to yes
I bump into all the places where I said no to my life
all the untended wounds...

.....the old wounds the old misdirection's and I lift them one
by one close to my heart
and I say holy holy. (Gertler, 2019)

An introduction to the path of the struggle

In this whole person mindbody encounter (*wpmbe*) the whaiora and HcS were expressing something about a struggle in their stories. As they talked about the lived experience of the *wpmbe*, they spoke of it as unique, being a somewhat new experience in a healthcare setting. There was a *felt* invitation to be with the struggle. All participants experienced the struggle to some degree, either wholeheartedly or tentatively. Its presence became a common and collective experience. Some participants had a sense of remaining at the edge of the struggle noticing an unconscious flexing boundary. Others experienced a deeper capacity for being “in the struggle”, they were able to venture right in. Encountering this struggle was not the experience they had had in other healthcare settings. Both whaiora and HcS expressed being accompanied in this healthcare relationship to explore their most deeply felt experiences. The surfacing of these deeply felt experiences had made them uncomfortable and others uncomfortable in the past. They felt they had not been allowed to have these uncomfortable experiences surface before, let alone view them as an integral component of the encounter. The reality of the struggle they were having, their authentically human experience of suffering had previously been swept under the table as if it did not matter. Now, in this *wpmbe*, they were able to tell these stories, their stories of the struggle had found a place here. Here, in this *wpmbe*, both whaiora and HcS began to purposefully

and meaningfully explore their real genuine *actual* experience of the struggle with one another (Cassell, 1976).

As Gertler said to me in her poem, *The healing time*, taking the wounds one by one and tending to them, as a real and present reality, can be an avenue of healing. Gertler talked of how heartfelt holding and paying attention to the suffering or tender spot, the untended wounds, brings about the healing time (Gertler ,2019).

In this chapter, on the path of the struggle, I will take you, the reader, through these stories using a vocative method of phenomenological enquiry to hear how whaiora and HcS speak of the experience of this ‘struggle’. I will show the varied, singular and particular aspects of this experience each uniquely situated in a personal story. This chapter will then draw together what each story holds in common. The stories encompass a truly felt human experience of illness. I do this in order to evoke a pathic response in a type of relational understanding which involves bringing my own interpretive lens to consider the experience of other. I am not looking for an explicit meaning but calling forth a response from the text that resonates with my understanding and stirs my sensibilities, in the spirit of phenomenological enquiry (van Manen, 2016).

The struggle

Cassell (1991), in his famous article the nature of suffering and the goals of medicine, talked about what is a truly human experience in illness. He is one of the first to recognise suffering as the dissolution of self. The self that you knew before illness, before this experience of the disintegrated self. In illness, the body can no longer be passed over in silence. It makes its presence known. The suffering comes about from this dissolution and loss of integrity. The pain and illness bringing with it a secondary suffering (Cassell, 1991, 1998; van Manen, 2016).

Cassell (1991, 1998) identified suffering as a specific state of severe distress induced by the loss of integrity, intactness, cohesiveness, and wholeness of the person. He

identified it as a threat which the person believes will result in the dissolution of his or her integrity.

The struggle to be with the struggle

Sarah, a student in the *wpmbe* programme, tells about her experience of being in an environment where you acknowledge the struggle:

In my other clinical environment, it was really stressful being with the struggle and having that pressure of having to fix it, having that responsibility. I found it a real worry for me that they wouldn't be able to find that sense of happiness within themselves and a sense of fulfilment in their life. I think because I have a condition myself, and a lot of the experiences were quite painful experiences to go through, so I knew what it felt like. It was nice to be in an environment where you could hear about the struggle, you could acknowledge that it was really hard.

It was ok to just not do anything about the struggle; it was ok to just listen and be with it which often I think is a more important aspect. When I wasn't in that clinic, I was working with people who had a lot of struggles that they were trying to work through. It was like they came to me as a physio just to fix all their problems. I didn't necessarily see that that was the problem with them; the problem seemed to be the way they felt about themselves which was perhaps more the real problem.

My experiences at the WPMBA continued on with me and helped to be ok with it much quicker than I would have been otherwise. With not being able to do anything that's going to change them hugely all you can do is like do a little bit with the time they are with you and hopefully make a little bit of difference in the way that you are with them; or the way that you listen; or the way that you make them feel when they are there. (Sarah)

In this story, Sarah is saying how, for her, actually being with the struggle was quite a difficult thing; it was not very easy to be with the painful experiences that patients were bringing. For Sarah, it also felt a real responsibility and a worry that people would not be able to find fulfilment or happiness. Sarah could feel this quite strongly as it resonated with the pain, she had had herself as a patient “*I knew what it felt like*”. Sarah tells of her previous experience of being in a situation as a HcS where you are expected to fix the problem when it is not fixable and may not be the root cause of the problem. In the past, this made it harder to be with the patients' struggle itself. It also felt like an

ethical and a relational struggle within as if the brakes were on. It made the sense of responsibility worse because you could not attend to the real thing itself. It was as if it had, in the past, been difficult to look at the truth. The expectations in the healthcare relationship were a barrier in getting to the real problem that the patient was facing. If you were able to literally take the gloves off or stop the pretending that you knew what to do, then all would be made visible and then you could get on with 'fixing' the real problem.

For Sarah, being in this *wpmbe* gave her a way to be with this situation. Here she felt it was okay to just be with it. It was sufficient to be with a problem itself that was not yet revealed. All she needed to do was to listen for what emerged. Sarah had difficulty in actually putting her finger on what happened, or even admitting to herself that something did happen despite her beliefs that a healthcare encounter could be about fulfilment and could ease the suffering. Despite this, she had the capacity to feel that something did happen. Sarah felt she had not been allowed to have this kind of experience in her past healthcare environments. Now she was free to attend to the 'person'. Being with the patient in this *wpmbe* way actually made a difference; yet, it still was not seen as the real 'intervention'. Sarah was conflicted and had difficulty in reconciling this unfolding picture.

The struggle-stuck in the illness experience

Whaiora story

In this story, Florence talks about her experience of illness as being stuck in the slurry of life. By entering the cave together in the *wpmbe* she found a way out. A light was shone on the struggle.

When I think of my illness, it feels like I am going further and further down into a deep cave with the cave wetas. Its gets worse and worse the further I go and there are a lot of nasty things down there. When I am down so far it's like there is no way out. This feeling is like I can't come to terms with my illness I am stuck and I am not able to move, I am going nowhere. And the going nowhere has no end. In the mindbody encounter, we trudged together through the slurry of life and somehow, we seemed to find a way out. It was like we put some sunshine in to a dark place. Depth of feeling that had been blocked off bubbled up to the surface. It wasn't easy and at times it was even frightening opening all

this stuff up, you are kind of forced to be honest and it could even be quite tiring. (Florence)

Florence describes the place where her illness takes her. It is a long way down into a cave; things get worse and worse the deeper she goes. She expresses that it is the feeling of not being able to come to terms with the illness and of that experience making her stuck and not able to move. It is as though she is resisting a force. This stuck feeling has no end in sight, no light at the end of the tunnel, no way out of the cave. In this *wpmbe* experience, Florence tells how someone went with her into this cave, they trudged together through this slurry, finding a way out together and putting sunshine into a dark place. Actually, going into the cave and the feeling of being stuck was not an easy thing; but putting some sunshine in there was equally frightening and exhausting. There was a depth of feeling that had been blocked off which now started to bubble up.

For me, when I hear this story, I feel the awfulness of this stuck place that Florence talks about. As a clinician I find myself very often there too. It is dark, it is damp, and it is lonely; but most of all it is stuck, there is no-where to go and no-way to get there. No one minds getting dirty if there is a nice hot shower at the end of it all but in this case there was no way to get out. The experience of illness is a truly commonly shared human experience. It seems Florence has already experienced life's challenges because she talks about living as not just life but *the slurry of life*. Right now, in her illness experience she feels stuck in this slurry.

Being accompanied into the cave in the *wpmbe* and trudging through the slurry of life together threw a light on this stuck-ness itself and somehow got it moving, bubbling, and shifting. For Florence to be here, she needed to be brave and fearless *as you were forced to be honest*. An uncomfortable place to be.

I feel Florence is describing a commonly felt human experience of illness, it is uncertainty, it is hardship, and it is *trudging through the slurry of life*. It is quite common also in a healthcare encounter to feel resistance from the other side of this relationship, hearing what is truly happening for patients can also be difficult.

Florence is describing how this *wpmbe* enabled her to be with this experience in a way that changed things for her. She moved from the stuck-ness of the situation to a future; this *wpmbe enabled a future*. Bright (2015) talked about the meaning of hope in rehabilitation and how it is not necessarily the solution or a change of circumstance that allows someone to rehabilitate. Maintenance of hope in rehabilitation, even in a

desperate situation, is significantly important in recovery. The clinging to hope is life giving. Like someone holding the life raft for you until you can manage to get on.

It would be easy to simplify this experience as an empathic encounter. Of course, empathic connection is more than likely a component; but I think, if you look closer, it was more than that. I think something here ‘*forced you to be honest*’ and the fact that it required bravery and fearlessness seems to point to something else. I think it is describing an experience of being able to be with the horribleness itself, a means to get to the actual struggle. While you are down in the cave of the humanness of illness something shone a light, it shone the light on that struggle. I wonder what experiencing a place that was hidden from the light was like. What was *the stuff that was opened up*? Maybe just being in this together, still not being able to see but looking anyway, not giving up, not giving in when it is tough. Maybe the experience was finding a way out by trudging through the slurry itself.

Permission for the most desperate thing to surface

Whaiora story

In this story, Sally is talking about the permission she feels in the *wpmbe* to bring her whole self. Here in this *wpmbe* her difficult experiences are brought to light.

You might remember I was quite nervous and worried that traumatic things might come up, I was afraid they might be in the room. I actually wasn't sure what to expect. This wpmbe experience actually brought to light these challenges I face which I found interesting in itself. One week I was really thrown and feeling quite sensitive which is not so unusual for me but despite this I felt cradled And I think for that to have been the case, a lot of time went into just really focussing on what was important and what was allowed you know I kept saying, am I allowed to? And there was that feeling of being allowed.

Having time to check in with these students and then come back and reflect made me feel like a human being, not a patient. It was like being a member of a team, not the focus that was being dissected and analysed and being talked at and made to wait and secondary to my diagnosis. Hearing others' stories was useful as well and made me feel included and through this I got a sense of where I fit with that. I felt a sense of agency about being able to say is it ok to focus on this or that and that was a different dynamic for me based on my history of health professionals. It made me feel as if all of me was allowed to be in the

room. That was so precious. Allowing all of me made it an enriching experience. (Sally)

Sally describes *all of her being allowed in the room*. She felt she needed permission to be there as a person to feel like a *human being* and not *the focus that was being dissected and analysed and made to wait*. Sally developed a sense of agency in the *wpmbe* also now able to see where she fitted in. She describes being included as a part of the process, *like being a member of the team*. Describing this as being *cradled* as in a safe relational holding space, a term one might use when talking about a mother cradling her child—a metaphor for safety. This safety was felt in the presence of fear, along with her sensitivity.

The open, revealing dialogue encouraged in this *wpmbe* sat within a culture of promoting and valuing authenticity and authentic engagement, not usual in our healthcare culture, as noted by Corradi Fiumara (1995), “the sort of logic that underlies our culture does not seem to allow for the more authentic openness that may sustain a revealing dialogue” (p. 33).

This *wpmbe* embraced a unique philosophy of listening and viewing. Corradi Fiumara (1995) discussed how the philosophy of listening sits within a tradition of questioning, how the one and the other are closely linked. In addition, the listening *is* an attitude, which is mirroring how the questions are being asked. This attitude creates an open dialogue. In the *wpmbe* there was a recognisable culture of listening leading to inclusive viewing of the subjective experience. Broom (2007) described this as having ears to hear and eyes to see that promote a whole person viewing; this attitude of listening uncovers that which is invisible and renders it visible.

Student story

In this story from Jack, he talks about the *wpmbe* being an experience of attending to emotional comfort in the physical domain and this allowed the most desperate thing to surface.

Usually people are seen for healthcare in two different dimensions: I think in the WPMBA because we were able to attend to the emotional comfort together with exploring the physical challenges, it was like the thing they were most desperate for came to the surface. If the client is nervous or discomforted, even the physical is hard to deal with and vice versa. I think one supports the other. I felt like dealing with the emotional stress helped them put more faith in the treatment and helps

with a better recovery. They are more driven to come again. There is a willingness because they feel cared for and someone has really listened to their story. That listening part I think is quite missing. I can imagine if I was unwell, if someone actually hasn't asked me what I want and let me have a session from my point of view, I would be upset and I think it would affect my health. (Jack)

Jack describes this *wpmbe* as not two separate dimensions anymore, rather one dimension allowing the other. I think Jack is talking about a multidimensional kind of listening. He feels that providing emotional comfort *together with exploring physical challenges* has the effect of the whaiora being able to look at what is most desperate for them. It let the most desperate thing come to the surface. The starting point becomes theirs not yours. Neither the physical nor the emotional are prioritised or privileged in the *wpmbe* over each other. Prioritising the listening means the whaiora feel cared for and this way of being with both dimensions and allowing them to surface means that the whaiora will have a better health outcome. Jack feels this himself to be true. He feels the whaiora will have more faith in the treatment (process) and become more engaged when the emotional elements are considered together with the physical dimension. By looking at the person in this way, it gave permission for the *thing they were most desperate for came to the surface*.

Broom (2007) described how moving away from a diagnostic disease-oriented attitude means that an unexpected pattern can emerge. Broom (2007), encourages mindbody practitioners to allow this emergent meaning and being space through an attitude and spirit that suspends judgement, relying less on diagnostic labels and taking an explorative phenomenological approach.

This spirit of meaning and being is apparent in the stories of the *wpmbe*. This spirit means the phenomena can surface and emerge together with the disease experience. Both the whaiora and the students describe an experience of something difficult

surfacing. To allow space for the phenomena to surface in this encounter one needs to hold a phenomenological attitude and suspend judgement.

The struggle being at the forefront

Student story

This story, from Sarah, describes the *wpmbe* as a unique and powerful way of looking at experience together. Here, the struggle finds its place at the forefront of the encounter.

In my 'normal' therapeutic encounter, it was very much a problem-based way of learning you would say what can I help you with/what seems to be the problem? You would start off with the problem and work towards goals based on that problem... but in this wpmbe yes, people had problems, they had things that had triggered them to come in the first place but that was not what was in the forefront of what we focused on. It was more about increasing well-being and working through things in a positive way. There was lot of sharing experiences and also looking together at what other people's experiences had been.

That sharing of experiences was healing and quite powerful too, that feeling that you are not alone. In contrast being able to be in this whole person environment where you are acknowledging that you're not going to fix them or change the situation... you can be with them. It was like that is still enough. The being with somebody is still enough. This being with them was having the opportunity to just listen, to listen to people's stories and acknowledge those stories. (Sarah)

Sarah describes a different therapeutic encounter where she was looking together at experiences rather than a problem-based encounter. The opportunity to just listen and acknowledge people's stories while also looking at the problems without trying to fix them was still enough. This on its own had an effect. It was okay not to be fixing the situation. The sharing of experiences in itself was healing and powerful. It enabled the whaiora to bring themselves as a whole to the interaction. Looking together at another's experience was at the forefront of the encounter itself. The other problems people came with were in the background. This way of being with others in the *wpmbe* meant the whole story was listened to. Sarah felt that the problems were there together with their stories. Stories were acknowledged along with *you* as a person in relationship being

acknowledged. It was as though you were welcomed as a person first with a real life, your problem or diagnosis came second in relation to that.

Whaiora story

In this story, Jill is telling us that she felt like she could be viewed differently in the *wpmbe*. It was like a meeting in the middle. She experienced being embraced as a person whilst being seen as more than her illness or diagnosis.

I just loved this approach, there was a vibrancy and liveliness to it all. Just to think it was happening for 'new'; HcP was just fantastic. Superb for future outcomes, for the next generation for people who are unwell. Reading the words on the flyer (invitation) I wondered how it could come about, I thought I can't believe this, it sounded so good, so strongly positive. There are people here who are going to embrace the whole person – you were a person at the end of the day. I wondered why more people aren't drawn to this. We were all quite different people. We weren't all stereotyped. It was like there are different ways to know you and to get well. It was extremely kind without ridiculously sounding touchy feely with a level of fun. Structured and I thought it embraced it. We shared our names and we were all remembered.

For them to understand that you are more than your illness, I just love the approach. It was superb. There are different ways to get better not just going to your GP or physio appointments. Combined with this, what was extremely noticeable was that I experienced an understanding that they wanted to understand how we felt as patients. They were wanting to be more encompassing and see me as not a diagnosis that feeling that they wanted to do something different, you know? I felt so lucky and noticed just even some of the questions were extremely enlightening.

*I still often find that sometimes you get a HcP that is purely, medical or drugs or so far a certain way that It's hard to get someone who just comes up the middle and embraces both the purely medical and alternative in a good way while still getting a highly trained HcP. They either do the medical thing or the alternative thing. In this *wpmbe* you are still getting very skilled trained professionals, but you are also*

getting them to see it from another perspective that was great. They seemed to grasp what is needed to help a person who is not well.

I was so pleased it was available because the health system needs to be more than someone just fronting up for a knee replacement. (Jill)

For Jill, the *wpmbe* was such a lively and vibrant experience, she just could not believe it. Finally, she had found a place where every aspect of her as person could be considered along with her illness/diagnosis. It made her very hopeful of the future, for herself and others. Being with these HcP who embraced both her medical story and her other story, she felt she was considered as a person not just a diagnosis. She just felt *so lucky* to have come across this way of encompassing both medical and other perspectives together, embracing both in a good way. It was meeting in the middle. She was more than her diagnosis. It was a feeling of others wanting to understand, wanting to feel how she felt and see her as something more and do things differently, of being remembered for who she was not what she was. It was *whaiora* being considered as different people, as individuals, not stereotyped and HcP were encouraged to take a look from another perspective.

Whaiora story

Jill is talking here about her experience of someone *asking* in the *wpmbe*. This type of ‘asking’ went deeper and could allow experiences to surface. It was not like problem solving.

*Sometimes I come out of an appointment and I think that was a waste of time why did I bother going. Of course, medically there are not always answers. I understand that but in the wider spectrum I feel there are answers: It just no one has ever asked the questions, not just the right question just any questions!! In the *wpmbe* I felt certain things you know that no-one has ever asked me in an entire 28 years.*

To tell you a story. When I was diagnosed almost 30 years ago my younger son was 8 years old. I was backwards and forwards to and from a major hospital and in that time no one ever said, or actually asked how your son is? It's not until now when I talk to him that I know he felt quite distraught seeing me in hospital. No-one actually asked,

including me to a certain extent, to be fair. You know it was a different generation really.

Now I feel it could be different – you might have thought well, God, how are my children? We were both very caring and loving parents, but it might have made us think a little more, not necessarily do something, it would have highlighted it, and made us have a wee think and talk to him a little bit more you know. I absolutely think that this asking it gives you a nice feeling for want of a better description that someone is interested in you ... and your family and how you are. I know they have the best intentions; I haven't experienced anything bad but in all this time I haven't experienced this asking.

Someone asking you, it gets you thinking, it jolts the person. I think that jolting is probably a little bit extreme, but it helps someone immensely, I think there is a lot more to chronic illness than just new drugs to give you. There is more to a patient, you might fix it for the time being, but they never ask you about the other aspects of your life.

Even when you take your dog to the vet, they ask you questions about food etc., but my experience is they never ASK the patient and I think they need to, with chronic illness generally, to take a look at a person's diet, their mental state, the person, and not just think 'we have these new drugs' I think there is a lot more to it than fixing them up. (Jill)

Jill felt this *asking* in the *wpmbe* was something very different. The *wpmbe* even made her think about the whole question and answer thing. This kind of asking, and that it actually happened, was in distinct contrast to her previous experiences in healthcare. She acknowledges that medically there are not always answers. She thought maybe it could be a generational thing, but she also wondered if HcP do not ask the questions because they do not always have the answers, as there often are no answers. Jill excuses them knowing that deep down they do want to do their best, but it feels like they are not able to acknowledge the other aspects of your life that are impacting on your illness.

This asking in the *wpmbe* was not an *asking* that led to an answer. This approach just seemed really healthy, holistic. It was like they could take a look at the real things that were going on. It took some courage to do this asking. The kind of asking was as if somebody is genuinely interested in you, your family, and how you are. Jill thinks it would even jolt her own thinking about what is going on. It would be an immense help

when you are struggling with a chronic illness to be able to put all these bits together as opposed to just one thing. Broom (2007) talked about this style of questioning which allows emergence of story: “The usual medical style of questioning does not engender emergence of story or life-worlds rich data and the assumptions of the clinician may even lead the clinician to suppress such data if it did emerge” (p. 100).

In these stories, about giving permission to the struggle, both the whaiora and the students are talking about the struggle finding a place. They talk of something else being at the forefront. They talk of a different kind of asking. Broom (2007) stated that this unique whole person style of questioning is in contrast to the usual medical style. It leaves assumptions at the door; the search for data no longer suppresses the rich life world story.

The call to the vulnerable edge

Student story

In this story, from Gabriel, she describes how the *wpmbe* takes you to the edge where you might choose to go deeper in relationship. It is a call to vulnerability. A call to relationship.

I feel so grateful that I had the opportunity to experience this. I believe it's everything, I believe that it should be the way everything should be. But I am also aware that could be just a belief but without that it's just empty.

It was like giving over of themselves and being open and vulnerable with another person. If you, as a HcP, are not willing to ever be vulnerable then you'll still do your job, your patients might get a little bit better, they might tick the boxes, but will they flourish? I don't know, I would argue not. It's like you are a mother and you just make the lunch, you turn up for the netball games, you chat to Jane or whatever but you are not actually there.

It's like that. You tick the boxes but if you don't give over some of that intangible part of being a mother which is essential, well its love, how can your child grow and flourish. It's that; it's like touching on love but it's not love, but we are giving the vulnerability. Even so it's quite deep, it's quite deep seated, if you allow yourself to be vulnerable with your clients. You might go above and beyond. You will also want to hold your

own boundaries too. It's a line, a fine line. Like any relationship you have with someone, if someone isn't a little bit vulnerable or show themselves in some truthful vulnerable way you might never get to a deeper level relationship with them. (Gabriel)

Gabriel describes a call to a deeper relationship. It was an experience where you had to be willing to give something over of yourself, and it required you to be vulnerable. She explains this using the story of a mother just going through the motions and what it would feel like if you were the child and this was your mother; it would feel empty if you were merely ticking the boxes. She feels this is similar to what some whaiora have already experienced in the healthcare system. She likens it to having a belief without which it is emptiness itself. She describes how you could manage to do okay practising as a healthcare professional in a 'tick box' way but that something *deep seated* would be missing. Something deep seated that makes the difference between existing and flourishing. She describes this giving of vulnerability towards the client from herself as showing yourself in a truthful way that could lead to a deeper relationship. It is what is needed in any relationship in order to go to a deeper level. Gabriel feels it is a fine line to walk where you need to hold your own boundaries. However, therein lies the call *to go beyond* if you can manage it. Gabriel also links being vulnerable to being truthful. This may be a reflection of her pre-reflective stance or be referring to her own understanding that one's own personal human capacity to give and receive love requires a trusting exposure of self in relationship.

Whaiora stories

In this first story from Brian, he also describes being able to be vulnerable in the *wpmbe*, because there is the right degree of protection. A surrounding protection that he uses a metaphor to describe as in the coming and the going, the meeting and the greeting meaning he could grow and recover.

It was because of them, because of who they were I shared personal things about my predicament, and I was able to cry, they were part of that. I don't normally tell people, but they enabled me to say things I wouldn't normally say about my background and how it was different. That was a sign they had the ability to listen, to hear what I was saying.

I was crying but I wasn't crying out for help I was just telling them about myself, my story.

When you have had a life changing experience like I have after a stroke or heart attack for instance and you have a disability you feel very vulnerable. People either laugh at you or they do the opposite and over protect you What you really want in your recovery state is for them to let you fall down and get up again like a child does when he is growing, you want to be allowed to get down in the mud and get wet, get dirty shoes, to go out in the cold, throw snow balls, but it is hard for those around to allow you. It's part of the growth process 'being allowed to'.

What I found with these students was an experience of being protected. It was kind of like part of their relating to me and it wasn't talking. We had this signature farewell which we shared, I was really conscious of it, like they were there, they would greet me and farewell me, without even asking. This felt protecting, like they were reaching out. It was part of the relationship. By getting to know each other like we did, your origins and your history it established a relationship. Unbeknown to them they enabled me to shed some of the onionskins to get down deeper, to shed the skins and express deeper things. Like the fear and loneliness you feel.

And the deeper you go in these relationships may mean you divulge your spirituality. (Brian)

This story of a protected safe space is similar to Gabriel's story. Brian talks about being able to go deeper in relationship; he talks about the *wpmbe* allowing you to grow in a protected relationship. In particular he refers to an experience of vulnerability when you have suffered a life-changing event and notices that the way you are held and protected allows you to go deeper. This safe relational holding allowed him to divulge his deepest existential meaning. It was an experience of *going deeper and shedding some onionskins*.

In this second story from Brian, he describes the feeling of vulnerability as one that is experienced by *both* students and whaiora together.

I think it is hard working out what is appropriate in these healthcare relationships – the students were so very professional but seemed somehow able to touch the vulnerable space. There is no desire to break the professional model but there were times when I really wanted to

give them a hug. And I thought no, that would not be appropriate. It was as if they were very professional and learning to get themselves in these vulnerable situations – I am thinking this could be a skill for them to be able to get themselves into these situations, maybe it comes with maturity?

In so many healthcare situations they are usually so busy, they haven't got time, they just ask about your ailment and hand you your pills. I think there is a need for the client and the HcP to interact on a personal level.

Here in the wpmbe it is about the person. What I experienced with these students was how it is and how it should be and I do not think it should change. I think it should be factored in. There is a fine line isn't there?
(Brian)

Brian is sharing an experience of getting close; he felt a shared vulnerability and an empathic emotional response. In this *wpmbe* he could touch and feel this vulnerable space as though it was really present. An essential element to the *wpmbe*. He was aware of his own vulnerability and he could feel a tension of not wanting to breach the line. He was made acutely aware of the professionalism of the students and he was puzzled about whether they were learning to do this or already had the natural maturity for it. He strongly feels this is the way healthcare should be. It should be about the person, but he acknowledges that it would be hard to manage this vulnerability, *to walk this fine line*.

Orange (2011) talked about contemporary psychotherapy having more emphasis on personal agency and active participation of each person, balancing an awareness of receptivity and suffering with another inherent in the process of understanding. I see here, in these stories, a strong call to vulnerability, experienced by both *whaiora* and student. The meaning of the call is expressed well here in this quote in calling for therapists to be participants in our therapeutic relationships.

Not only are we required to witness and to participate emotionally in the suffering of our patients, but in addition, the process of understanding itself means we place ourselves at risk and allow the other to make an impact on us, to teach us, to challenge our preconceptions and habitual ways of being, to change us for their sake, even to disappoint and reject us. Often this requires clinicians to leave aside their own sense of agency

and competence for the sake of the other – working in the dark and experiencing our vulnerability. (Orange, 2011, p. 23)

The struggle to be with the horrible side of life

Whaiora story

In this story, Florence describes the tension to be with the struggle itself. The horrible actual experience is not dismissed. Being with the struggle in this way led to an opportunity and freedom.

For me this wpmbe experience was like an openness and a willingness to hearing what had to be said, without judgement from HcP. It was like being able to say that yes we did have these experiences and yes they were horrible in a room full of people listening without being told that's not how you behave or you simply can't have had that experience. It was affirming for these horrible experiences to be heard.

To tell a story, one of my friends recently became sick while we were on a cruise with a group of family and friends. She kept declining and worsened to the point where they were going to medi vac her out. There was a group of highly experienced health practitioners all expert in their respective fields who huddled together to come up with a plan. From where I was standing it seemed like they were just using their clinical assessment tools to watch her, like this was all they had. By deciding as a group that she was slipping into invalidism and that maybe she was actually enjoying the attention that came with this they seemed to miss the one thing that was simple and could make her better. They had dismissed her; this highly intelligent woman who had done nothing like this before in her life because they couldn't work it out. It was like the illness became her fault and that happens so often and it stopped them seeing a solution. Instead of searching for a wider understanding they got stuck somewhere. I think we have all been on the receiving end of this. It was different in the mindbody encounter, the students understood that not knowing the answer didn't mean frustration or anger it was an opportunity to go out, learn, study and look harder for the answers. Not being frustrated by not knowing actually provided an opportunity to go and look for it. (Florence)

For Florence, this wpmbe allowed the horrible stuff to be looked and listened to. She describes a feeling that she was heard and listened to in way that did not dismiss her experience. Her illness experience, which was horrible, was here in all its horribleness

in this *wpmbe* encounter. The horribleness was specifically important. She felt it was affirming of her, she could be heard. Her actual experience was listened to. Here she was not seen as separate to her experience. Nor was she told to behave in a certain way. She was not asked to change her relation to her experience by behaving differently. She was just allowed to have it.

Florence tells her story about a group of HcP looking for a solution when someone is ill in order to explain what it feels like to be dismissed when you are ill. She uses this story to compare what she has experienced herself as a common occurrence in healthcare. She tells about how these professionals get stuck in a place where it seems they cannot see for looking. Because these HcP could not work it out themselves, they then could not see the solution. Once the illness was un-seeable it then became the patient's fault, her friend was dismissed. It led to even the simple solutions being overlooked. Florence is quite sure that the *wpmbe* was very different to this experience. In the *wpmbe* not knowing the answer opened up a space that to Florence so commonly becomes a dead end. An experience of being with a patient and 'not knowing' in the *wpmbe* did not bring with it frustration or even anger. It opened up an opportunity to go out and look.

This opened up opportunity is linked in Florence's mind with not trying to fix things, and allows the experience of being with the horrible stuff. By remaining with your own solution-based process, it seems that it dismisses and negates the others experience. Florence tells how easy it is to get stuck because you are wanting an answer and how this attitude stops you seeing things. Welcoming 'not knowing' into health care relationships brings a certain freedom to explore and means you keep looking, not giving up because you do not know. An attitude of curiosity was at work.

Florence is telling us about what to do in the healthcare relationship when you are faced with a dead end, the uncomfortable place of the struggle. There is struggle; a tension lies in the choice to not dismiss the person in favour of the solution and let the horrible experiences actually be talked about. There are a number of reasons that this could be difficult. Many hurdles are faced here, one of them emotional capacity. Human

capacity is a possible limiting factor which affects the healthcare relationship, preventing it from moving to a deeper level of connection (Broom et al., 2012).

Student story

In this story, Sarah talks about how it feels when you are unable to bring yourself to the healthcare relationship. It was a disembodied experience. Sarah also describes an experience of being dismissed in a similar way to Florence. Unable to bring her whole self. She describes the *wpmbe* as a place where she could bring her whole self.

I think my own experience as patient has informed the way I have become. Even before I started my healthcare training (as a physio). When I was first diagnosed (with my own condition) I was lucky enough to work with some practitioners who you know were more holistic in the way they worked. I remember it was quite a profound experience as it was the first-time people actually saw me for who I was. And that experience made me think I want to work in rehabilitation, and I want to show people there is a different way of working, for me it just feels normal to work in that way. But there are other experiences I have had where the practitioners who were not working with that whole person approach. I felt marginalised by the whole experience, there was a lot of blame that was going on and if I didn't do what they advised it was my own fault if I was getting worse

I think healthcare in many ways tries to divide people's lives into compartments. Or only see a certain part of a person. In actual fact that is not the way they experience themselves. You know it's not just let me look at your ankle and treat your ankle it's like well that ankle is part of me! The way that I experience my ankle injury its part of my person, so to not actually see the person as part of the equation seems odd. Compartmentalising peoples experience by removing things or thinking it's not related to anything else that's part of you. It's kind of like this whole sense of disembodiment.

In real life your experiences are not divided up in to compartments Your story and what you live with and that you tell about yourself it doesn't divide your life in to compartments, you know like there's work

and there's study and there's family life and maybe we do that in our heads but when you experience it it's all just one continuous line.

Maybe the whole person approach is about an embodied experience?
(Sarah)

Sarah describes her own experiences of healthcare. She has had both the experience of not being seen as person and being seen as person; she knows which one she prefers. When practitioners exclude other components of your life and story as not having any associated meaning this creates a feeling Sarah described as disembodiment. This way of delivering healthcare made her feel shamed and blamed for her lack of progress. Seeing one part of your body as disconnected and separate is like a disembodied experience. She felt side-lined and ostracised (marginalised). She thinks HcP way of compartmentalising is not the way people experience their own lives and illnesses or their bodies. The experience of a whole person approach is an embodied approach. In the *wpmbe* Sarah identifies and remembers being seen for who she was, it was a profound experience which she wonders about. Is this what embodies means? Sarah wants to work in this way herself as a healthcare professional.

The struggle –the *real* things that were worrying

Whaiora story

In this story, Keith talks about the experience of the intimate details being known and the transformative effect this had on his recovery.

You did wonder when they started asking you questions, well what's all this about, but then when you settled in a bit and realised they were really interested in their profession and they actually really wanted to know how you felt and what it was like. It was chance to talk about the experience.

I felt that apart from my wife you didn't talk about the horrible messy stuff like when the (colostomy) bag would come off on the middle of the night and you have to get out of bed and clean it all up, you know it's quite personal. I mean you go to the doctor or specialist you might talk about it very quickly and it's on a very, very professional level. You don't get the opportunity to talk to anybody really about that horrible stuff and to talk it through with people. Getting this opportunity meant you can ask different sorts of questions; you can talk about the real things that were worrying. You could talk about the experience. For me

at that time my condition was so constraining I couldn't leave the house for more than 6 hours, as I needed to be near a toilet. And there was no pattern to things.

It changed things for me coming to the wpmbe programme. It was the first time I had been out in public really; you know where other people were. It was about this time that having a colostomy bag just seemed to become normal. It was during the course. I felt that suddenly people did know and understand. It gave me confidence to expand out. (Keith)

What mattered to Keith, and significant to him in the *wpmbe*, was that you get to talk about the actual experience, *the horrible messy stuff*. In the *wpmbe* he was still with HcP in a professional capacity, but this was different. Here they wanted to know how it felt, they were happy and willing to explore the experiences he had had and was still having in an open and explicit way. This had a profound effect on his situation and meant that it *became normal* for him. He was able to go out in public again without constraint. Through the *wpmbe* he became re-integrated in his community and now had confidence to *expand out* and live a fuller life.

I think these stories pose two questions. Firstly, why don't HcP take time to go to the horrible stuff of human experiencing? What lack of capacity prevents this engagement? Secondly, could it be that a person's actual experience does not rank highly in patients or HcP recognition of what it takes for a person to become well?

Exploring understanding in healthcare about re-integration after an illness or operation may enlighten this discussion. Keith felt these HcP wanted to know deeply and were happy to share in something on a very personal level. This more intimate sharing gave added value to the experience itself.

In our predominant physico-materialistic model of health we discount the place of experience in illness. We discount that disease and illness have both physical and a phenomenological aspects or experiential aspect. Broom (2007) stated that we should expect that illness is experienced in the lived-body or in the experiencing of subjectivity and that we should not be surprised by this. The reason that standard healthcare does not

or is not able to take this into consideration could be that the underpinning notion of dualist care is predominantly that illness is only ever a physical experience.

Disease is both a disturbance of the physical and an expression of 'experience'. If we have 'eyes' to see and 'ears' to hear, experience and its associated meanings can be discerned simultaneously in both speech and the physical diseases of patients. (Broom, 2007, p. 157)

When people are able to explore the connection and experiences, they have in a whole person mindbody way, multidimensional aspects of personhood are invited to contribute to the experience. The person feels valued in an entirely different way. Here in the *wpmbe* whaiora are accompanied to make a connection. They became well because they were 'seen' and treated in this way. Broom (2007) talked about this making of a meaning's connection along with the integration of the multidimensional aspects of personhood having a transformative effect.

Putting sunshine in a dark place

Whaiora story

In this story, Florence talks about the effect of shining a light on her struggle and how this helped her make her experience her own.

Being told that I had a yet another serious illness was just one thing too much. I had been struggling to come to terms with it and was still fending it off. I was probably sulking as I do when I get bad news but these lively young people helped me come to terms with it that it wasn't the worst thing that could happen. I think this encounter just sped it all up and made it easier to move on. What they offered were really good ears Being able to talk it through and be listened to and them understanding my struggle seemed to shine a light on it, it just opened it up and helped make my experience (of illness) mine. (Florence)

Florence talks about how the *wpmbe* helped make the *experience mine*. She is talking about how the *wpmbe* helped her integrate herself with her illness. This *wpmbe* shone a light on the struggle itself. She tells how taking a look together in this encounter *just sped it all up* for her. The nature of the listening to the struggle itself meant it could be

understood. Florence was able *to come to terms with a serious illness* in the presence of the struggle.

Student story

In this story, Sally talks about the experience of *hearing the story in yourself* as though it comes as a gift. In *wpmbe*, it became easier to be with the deep experiences of others.

I don't know but I think that acknowledging the stories, it's like you describing your own story to somebody and then having them name what it was you were feeling or what that experience was. That telling can change the way that you frame that experience. I think in telling your story and have someone else listen that can change your own perception. It's almost a way that you hear the story in yourself. The way that you tell your story might be different next time because someone else heard it and you might even feel like it changed something.....It's a vulnerable space for people to be in, you know that sharing, the listening and the sharing things that are difficult and it's a kind of vulnerable place for the practitioner as well, being gifted with that information and it's quite a powerful thing too. Often for me earlier in my clinical experience people would tell me things and I would be like, what gives you the right to tell me that? You know there are some deep things people tell you and it's difficult to know how to deal with those if you are not used to that responsibility.

The wpmbe helped me to kind of be ok with that, like not panic when people share those things still not knowing how to deal with them but it's kind of like ok. There is a whole spectrum of experiences that people go through and not necessarily having to do anything about it, that's ok. Sometimes just the talking about it is enough and being with that gift. (Sarah)

Sarah explains what it is like to hear and tell a story, the telling itself has an effect of changing something. She describes a change in perception. Telling of the story, you can begin to *hear it in yourself*. This experience of dual acknowledgment is as though processing something. It is a vulnerable space for both the storyteller and the listener. For Sarah, earlier being able to be okay in this space was difficult and held a responsibility that she was not used to. The sense of responsibility was great and made it difficult to receive. Now it is much easier to hear the deep and difficult things and

accept being with that as a gift. It became easier to accept you cannot change these things and be in this vulnerable space.

Becoming an integrated self in the *wpmbe*

In this story, Florence describes her *illness as becoming part of her fabric*, she could be a whole yet broken person in this *wpmbe*. This changed her experience of her illness. In the *wpmbe* everything about her was given the same weight and accepted as integral to who she was.

Before I had that experience in the mindbody encounter it was like my illness was something that was latched on, that was heavy and weighing me down, something I would take on and off. It was an alien thing, but now it's as if it's just a part of my fabric. It's (this illness) not an accessory anymore, it just feels part of me now. I didn't have any freedom to express the impulsive part of me but now I do. If my friends ask me now to go to some far flung place in the world now I will just go, I am not putting it off anymore because I shouldn't, I just do it. My life seems much more vivid and it is more my life. I can allow myself to live more intensely. I feel a sense of freedom in a way. Somehow those students saw the whole of me, the mad bits and the sad bits and the wonderful bits and the clever bits and the dumb bits and they all sort of came together. It was like giving everything about me the same weight. So there wasn't one part more, more important or one part more rewarded and another part stomped on or ignored. It was like all of me, here I am, rashes and all. And it was just accepted. (Florence)

Florence describes being seen, as a whole person in the *wpmbe*. This did not just include the good things about herself, it included everything. In the *wpmbe* all the bits of herself were coming together. It had the effect of her being able to live a more vibrant life. She says she can now allow herself to live more intensely. She has regained freedom to live her life, the one she knows. Her illness is no longer an accessory weighing her down. I think this could have been a part of her struggle that despite being able to see all the not-so-good and good things together she had not looked at it together with another. Her illness had had the effect of fragmenting her.

Van Manen (2016) talked about the effect of illness. The pre-reflective nature of the experience of the body – *le passe sous silence* – the passed over in silence body state becomes something to which we are desperate to return, which we are trying to return.

Serious illness changes everything, our sense of time and priorities, our experience of space, our felt relations with others and our sense of self.

Van Manen (2016) also talked about how we experience our bodies when they are ill compared to when we are well and how these two experiences are quite different. When we are well, we do not notice the body. It just performs for us and is an aspect of our world. When we become diseased, it is not only a bodily sensation, it is also a changed physiognomy of the world, which we inhabit. He gives an example of how we do not necessarily notice the symptoms of a disease, such as the flu, but we notice changed aspects of the outside world which became symptomatic of what is wrong (e.g., the sunshine becomes too bright, food loses its taste, the sky becomes depressing, and literally the world becomes sick)! The sense of disease come like an intruder, the body encumbered “we discover the object body when the unity of existence in our world is broken” (van Manen, 2016, p 329).

Van Manen (2016) describes the healthy body thriving on the smoothness of forgetfulness, whilst the experience of the unwell body is disintegrated and unarranged. Florence seems to be describing this disintegration or fragmentation as her experience of illness. She had a longing to return to her previous state, an experience van Manen describes. Being in the *wpmbe* just made this reintegration happen for her, as she said it just sped things up. She became reintegrated and was able to live her life more fully and vibrantly

Student story

In this story, Gabriel talks about becoming integrated as a therapist through experiencing the *wpmbe*.

It was really difficult to sit with in the beginning. It was like my identity as a psychologist started to begin, it was like the budding of my identity. It was a moment of taking ownership of your own process and taking ownership of your own self. I could see other people resisting that a bit and I did too. I guess I am a student, but that was like the next level. It was actually quite good for integrating the theory, the practice and myself. The aspect of being in relation to other HcP was almost like having an observer self. I knew how to be a person in the room quite well, usually I would just run the session regardless, but here I had to give it over to someone else, give them some space too. Having another HcP there when we were with the whaiora helped the observer self and how am I in this relationship? Just having to give over that space and not take control of it. It helped my understanding of me as a psychologist, you know I am supposed to be the mental health expert in that room, but it felt like a really different position. It was a very different position that I hadn't been in before. There were a few different dimensions for instance seeing how other HcP formulate an understanding of a patient, even what they actually call them, that was news to me: it was enlightening and challenging on different levels.

The many different dimensions seemed to help me integrate myself, there was the observer self, there was me in relation to other health care students, me in relation to the teachers, there was a kind of role modelling and then all the reflections, it was like supervision before supervision. It was hearing about how other people talk about what is going on and how my perspective might be different, that helped guide us a bit and I think in some ways it bonded us because we could be quite open out there. (Gabriel)

Gabriel describes her experience as a process by which she took ownership of her own self. It was a place where she integrated theory and practice. She was forced to sit back and let others have some space and it felt like a really different position. Being in relation to others also participating on many different levels played into this. Being able

to be open and hear ‘the talk’ about how others were perceiving the situation (in the group discussion) helped with guiding the process and created a bond.

This was a process of integrating self through relationships and relating with others in a spirit of openness. The *wpmbe* had the effect of both participants seeing a perspective that helped them to see themselves for who they were. It was a shared experience.

Summary

All of these experiences share aspects of the whole experience of being with the struggle. They reflect component parts of the struggle finding a place in the healthcare encounter. From these stories, it seems that this experience of a struggle is inherently common to the experience of illness or ill health. This *wpmbe* way of being with the struggle is not about finding the answers or solving a problem. Looking at the struggle itself takes courage and fortitude. It also takes a deliberate intention. Being with the struggle is about going to the experience itself in all its horribleness. It is an experience of experiencing the experience of the struggle itself. It requires you to feel safe and encompasses a shared vulnerability. It allows the truth to be heard. To be with it one requires an invitation. There is tension, a not knowing, an uncertainty. This path is not easy to walk with an unknown destination. Being with the struggle assisted a reintegration, locating oneself again. It is about re-connecting and recovering identity. Hearing about and listening to the struggle requires good ears, a particular type of listening. It counts on goodwill. It requires a certain attitude or stance from each participant. A kind of space where people can make an honest disclosure. A place where *whaiora* feel secure and not judged. It is an emergent organic creative space that leads to opportunity.

Orange (2011) discussed how the hermeneutics of trust, an intersubjective clinical sensibility, can be intricately woven in the interface between client and clinician in healthcare relationship. This is a place where a holistic experiential world of persons collide as they search for understanding from the premise that this is shared hard work. Known as intersubjective systems theory. She talked of having the ability as a clinician to learn from our patients, as their suffering makes an impact on us as clinicians. I think this sensibility is alive and well in the *wpmbe*. A lived experience of travelling together

on a shared dialogic pathway through the struggle to get the other side. A learning through shared suffering.

Reflection

In all of these stories, the struggle is slowly appearing and being uncovered. It is an enigmatic appearing but, in this case, it was beheld. Each person's experience of being with their struggle was entirely unique and entirely their own experience. They all, in slightly different ways, express that the *wpmbe* was a place where the struggle was allowed to be looked at, it was allowed to be there as a part of the encounter itself. It was a commonly expressed shared experience. The *wpmbe* was, for some, the first time they had been in a healthcare situation where they could bring everything to the table, the good bits, the bad bits and the sad bits, the dumb bits and the wonderful bits. All of these experiences of personhood intermingled with their own distinctive story of illness or disease could now be looked at and spoken about in the open. What was once hidden in a dark cave was brought to the surface. The *wpmbe* was described as an opportunity for emergence of the truth, the deeply and sometimes darkly felt authentic real human experience of the slurry of life. The *whaiora* felt seen and heard. This seeing and hearing had a profound effect on them each coming to terms with the challenges they faced. They spoke of experiencing a returning to themselves. For them this meant being able to live a vivid normal life again, with freedom and vitality.

CHAPTER FIVE

The Experience of Being Known

*The passageway of illness also brought me into life-giving contact
With the presence of others,
In which my being was acknowledged, respected and stirred.
I began to learn how I embody the truth of who I am.
This learning is the first step in integration and healing.*

(Murphy, 2013, p. 56)

Introduction

Being known through everything, being acknowledged, and respected as a person with an illness in the presence of others is the theme of this chapter. Welcomed to this depth of being known within the framework of this protected relationship, these participants experienced a place of meeting where their deepest truths can now be shared. A place of an intimate field of relational knowing in WPC is described by Murphy (2013) where acknowledging our wholeness as persons with each other creates a space where the ‘I and thou’ became a ‘we and we’ of the intersubjective space.

The meaning of a person’s illness must be truly discovered through a genuine dialogue of what is happening. We need space to hear and hold the many voices of the dialogue (the patients fear, the doctors modelling, the symptoms phenomenology, the illness ‘onset, shape and development; the patients actual words to us, their story, their energy in the session, our story, our energy, life-context, fear and modelling) and the surge of what happens when we meet. Illness at the very least, reveals our vulnerability, and this is always tender ground for our meetings. (Murphy, 2013, p. 56)

The *wpmbe*, a tender ground for meeting, uncovered many voices through a genuine dialogue. It allowed a space to meet, hear and hold one another in relationship. Here, in the *wpmbe*, illness is explored in a multidimensional context of personhood. Each story within this chapter captures a diverse aspect of this ever-deepening encounter. *Wpmbe*

allows a profound distinctive experience of being known not prevalent in previous healthcare encounters. An invitation in to a realm of knowing not familiar in the past.

Whaiora and students told stories about experiencing their own lived experience of illness with one another. The sharing of this lived experience was within a relationship. In and through the company of another they told stories about becoming authentically known. It became an encounter where hidden things could come to light. Not unlike Heidegger's meditations on the question of being where he talks of a space as the clearing:

In the midst of beings as a whole an open space occurs. There is a clearing, a lighting... only this clearing grants and guarantees to us humans a passage to those beings that we ourselves are not, and access to the being that we ourselves are. (Heidegger & Stambaugh, 1996, p. 53)

Something began appearing that was previously hidden or even forbidden. Something was coming to light that was not previously able to be revealed. This something, seemed to have been lost in previous relations in healthcare settings, is now present. In this meeting, where one could be known, there now appeared a space and a place for deepening revelation. Something considered integral to healthcare was now re-integrated in this (*wpmbe*) encounter.

The clearing provides a passage for the 'being' that 'we ourselves are' and the same time, to the beings that 'we ourselves are not'. The same passage through which we discover ourselves, we discover who and where we are not as well... this insight is pivotal to becoming whole as a person, and to (being able) emphasis added, to work in a way that deeply acknowledges both our connectedness and separateness on many levels of our being, mind, body and spirit. (Murphy, 2013, p. 45)

Murphy (2013) put the idea of the clearing into human relating. The clearing provides a passageway where we can rediscover ourselves, providing pivotal insight on the journey to become whole. *Wpmbe* is a place of human connection, where each person comes to experience their 'being' on many levels. Connectedness, along with the mirror of separateness in human relating, forming the nurturing ground for growth. The to and fro of the dialogic relationship in the *wpmbe* creates a place where deep acknowledgment reveals deeply held truths. Each person beholding the other. Broom (2018) described

this coming to being known as a calling forth between one and another. A depth of encounter into a realm of experience not commonly sought in healthcare.

Being known – as being recognised

This first story reflects Jill's experience in the *wpmbe* quite simply as acknowledgment. What she asks for is for things to be recognised as true, a simple recognition, a receipt of something. A simple yet powerful act. When lacking, it contributed to her feeling unrecognised and dismissed.

Jill goes on to talk about a contrasting experience of being known and cared for in the *wpmbe* describing an all-encompassing experience of warmth, care, and love. This was an understanding of being unwell she had not encountered in healthcare much before despite understanding that that was the intention. In the *wpmbe* she encounters all the components she believes are *required to make a person well*. The acknowledgement was encompassing. It was the inclusion of other elements of a person that was even extended to including families. This was different. She experienced being listened to. She was understood *as more than her illness*.

In the wpmbe I think you did build a little bit of a bond with them, because you saw the same person week by week. And you know they got their chance to ask you whatever they like and to talk to you about whatever they like.

It was so good they actually wanted to do this mindbody thing. I felt they could feel who the person was and their being unwell. It's quite a different way of doing it.

They seemed to grasp what is needed to help a person who is not well. They were doing mindbody (with your guidance) they were doing care and love, families and most things that need acknowledgement. They were quite exceptional at understanding people.

For me It was being listened to, which I suppose is part of caring. I felt a very strong sense of there are more ways to keep people well than

purely by taking your medication OR an operation, OR “come and see me next week”.

It was superb even the students felt it too. I got a strong sense of caring and warmth. It was a different level of healthcare.

I suppose because I haven't experienced it terribly much in the past, don't get me wrong, I have obviously met some very kind people. I think everyone sets out you know to put their best foot forward with good intentions to help and to heal absolutely. But I think there is a lot more to getting better. (Jill)

Jill's story of other healthcare encounters:

When you go to the GP you are always conscious of taking up their time – if you go on too long you get a little bit of a shuffle along and you also feel guilty you are taking up someone else's time too – even when they are helpful it's still not quite like this experience (wpmbe).

I had an experience last year when I was becoming quite unwell again coming back from London. I was probably feeling not quite as happy being back, not walking etc., I had poor blood results and more inflammation. I thought this has got to stop I have got to get well and healthy again, so I went on a good diet etc. Well I mentioned this to my specialist – when I started to get better again, have you seen my bloods, aren't they brilliant? He disagreed and said it was the exercise I was doing, and I said no it's the change in my diet as well and he, nothing, he didn't say, wow what have you done or yeah that's interesting. ...No, not even a nod he just didn't acknowledge me, there was just kind of nothing.

Admittedly maybe it's a bit of time, I don't know or maybe he's geared to his going in a certain direction. But if he had done the wpmbe he may have thought other things do have a part to play with how people get well.

If I could say how to do this I would say be very open to all sorts of treatments, its more than just the person you are seeing, the person

there, there is more to them than the sore knee, sore leg or sore mind.
(Jill)

Jill describes her specialist not taking any interest in the other efforts she has made to get well. It was as if he was one eyed and had no other focus other than his own. There was not even a nod, she just felt kind of nothing. She was not acknowledged as a person in her own illness story. She felt she was seen as just a sore knee. This doctor was geared to go in a different direction, maybe it was time. Jill just did not know. She muses time may be the factor. Maybe Jill uses this as an excuse as this lack of acknowledgement deeply affected her. She felt dismissed. She even felt guilty for taking up their time. She thought if this specialist could do the *wpmbe* training, he might see things differently. He might acknowledge that other things have a part to play in a healthcare encounter.

Despite Jill meeting some very kind people in healthcare, with good intentions to help and to heal, Jill had not experienced the particular caring she had felt in the *wpmbe*. This caring for her was encompassing what helps to make people well. It seemed to make Jill feel she was more than her illness. She felt that by being treated just as a sore knee, was overlooking her as person who contributes to her own wellness. This *wpmbe* allowed a freedom and space to go in a different direction; one inclusion of other components of the experience of illness. In this case it begins with acknowledgement.

Jill describes being listened to, it was more than just take your medication and come and see me next week. This listening had components of its own. There was freedom to talk about whatever you like or ask whatever you liked; it was an unscripted encounter. There was something different here. These HcS were quite exceptional at understanding who the person was. They had a grasp on how to help a person who is unwell. Jill could sense the caring and warmth, and it was felt together in relationship.

It is a natural human capacity, to love and to care, especially for those who are suffering. It is engrained in the call to be a healthcare worker. For Jill this had been strangely absent in previous encounters. She was longing for a place where she could be acknowledged as a person rather than a body part coming to be fixed. Here, in the *wpmbe*, her whole story could be considered alongside everything else. Much is written about health carers called and motivated by this call to alleviate suffering. It is a common reason they enter the profession, but somewhere this is getting lost (Epstein,

2017; Mayes, 2017). Jill believes they genuinely want to care but it has gone missing. She feels that being able to feel this care and love assists in the healing journey. This acknowledgement was very important to Jill in her 'illness versus wellness' journey. Acknowledgement, a recognition of the other, is the beginning of coming to be known, a receipt of 'knowing' passed between people in an unscripted way.

Being known - as a person with a life

In this next story Jack, an HcS in the *wpmbe*, also speaks about the caring being lost as he grapples with his own personal experience of illness. He explains by telling a personal story from his own experience as a patient when he was not acknowledged as a whole person with a life. He felt helpless; it was a very mechanical experience. Along with Jill, he felt the symptom was dealt with but not the person. He also had the belief that if treated this way it severely affects your health outcomes. Caring and intention brings connection and here in a healthcare setting that matters to Jack. He started to question what the intentions were of the HcP:

I think I can explain this from my own experience of having a serious long-standing illness when I was young. Every time I went to the practitioner, they always did the same thing, it got really boring. Somehow, I felt helpless. If you are not, actually, getting well or your condition is not improving, and you just keep on doing the same thing every single week you just feel like you are doing a mechanical thing. You start questioning whether the practitioner actually cares if you are getting well or not. It's not like someone had actually asked me about my personal life or how it's affecting anything other than my physical body. It's as if they only deal with the symptom and not the person.

*I recall every time just going back and doing exercises and just blow in a tube and they would do a test and that's about it and then they would kick me out the door. But if someone had actually talked to me and asked me how do you feel when you have this difficulty, how do you go to school, how do you behave, how do you feel even? I think that is caring other than the body, this long period of time going into the same session with the same practitioner the caring got lost, you don't have that feeling any more. This *wpmbe* way you still feel that connection*

that the practitioner is seeing you as a person not the routine job where they have to tick the box.

Caring/what is that caring? Well I think curiosity is the first thing: it's like the practitioner is willing to know more about me, other than my symptom. Secondly, they want to know more about my ordinary life (with this symptom). They may even notice and remember something – we might chat about my friends or my family and if they actually remember and ask me later on, that would be quite a warm feeling because I would feel like I am a person in their mind not just a case number. When you feel like a person, like the practitioner knows you as person you feel more connection and you will be more open to talk about your issues and that can really help improve the intervention.
(Jack)

This is a very personal experience from Jack from his own healthcare experience. Jack can speak from two perspectives, that of a receiver and a deliverer of healthcare. He had this experience as a child of over an extended period of time. It had made a lasting impression on him. At this time, he had started to feel that no one cared any more. On reflection, he noticed there had been a strong focus on the physical body and its symptoms and the routine mechanical tests. Jack talks about this other life he was having that no-one had ever asked about. There was no connection between his real day-to-day difficulties and this medical intervention. To him, it felt like the caring had become lost. No one had seemed to care if he got better or not. Being treated only as a body and never being asked how you were going or what the other parts of your life were like with this condition did not have a caring feeling attached to it.

Jack uses this experience to explore what he has now encountered in this *wpmbe*. In contrast, in the *wpmbe* there was a willingness to be known and a curiosity about *the other life* (Broom, 1997). This created a relationship with a connection and the caring feeling that goes with this. In the *wpmbe*, you were known as a person not as a routine job. Feeling you are a person and not just a number through *being known as person with a life* meant Jack was able to bring what he considers matters to the encounter; you

could be more open to your issues. Jack is convinced that this improves outcomes in healthcare.

Being known – as experiencing people

Here, Sarah (a student) talks about coming to know each other as people. She is feeling a connection with the other life in the *wpmbe*, the life Jack was unable to talk about as a child at his healthcare appointments. Sarah describes it as a shared experiencing of just life. Simple and beautiful. It was an extended knowing into one's life story:

The whaiora came and it was like you got to know them as people. They shared their experience with you, and they were interested in what you were doing as a student. And you could share your experience with them and that wasn't confined to your clinical experience it was kind of like just life, which was quite beautiful. (Sarah)

Sarah expresses the ease of being this way with her whaiora in this story. It was a way of being with another in healthcare relationship where you could each share your personhood. This sharing of these other aspects of your life which are not usually considered relevant to the clinical healthcare encounter aspects means that the person is not divided into what is clinically relevant and what is not. This reductionism in healthcare leads to not feeling whole. Sharing and allowing aspects of each other's stories means you come to know each other as people.

Being known – was being accompanied

Here Jack (student) talks about the everyday being together as integral to being known as people:

I think to some degree the whaiora when they came didn't really know that this was going to be about relationship. It kind of came a reality about the third encounter. The whaiora probably had no idea when they enrolled. By just being together (one to one session) as a first thing and secondly sharing morning teas together played a significant role in the programme. Students were helping their whaiora get coffee and food and remembering how they like it. Usually most practitioners won't have time to do this. This daily life thing might make you feel warmer in the heart. For the whaiora it's like they get a daily life element inside the other treatment. As a practitioner normally that relationship only lasts in the room, with a beginning and an end. You wouldn't get that feeling outside. But if you have this daily life element inside that

treatment then when you are at home making coffee you may actually remember that moment that your practitioner made you the coffee. If you actually do this, it's like another kind of care outside the therapeutic world. (Jack)

Jack notices a daily life element. He has not experienced this daily life element as being or playing a significant part of the healthcare experience before. In this case, in the *wpmbe* he notices that it does. Here it was inside the treatment. This focus on the simple daily life elements of just being together and sharing morning tea meant the whaiora felt a warm 'different' human kind of connection. This connection extended beyond the room, beyond the beginning and the end of the therapeutic encounter. The whaiora felt accompanied outside the room into their real lives. The *wpmbe* connected them to their daily life experiences. Through this connection they felt deeply attended to as a person with a life. It allowed meaning to emerge. Again, this was an extended knowing into one's life story as expressed by Sarah.

The experience of being cared for here, in the *wpmbe*, is not only felt in the present moment of this therapeutic encounter; it extended over time beyond the therapeutic space. Being known extends beyond the therapeutic engagement into what has been termed *enduring connectedness*. A relating extending beyond the therapy room. It facilitates a strong feeling of safety; becoming a place where existential thought and realities are visited. This work in relational depth creates an enduring experience of connectedness that can facilitate profound change (Mearns & Cooper, 2018).

Being known – was being listened to and remembered

In this story Florence (whaiora) describes her experience of being listened to and remembered. This *wpmbe* was made to look simple but held complicated layers underneath. Florence remembers how the connection, continuity and progression of the experience from week to week helped to see where the bits all fitted in:

Our conversations were remembered and brought back to the table the next week which was really interesting. You could see where the bits fitted in. It was actually really engaging. It wasn't like a HcP looking at you for 20 minutes and taking notes, it was more obvious that they listened and remembered. It was made to look very simple on the outside but you could tell it was complicated underneath. It was like a beautiful sheath dress which controls the bulges underneath by complex

under layers. Very chic on the outside and complicated underneath.
(Florence)

Florence is trying to grasp the essence of her experience by using a metaphor. One expects that she may have been familiar with this metaphor. It may be part of her own world of experiences. She describes what it felt like to be listened to and remembered. She noticed the conversations were linked week by week. Her description of the creation of the beautiful dress created by complex layering underneath makes one curious about what goes in to creating something what becomes for others beautiful to behold, very chic. The creative concept, the fabric, the intricacies of design, the craftsmanship, the time taken with each component all chosen carefully and known for their inherent qualities coming together and becoming a thing of beauty. This creation of something complex with many 'hidden layers' could be akin to the layers of conversation recalled and remembered each week. This story conjures up an experience of the creation of something that has taken time, trouble, effort, and creative licence. Something that needed a sustaining vision. Because of the fabric of conversation Florence felt listened to. She beheld something creative, dynamic, and beautiful. Human complexity and liveliness in relationship. Persons were honoured as their inherent complicated beauty was revealed and experienced. Florence's experience evokes the nature and beauty of complexity in human relationship along with deep trusting that comes from deep acknowledgement.

The simplicity of the *wpmbe* was apparent. Listening and remembering was obvious, it was not like the usual note taking. This listening was something in itself, as though it had its own place. The story could be heard in its simplicity. Beautiful despite complex under layers. This listening was again described (by a whaiora) as a contrast to previous healthcare settings. It was a multi-layered experience. Maybe the *wpmbe* was the creation of something complex and beautiful to fit (make sense of) the individual person's bumps and lumps in one's life experience. The multi-layered dress a metaphor for a container that holds the complexity together as it controls the bulges. Being remembered week by week was also a container where you could take a look and see where the bits fitted in.

Florence is having an experience of being with others who deeply listen because they hold a differing openness or attitude. No longer ruled by reductionism, they are able to take a whole person view. For listening to be so apparent and in contrast to her other

experiences, it must have had a distinctive character. Florence noticed that it was privileged over other more usual activities such as note taking. It seemed to be integral to what mattered in the encounter itself. Being listened to in her complexity had the effect of her being known.

Orange (2011) encourages clinicians to avoid reductionism by actually embracing complexity as a holistic practice. This attitude differs from the current dualistic model with its linear view of cause, effect and its working towards a uniform solution and the reduction of the person (to a disease or condition). This type of holistic practice fits in with a willingness to explore deeper and wider connections.

Being known was being protected in relationship

In this story Brian (whaiora) describes going deeper in relationship whilst being protected enough. In the past he had felt overprotected at times but here in the *wpmbe* there was just enough protection to allow the experience of vulnerability without restriction. Being allowed to grow with the right amount of protection helped him to find a passageway way to knowing and experiencing himself:

When you have had a life changing experience like I have after a stroke or heart attack for instance and you have a disability you feel very vulnerable. People either laugh at you or they do the opposite and over protect you What you really want in your recovery state is for them to let you fall down and get up again like a child does when he is growing, you want to be allowed to get down in the mud and get wet, get dirty shoes, to go out in the cold, throw snow balls, but it is hard for those around to allow you. It's part of the growth process being allowed to.

What I found with these students is that there was an experience of being protected, it was kind of like part of their relating to me and it wasn't talking. We had this signature farewell which we shared, I was really conscious of it, like they were there, they would greet me and farewell me, without even asking. This felt protecting, like they were reaching out. It was part of the relationship. By getting to know each other like we did, your origins and your history it established a relationship. Unbeknown to them they enabled me to shed some of the skins to get down deeper, similar to the experience of this research

interview itself. To get down to shed the skins and express deeper things. Like the fear and loneliness, you feel.

And the deeper you go in these relationships may mean you divulge your spirituality. (Brian)

Brain talks here about being enabled through this ‘knowing’ relationship to uncover the layers as if they were an onion skin, peeling back to the struggle and pain of loss itself. Whilst this was happening, Brian expressed a sense of being protected or held in a relational way but not too tightly as you would a child as you allowed them to grow up. This safe relational holding is talked about extensively in psychoanalytic literature. Through the experience of a relationship, it allows a return to vital living. This is not often explicitly acknowledged as a component in other therapies which largely emphasise physical improvement as here in this case, as recovery from a stroke. The nature of this relational holding in a healthcare encounter is not commonly explored in the predominant physio materialist area of rehabilitation (Bright et al., 2012; Stolorow et al., 2002).

In every way, humans are connected and even more so in this experience of loss as described by Brian, and Orange (2011). These human experiences are our essence. Brian expresses a previous lack of linking with others whilst he is able to fall down and get up again. I wonder if he felt separated from his life concern or human essence. Here, in this *wpmbe*, he felt he could now do this physical bit in relationship as one does parent to child. The parent allowing, safely protecting, standing by while the snowballs are being thrown. This therapeutic relationship has added a new layer to the rehabilitation experience. Now Brian can get down, get dirty, and feel things for himself.

This therapeutic encounter happens in a space where things are safe but free enough to access *enough* vulnerability to be creative. A safe relational space for difficult things to emerge. Shaken up and shaken out enough to be looked at. A therapeutic window was

opened up through this encounter, which allowed growth, a safe place for truth to be experienced in both bodily and mind dimensions (Briere & Scott, 2013).

Being known – as a shared vulnerability

Brian shares another story of apparent awareness in the encounter. He noticed that the students were able to be present with the whole range of ability as a person to relate as well as with their health practitioner knowledge. This was not just a knowledge-based encounter. Brian began to feel known in a deeply protective way. These students with the x-factor *were aware, really in tune* with what was going on and *where this person was*. This approach was not concern, but more like a genuine empathy, healing, and therapeutic. Now, in this relationship, he is able to bring very deep and personal things, because each was open in this mutual engagement. He states he was not alone in his vulnerability, as the students felt it too. It was a shared encounter in which Brian was enabled to experience his own and others' vulnerability, even to the point of sensing his own needs. The encounter providing a reflective mirror to view oneself.

The approach was not concern; it was more like genuine empathy. So I wanted to talk about just about anything. It is hard to name but I experienced not the whole range of (physiotherapy) health practitioner knowledge but the whole range of her (this students) ability as a person to relate.

They had the X factor, the ability to empathise with me as a "stroke survivor". They were open, I guess I responded to that and it made me feel open as well (to discussion). I found myself being very vulnerable because I could tell them what I felt. It felt like the vulnerability was also there (a more experience) for them. They were really in tune with what was going on. I could sense my needs through their awareness. It was healing and therapeutic. They were aware where this person was, and they were very protective.

I think I was grieving; I was trying to find the new me and they were part of that, me finding the new me. (Brian)

In this encounter, Brian has been able to tell his story, his real story which he had not been able to tell anybody before. This feeling of support and genuine empathy was powerful and therapeutic. He felt known and the students here were present as real people in their own vulnerability. The *wpmbe* became a meeting place of *shared*

vulnerability. Together, as persons, they could feel the pain of loss that Brian had experienced. There was mutual engagement with an empathic other. By listening to himself and his own story, hearing himself through the other in a therapeutic relationship, he could now rediscover himself and become re-integrated as a person after his stroke. Through being accompanied in this way Brian was able to move towards *finding the new me*. There was transformation through listening to oneself through the other.

Experiencing therapeutic engagement in this shared alive intersubjective space of the *wpmbe* invites whole person viewing and allows story and meaning to be approached.

In contemporary post-Freudian psychoanalysis, psychotherapeutic world there has been a distinct move away from interpreted translated unconscious mental conflicts (Orange, 2011). There is now a move towards trying to understand suffering in a lived intersubjective space rather than trying to explain or translate the unconscious mind or mental conflicts. There is a turn towards working dialogically in a relational space (Mearns & Cooper, 2018; Tudor & Worrall, 2006). There is now more a method which is a common or shared project of intuitive understanding and experiencing, no longer a search for certainty and what is right. The way of viewing the therapeutic relationship is changing and considered in some avenues to be integral to all therapy itself where there is a growing understanding of its importance in the care of the suffering other (Tudor & Worrall, 2006). Mindbody clinicians or whole person clinicians are encouraged to foster a relational clinical space, where the clinician is also fully present for the patient, drawing on their own feelings and embodied awareness whilst being present to patient's needs; aware as in Brian's experience it allows him to share his subjective story.

Being known – as being enabled to authentically speak the truth

This next story takes us to a very sacred place. To a place of ultimate trust in relationship where we are able to speak the truth. For Sally (whaiora), this was really frightening as she had had her hopes for this dashed many times before. She found she had started to protect herself from self-exposure. She had become uncomfortable (with her own truth) in the presence of others. She had noticed that others were too. Being

able to bring her true self had become scary and difficult. She was treading very carefully, but this time she had the courage to step in with both feet.

I had to reassure myself that everything was going to be ok before I came because it was a pretty scary proposition for me. I was attracted to the idea because I had issues with being called a patient before and the notion of whaiora, someone seeking wellness appealed to me. It made me feel I could be on a level playing field. But even so it was very scary because I had had high hopes before about these types of programmes and the disappointment I felt was huge and I almost felt cheated when the programmes turned out to be very different in practice to my idea of it. So I was being careful. I think maybe I was hurt and worried about being vulnerable again. I kept asking is it safe to be bring all of me. I decided to just put my both feet in and I would just have to trust it would all work out. The first time was the worst but every time was scary. I had memories so often of being misunderstood or taken the wrong way or the words taken only at face value and people not seeing the caring heart behind it. Like when I go to the doctors hoping to have a good encounter and then not being able to tell the truth of how I am really feeling... Making out I am coping when I am not. It gets to the point where people aren't comfortable with your story and I wasn't comfortable with people and that was part of my fear too.

There was a lot of feeling in that room, and I felt really touched. It was so much more than expected. I don't think it's an easy thing to do. Being able to speak the truth when people are trying to and encouraged to understand has had an effect which is still ongoing.

Now I feel I am able to be more authentic, like the two sides of me have come together. It was a new experience for all of us, we were sharing the same journey together, whatever the journey was. I can clearly remember how I felt and I don't feel that fear anymore. (Sally)

Sally was reassuring herself when coming to the *wpmbe*. It was scary every time. Constantly reliving her fears of her many past healthcare experiences, she had become reluctant and protective and almost ashamed of her own vulnerability. Here, in the *wpmbe*, she was hopeful it would be different. This time the environment became safe. Here she was able to speak the truth about her experiences. She was heard, seen, and listened to. Here her *deep caring heart* was protected. This took away her fear of being

misunderstood. Sally was enabled to tell the truth about her painful experiences because she was known and understood.

In this *wpmbe* it was a shared new journey for both parties. Each side were on a level playing field in this relational arrangement. Reaching out for authentic engagement was encouraged and considered integral to this healthcare relationship. The deeply felt real struggle could be present. The real deep ‘horrible’ feelings that Sally wanted to share on the steps of her journey could be in the room. This was profound for Sally. This time the relationship did not break her trust and hope that this could be different. Sally could tell her story. Others not being comfortable with her story had affected her deeply in the past and this had made her uncomfortable and wary.

Feeling uncomfortable is part of the tension in a healthcare relationship. Each person arrives uniquely bringing with them their prejudice and own experience; it is important to identify why there is an unwillingness to explore the uncomfortable. It is very complex and unexplored territory in most domains of therapeutic encounter. It can come about because of professional boundaries are held too tightly or even too loosely. In Sally’s case, she had to learn to trust again in order to tell the real truth. A healthcare relationship requires safe holding in relationship to do this.

Wpmbe now became a place of meaning, trust, and truth. *Wpmbe* was a place where Sally could be authentically herself. It became a place where the two sides of herself came together. “We count on the goodwill of both participants in the dialogues as we search for meaning and truth. Furthermore, we expect meaning to be both transparent and hidden; both there to be discovered from the dialogic process” (Orange, 2011, p. 34).

Orange (2011) talks *about a way of being* authentically with others in dialogue whilst being aware of the hidden whilst remaining transparent. In the experience, Sally is conscious of this hidden truth and apprehensive about whether she could safely bring it. It required goodwill for this search for truth together. Sally had an experience of being able to speak the truth, to be known for who she was.

The hermeneutic attitude supposes only that we self-consciously designate our opinions and prejudice and qualify them as such. And so doing strip them of their extreme character. In keeping with this attitude, we grant the text (the other) the opportunity to appear as an

authentically different being and to manifest its own truth over and against our own preconceived notions. (Orange, 2011, p. 16)

This quote brings to attention what could possibly be a barrier to authentic accompaniment in healthcare encounters. Prejudice is one and it remains strong, along with power imbalance. I think that Sally feels the opinions of those caring for her have mattered more than hers in the past. Barriers in relationship to authentically engage with one another exist. Here, in a healthcare encounter, where by its very nature vulnerability is pronounced, the previously unspoken or unspeakable dilemma is not revealed if the relationship is not deemed safe enough and the discomfort (from not being able to authentic) grows. “The clearing is one path to wholeness. We reach the truth of what is, and what is emerging together, by turning to the experiential openness of the moment” (Murphy, 2013, p. 44).

These HcS were encouraged to develop a hermeneutic attitude in this encounter. What was surprising was that taking a more ontological stance and privileging it ‘over’ an epistemological knowing was so powerful yet simple.

Being known – as personal surrender

Brian (whaiora) shows the further deepening of the experience of being known:

Being with them made me feel at ease. I am quite used to working with students and young people as I have worked with them over my whole life so the rapport was easy. They made that rapport easier by who they were. But here there was something different. Their being there was not a knowledge based one. I sensed it was based more on the personal. I discussed things with them things I wouldn't discuss with my friends. I felt as if someone was listening to me. It had a spiritual side and an emotional side and it made the whole process (of rehabilitation) relevant. They told me about themselves and who they were and we established a relationship. It wasn't therapy as such but once that relationship was established I trusted them. That complete trust in who they were was so deep I would have let them take my heart out if they wanted, like a cat I was happy to lie back and let them do anything they wanted because of what I felt. It was the quality of their being and it wasn't a knowledge based one. It wasn't about their knowledge it was

about them as people. I sensed that that made the difference. It was a personal encounter and now I feel like another person too. (Brian)

Brian describes how deep the trust in this *wpmbe* became. The encounter was deepened by each person revealing something about themselves. It was who they were as people. It was much more than the easy rapport Brian had experienced in the past. This was different, it was not a knowledge-based experience. It was the establishment of relationship. It was a deep encounter person to person. The intensity/depth of this relationship was so trusting that Brian would *let them take his heart out* if they wanted. What this shows to me is that despite their inexperience these healthcare students had the ability to connect deeply as human beings. This connection really matters to Brian and changed the way he feels about himself; because of this encounter, he feels he is now a person too. What is shown here, is that human connection brought about from sharing who they were can have a strong impact. In Brian's case it situated the whole process of rehabilitation and made it relevant.

Summary

The experience of being fully known in this encounter (*wpmbe*) encompasses a warm, vivid authentic experience of being seen and known in one's entirety. Through acknowledgement it has become a valid place of safety to explore multidimensional personhood. The person/s separated from their wholeness (selves) due to disease, illness, and their experience in healthcare to date, has found a place where a re-connection to personhood (knowing oneself) has taken place. The way the illness experience had been managed in previous encounters had further separated them from themselves. The experience of fragmentation and compartmentalisation in (healthcare) had created even more distance from life as they had known it and added to their suffering. Here, in the *wpmbe*, they found a place of re-connection. The person with a life has become visibly and tangibly present. Being welcomed and invited to an encounter to be known as 'whole persons' was an integrated experience of giving and receiving in the *wpmbe*. The *wpmbe* was an experience of being able to bring everything to the table. It is one where the authentic self is welcomed and supported to have expression. The *wpmbe* is geared to go in a different direction where seeing everything that matters to a person and their life is vital and necessary in their illness and wellness journey. It is as though life itself is fully realised within the encounter. Life is present

and it becomes vital again. In the *wpmbe*, being fully known was itself the therapeutic encounter. No longer was it I know of you or I know about you, but now *I know you*.

Being ‘known’ in the *wpmbe* appears quite simple and uncomplicated, easily grasped and recognisable, whilst at the same time complex and multi-dimensional. Being known has depth, power, and even beauty. It has an impact on the therapy and healing trajectory. The whaiora and the HcS have, in the past, had their identity as persons constricted in their socially and culturally constructed roles in the milieu of the healthcare encounter. Their behaviour toward one another has, in the past, been scripted. They had some unfortunate experiences. For some whaiora, their personhood felt unravelled and further disconnected, disjointed, spread out, and exposed. Feeling *looked at rather than seen*. These experiences brought a sense of disconnection from their life and their story. Being looked at rather than acknowledged as a person with a family, a home and a life story that matters was a common experience in previous healthcare encounters. Not beheld as a person but an objectified unembodied body. Stripped of their capacity to be able to bring themselves to previous health care encounters, they had felt unheard and even at times dismissed. Subjectivity and story had not been invited as part of their previous healthcare encounter.

In this *wpmbe* they were on a journey without a known destination. The destination was not pre-determined or prescribed as in other healthcare encounters. There was not a foregone conclusion. Circumstances had altered. Here, in this *wpmbe*, they were experiencing a dialogic framework in a meeting one with another. Other therapies had just scraped the surface but here they were entering relational depth (Mearns & Cooper, 2018). They were becoming known to each other in relationship. It has direct parallels to Buber’s notion of dialogues and the I-thou attitude rather than the I-it of the

objectified relational stance. This being known in relationship comes with an enduring sense of interconnection. It enhances therapeutic effect.

Reflection – Poem

I conclude this chapter with a poem, honouring this experience of being deeply known for whaiora and students. This leads in to Chapter Six—the emergent landscape—exploring how one becomes deeply known in the path of the struggle.

The Invitation

Prepare the path we take together.
 The road less travelled
 The suffering stranger & the Good Samaritan
 A path hidden in the undergrowth
 Softly cradled in the green moss
 Beckoning my pain
 Exposing my truth
 In this safe protected place
 Where I lie back and you take out my heart
 I am remembered
 A place to bring all of me and all of you
 Re awakening my soul, my whole and my identity
 Holding each other broken and fragile
 Together we hold the boundaries
 Contain me
 Please
 Not too tight so I can move to find the freedom that is me
 Vividly intensely to become me again in your presence.

Janette Tolich

CHAPTER SIX

Arrival

To hold a space

*I am asking you to hold a space of grace for me
 In trusting that I find a place of grace for myself
 Instead of asking you to provide it for me
 I am asking you to hold this space for me with the gentleness and reverence you would
 cradle a newborn
 With the gentleness and reverence you might lightly gaze upon a loved one
 With the lightness of feeling
 Like a fleeting memory
 Not a prayer with fervency
 Rather a silent invocation
 I am asking you to hold this space for me
 For that is what I see in you
 Until I find it for myself and even then hold sacred that space for me
 As I hold sacred the trust with you
 (Karen O’Leary, whaiora, 2017)*

Introduction - Framing the emergent landscape of the *wpmbe*

This chapter is a collection of the multiple views and perspectives of the landscape framed by the whole person mindbody encounter. It is about how the framing of a landscape in this *wpmbe* allows this experience. It is a landscape with a multidimensional nature just as the persons who inhabit it. Again, this chapter draws on the stories of the whaiora and students as they each capture the essence of their lived experience of the *wpmbe*. They tell how the experience occurred, identifying a scaffold that was in place which supported this encounter. They talk of the creation of a space which allows an empathic connection. The experience of this connection embodies a discovery of and a re-integration of self. Through the combining of the essences, parts and intricacies of each individual experience light is thrown on the whole experience. The *wpmbe* is described as a place and a space where the whole person is acknowledged, heard, and their life co-witnessed.

This (landscape) space is described as a marketplace, a place of exchange, a healthcare encounter where the participants are on a level playing field with one another. It is also

one of deep compassion. A place of simple yet complex human connection. Both whaiora and students have walked a fine line of vulnerability to reach this landscape.

This landscape is organic and emergent in its essence. It encompasses a dynamically occurring reality of interpersonal relationship. It is a place where subjectivity and objectivity are equally valued where they come together and are co-emergent. It is a place of meeting.

Epstein (2017) talked about the challenges in creating a landscape where compassion can flourish, for him it is to do with our inner landscape. Compassion is reliant on our environments, including the systems we work in.

For compassion to emerge we have to create the right conditions. These conditions have to do with our inner landscape – our own emotional life, and self-awareness- and the outer environment, the institutions in which we work. Compassion is cultivated, not a product to be manufactured... and it doesn't easily submit to checklists and industrial models of healthcare. The challenge is to create the conditions in which compassion is most likely to arise. (Epstein, 2017, p. 129)

The marketplace a reciprocal arrangement

In this story, Florence (whaiora) talks about the *wpmbe* as being like a marketplace. An experience of a good exchange, a reciprocal arrangement. The ebb and flow of this shared contributing was powerful and empowering.

I think In terms of working with these students, it was like there was an ebb and a flow. There seemed great strength in them interviewing me in depth like that together, bouncing ideas off one another and coming back again the next week. From my perspective I was able to contribute as well as them to the knowledge we were all gaining together. I was giving as well as receiving which is always powerful. It was more like a reciprocal arrangement.

Reciprocal arrangements like this when you give as well as receive, I think are always powerful. It impressed me. In the exchange we were learning off each other. Each bringing a different kind of wisdom. That made it a good exchange, as if we were in a marketplace. The experience of being in a marketplace exchanging something with each other was different than just being on the receiving end which makes you feel powerless. (Florence)

In this exchange in the marketplace, both sides were giving and receiving from week to week, each bringing a different kind of wisdom. In previous exchanges, Florence had felt powerless; in contrast, being reciprocal made the current experience powerful for Florence.

Being in the marketplace of the *wpmbe* was a reciprocal arrangement. Being able to contribute changed the nature of this relationship. An exchange like this where the nature of the relating is altered, had an effect of empowerment. Florence wonders about the *interviewing me in depth like that* and the coming *back again week by week* also giving the process strength. It mattered to Florence that other exchanges where you are on the receiving end had made her powerless in contrast to this exchange.

Florence's account of being in a marketplace describes an intersubjective space. It was an in encounter between, a reciprocity. In this reciprocal arrangement each person is bringing something to the marketplace in this case their own wisdom and each is equally valued. Here in this marketplace there was a space for this to happen. The ebb and the flow like receptivity allowing a transaction to happen in this in-between space of subjectivity. Both parties were sharing and contributing. It is no longer one person or one directional, it is more like I and thou as described by Buber (Buber & Smith, 2006).

Mearns and Cooper (2018) discuss mutual intersubjectivity in the context of qualities that allow working at relational depth. A wholly genuine open and engaged manner of two people coming together leads to an experience of realness. "There is something about being there absolutely just as a person, where the therapist is not play acting a role but is simply being himself/herself... that it becomes a genuine human encounter" (Mearns & Cooper, 2018). This turn away from detached therapeutic arrangements toward a meeting in therapy is now more considered as therapeutic in itself even in the psychotherapeutic and psychological realm.

Herein access is given through the depth of trust where one can make one's needs known. Mearns and Cooper (2018) talk of a naturalness and spontaneity that brings about genuine human encounter. A willingness to take risks, *to be yourself* in the intersubjective space makes the encounter *real and genuine*. The deepest and often unspoken fears can be brought to light. The *wpmbe* is an experience that does not pay lip service to the relational power of human engagement. It honours it as vital. All

healthcare encounters are between persons despite what health circumstances bring about its happening. One is in relation to self and in relation to others.

Willingness and curiosity – contributing in relationship

In this story Jack talks about a shared contribution similar to Florence. There is a willingness and a curiosity to show the self, one to the other.

In this wpmbe there was a real willingness and curiosity to hear what others wanted to express. I got the feeling that nearly all of us had this kind of willingness to explore, willingness to actually notice what our whaiora wanted to express. I don't know if it was the calibre of the students or the time but generally it's hard to find this in healthcare. I think the relationship is built on contribution. So if I was client and I give you a piece of information. I would actually expect you to give me some of your information as well, not in the same quantity maybe but at least you give me something back. When a practitioner for instance ask your pain score they don't take in to account your emotional expression and I think something is lost here in the communication. This sense you can get from the emotional expression helps to get more information which could really help. If I share my emotional response with my whaiora, I think they are more willing to share theirs. This is a relationship where you are both giving something back. This willingness to notice a showing of the self builds the relationship and it meant the whaiora can express themselves too. (Jack)

Jack describes the nature of this relationship in the *wpmbe* as one where each person makes a contribution. Jack notices a real willingness to explore, and a curiosity to hear what others wanted to express. Attending to emotional expression inside the engagement means the whaiora could do this. The relationship was built on this contribution. Sharing an emotional response creating a willingness to share. It was a way of showing yourself one to another.

Jack's experience in the healthcare system was that when asked the pain scale it was only on one level; the practitioner did not provide a space to perceive an additional expression. Something *had been lost here* in the communication.

Contribution became a platform for sharing at a deeper level of emotional response. This relating in the *wpmbe* had two participants. The emotional response of the practitioner also playing its part. This response to the other and a willingness to receive and listen means that the whaiora are able to show themselves. It is a vulnerable

position for both, the whaiora will not show themselves if they do not want to be seen. Feeling safe in the relationship because of the showing of self allows more showing and a deeper connection.

No longer a spectator

This ability to fully participate and contribute was Sally's experience also. Sally talks about an *enriching experience* where she had a sense of agency. She describes it as feeling cradled. Being allowed to participate here in the *wpmbe* (as a member of the team) and not be dissected or analysed she felt like a human being, not a patient.

One week I was really thrown and feeling quite sensitive which is not so unusual for me but despite this I felt cradled And I think for that to have been the case, a lot of time went into just really focussing on what was important and what was allowed you know I kept saying, am I allowed to? And there was that feeling of being allowed.

Having time to check in with these students and then come back and reflect made me feel like a human being, not a patient. It was like being a member of a team not the focus that was being dissected and analysed and being talked at and made to wait and secondary to my diagnosis. Hearing others' stories was useful as well and made me feel included and through this I got a sense of where I fit with that. I felt a sense of agency about being able to say is it ok to focus on this or that and that was a different dynamic for me based on my history of health professionals. It made me feel as if all of me was allowed to be in the room. That was so precious. Allowing all of me made it an enriching experience. It was different being able to fully participate rather than sit back like an audience. (Sally)

Sally describes a feeling of being included because she was able to participate. Being permitted to participate in this way was a different dynamic compared to her other experiences of health professionals. For Sally, finding a focus together, rather than being the focus (and secondary to her diagnosis), allowed *all of her to be in the room*. In past experiences of healthcare she had felt dissected and analysed. She was not supported specifically to find a focus together. Here in the *wpmbe* Sally felt included. She gained a sense of herself and remarked that *she found a place where she could fit in*. She felt a sense of agency within the interaction. No longer a spectator and not just

the audience, here in the *wpmbe* she was an actor inside the play, she had a voice and it could be heard. This dynamic of the *wpmbe* allowed Sally to fully participate.

Sally, in the past, had an experience of duality or split between her subject body and her object body. In *wpmbe* she is now having a contrasting experience, allowed to be there in her entire self. The gaze of the health professional and her gaze are combined as shared horizon. Shared horizons are described by Gadamer (Orange, 2010). Through this experience of a shared horizon she could gaze at her own fear and her trauma experiences along with others. Previously she was only 'seen' by the gnostic eye and hand and not the pathic gaze. These experiences of being one or the other are well described in health and philosophical literature. The previous experiences Sally had with health professionals, where she was talked at rather than considered part of the encounter, contrasted strongly with this different dynamic. No longer in the audience she was now a participant. This allowed all of her to be there in the room (Broom et al., 2012; Merleau-Ponty, 2002; van Manen, 2016).

Co-witnessing a lived experience

Sally (whaiora) goes on to describe the *wpmbe* as an intangible experience where the intention was to co-witness each other's lived experience and make it meaningful. Intangible magic was in the room, this experience had a deeper, existential component.

It feels like more than inclusiveness. It was in the inconsequential things, that there was so much more. There has always been that feeling I want to help the students but in a way it wasn't my place. But here we were very much on a level playing field. I mean I'm the person with lived experience of cerebral palsy. The students were, their lived experience of learning about and applying what they were learning in the classroom from books or whatever, but for them it was able, to be, to co-witness a lived experience and make it more meaningful. I didn't expect it to touch them as much as it did. And I didn't expect the class to touch me as much as it did. It, touched me and impacted me in ways that I, am still feeling. And I really feel that it's because the intent of the class was so much bigger than all the mechanics of it.

It's that intangibleness and if you like the magic in the room. I mean I remember my excitement at thinking well goodness if we've been able to do this with a group of students, from these different disciplines, just imagine what it would be like if a little bit of that can go over to the medical profession and my excitement to think that it would be possible

to change the mechanistic to something that was more embracing of intangibles. That's my hope. I don't know how it might be possible, but it was exciting, it was wonderful, and it was amazing to be a part of. You know it was like the birth of something that um, was very, very special. I mean, looking at the description of what we covered each week, that was, important but it was incidental to the connections that people made and the relationships that were formed. ... Just being there for that person was enough. It's not about whether you were able to grab this or grab that it's just by being there with them that's so much more important than what you do. (Sally)

Sally talks about both her and the students being touched by the experience, as if they were experiencing it together; not learning about each other's experience but co-witnessing and in that way the experiences themselves became meaningful. Sally thought it was the intention that was very different than her previous encounters; here, everyone began on a level playing field. It had shifted from a mechanistic, nuts and bolts thing to being able to be with intangible elements where the intent of the class was much bigger than all the mechanics of it. She became excited and hopeful that healthcare could be altered and become something else.

The intention here was to co-witness and make something meaningful together. The connections and the relationships that were formed by being able to be there were enough, being there for that person was much more important than what you do. The inconsequential elements provided the way to feel the magic. It was a week by week forming of relationships where one could find meaning together and embrace intangibles.

The essence of the *wpmbe* – the creation of space

In this story, Sarah (student) experiences the *wpmbe* as the creation of a space, a space created from a letting go of the fixed agenda. Her story captures this letting go. In the *wpmbe* you are free to interpret the dance. She describes the *wpmbe* allowing a sense of opportunity to connect and find meaning, allowing what matters.

The best way to express this is to tell it through stories. I am a little bit of a perfectionist and certainly try too hard sometimes. I like to prepare a lot but there was something here that showed me a different way. I could still practice, and it could still be fulfilling and worthwhile and get good outcomes for patients. It was a powerful learning experience

teaching me to rely on perhaps my intuition rather than planning things so much.

To tell it through a story, I have friend who is a national competitor in roller skating in NZ when she was coming up to a major competition her coach would say to her to just try 50%, just go along for the ride. And if you only try 50% you are not going to get anxious about it and if you do this you can kind of put your energy in to the things that really matter like the way you know you might musically interpret the dance. I guess in clinical practice it's the same you know ... if you are trying 100% before you even get in to the clinical situation you are probably going to be a little bit anxious and then anxiety is going to affect the way you interact. It's probably not going to go as well, whereas if you kind of let go a bit and think I don't know how this is going to pan out, the patient could come in with anything. Then you know that provides some opportunity to kind of connect with the patient and you know do things that they find meaningful on the day. There is a sense of opportunity. Not being so fully prepared doesn't necessarily make you a worse practitioner. It's a different set of skills. (Sarah)

Sarah describes how letting go a bit of the pre-planned thing (and a perfectionist tendency) was a powerful learning experience for her in the *wpmbe*. It provided a connection which also allowed meaningful discovery. It was like learning a new skill where you have to rely on something else. Sarah thinks this is possibly intuition. This kind of letting go of one's own plans created an opportunity to do things that the patient finds meaningful and also provides an opportunity to connect, with the patient. If you take with you your own anxieties, this can actually get in the way and affect the interaction. Being able to do this letting go thing is actually a different set of skills and Sarah thinks it does not necessarily make you a worse practitioner. The *wpmbe* created a space for the interpretation of the dance.

An organic space

In this story from Gabriel (a student), about the essence of the *wpmbe*, she is experiencing what she calls an organic intangible space. She describes it as an organic, dynamic moment by moment creative vibrancy with an ebb and a flow. A living gradual arrival where *the person comes into the room*.

At the beginning a few of us found it very difficult to sit with because we didn't quite know. It was very open and organic and kind of had a semi-structure. There was no black and white structured guidelines.

Being organic it meant that things happened in the moment, that they may go one way but they also go the other. Organic means it's not dictated organic means that it's creative, that's its vibrant it can have its kind of ebbs and flows.

You know I am still struggling with that black and white rigidity I literally have four folders of worksheets that I need near me at all times. That's the structure, that's the tangible, that's the just in case back up. And then, well, there's this, the sitting with myself, sitting with the person, how powerful that actually is. I guess it's about stepping out of my head and the asking what technique I should use now. Getting out of my head and just being with the person in the room, how easy it is to get lost in the technique, in the worksheets, I am still struggling with it.

But what is so nice is I have seen the other side too.....the other side? Well it was kind of like in this space it's going to be different from anything else you know, and that's ok, like that was the purpose of it. I don't know if I will get that space again or that experience again because workplaces can be so rigid, so I am quite grateful. I think letting go creates the space. The letting go was ourselves being present, listening, reflecting on ourselves and being honest. Building relationships with other people, that was like the essence of it, the person who comes into the room, it's not just their diagnosis, the whole person approach is essentially everything that they are, not just one diagnosis or one dimension. (Gabriel)

Gabriel describes the *wpmbe* as a letting go of what is tangible. This letting go is something she struggles with as an emerging clinician and she thinks she still will. Letting go and sitting with the person and also herself, she noticed was powerful. To be with a person in this way meant she had to get out of her head. She was so grateful to have had this experience. For her it was like seeing the other side. It created a unique space that built relationship. The essence of this approach was building relationships with people as everything they are not just a diagnosis. Its purpose was to create a space that was no longer unidimensional.

For Gabriel, there are different ways be with a person in the room when you allow everything they are to be there. To do this, you have to let go of something, in order to sit with the other. Being with the person meant she had to be with herself too. I think the space that was created made way for the building and acknowledgement of the therapeutic intersubjective experience – a place where both persons could be present

Gabriel attests to this approach allowing people to bring their whole selves, as a multidimensional unitary reality. It became an ontological being with (Driver et al., 2013). Orange (2011) discussed this understanding of the suffering other occurring in a deliberately authentic shared dialogic space. Two whole experiencing persons step into the therapeutic space and their arrival brings an understanding not possible if we stand apart and unknown.

Our understanding is formed through the dance of conversation, a dialogue of human connection.

Our human form of life has an “I and thou” character and also a “we and we” character. In our practical affairs we depend on our ability to arrive at an understanding. And reaching an understanding happens in a conversation, in a dialogue. (Gadamer, Dutt, & Palmer, 2001, p. 79)

Gabriel is still trying to explain this feeling of grappling with the tensions that this organic space creates:

This big vacuous unknown kind of space doesn't really have a bad meaning you just don't really know where you are going to tread next or how to manage it. This feeling of what do we say in that context and then not in that context was pretty constant, and then what ethically am I allowed, it didn't really go away. So when our whaiora asked us to go for a coffee, this kind of says we will have to have a think about that. As a HcP ethics wise it doesn't even go there. I guess there was a tension of what my rules are and what this expanse looks like without the rules.

The meaning of the space, we were all of us grappling with that. We were all of us trying to name what it was and trying to have something tangible, but space isn't tangible, you can't have that, it's not what it is. God damn it. The meaning that I took from it was that integrating myself and being flexible and knowing myself is really important in the work that I do and that rigidity doesn't necessarily lend itself to building therapeutic rapport. (Gabriel)

This grappling with the intangible space was not only for herself but for everyone in the *wpmbe*. The space had a feeling of treading in to the unknown, *that didn't really go away*. This created tension as the rules and boundaries were not visible or tangible. It was challenging to describe as it had a flexible, moving boundary but did exist as its own entity. At times it seemed there were no rules. This space did not have a bad meaning, despite being something to grapple with. It provided a freedom to be open and

discover equality in this therapeutic relationship. Present and existent in this space one was able to integrate oneself, through this flexibility. There was a realisation that being with uncertainty can lend itself to building therapeutic rapport. This is akin to holding a fallible attitude, as a continuously emerging clinician. No longer choosing certainty, which closes one off but remaining open to possibility.

Orange (2011) described adopting a clinical attitude where holding an awareness of existential finitude alters our clinical posture. Accepting our limited perspectives keeps us humble in a hermeneutic attitude. It creates possibility for an emergent landscape. For the unexpected to make an entrance.

Maintaining this attitude keeps us always in recognition of how limited our perspective is – our own fallibility. It allows freedom to play in the clinical situation, to explore possible meanings without feeling too committed to them. It means we can make mistakes with the patient and to recover with them, to learn from them and make space for the emergence of the patients own sense of things. It is a way of acknowledging we are but small in the universe and the large systems we inhabit. It helps us not take ourselves too seriously! Rather enjoy what gradually becomes possible given the particular circumstances. (Orange, 2011, p. 24)

I think Orange (2011) described well this kind of to and fro in the clinical dialectic. This way of having a natural flow to conversation where you are not fixed to an agenda or taking yourself too seriously creates a mood or sensitivity of being on the same playing field. Orange called this a fallibilistic attitude. It is not commonly encouraged in healthcare relationships where power and knowledge seem to dominate. The *wpmbe* is allowing room to play and space to explore. The space created by the *wpmbe* is organically occurring.

Allowing this emergent space

Sarah (a student) tells a story about this just kind of being with people means you can be responsive. This emergent space allowed you to just see what turned up.

We talked about this a lot that when you are in clinical practice you often go in with a list of things that you need to ask and in your mind thinking what are we going to do, we have to plan, plan, plan, plan but the more we were able to just kind of be with people it was just like oh well you know we'll just see what turns up, you know.... That's really valuable, because then you can be responsive to what your patient brings up. You have a sense of flexibility, and you can ask what is actually going on for them? Rather than something you have prepared and are invested in and therefore should do. We were able to just kind of be with people each week and just see what turned up, you know.
(Sarah)

Sarah describes the experience of letting things emerge when you are in the encounter itself. Seeing a patient without a fixed agenda can change the outcome. She believes practising in this way is really valuable as it allows you to be more responsive to what emerges in that space, in that moment that you are together. By being this way Sarah had the experience of the *wpmbe* allowing an opportunity to get to what really matters. It takes you to the heart of the matter, where you can *ask what's actually going on for them*. She expresses that essentially this is the very reason you are with the whaiora. Alternatively, remaining invested in your own agenda stifles emergence and diminishes opportunity.

These stories about the creation of a space link together for Sarah and Gabriel. They both speak of letting go in order to be fully present with the person in the room, listening and reflecting on their own reasons for being there, bringing open responsiveness to the encounter. Being present, responsive, and flexible created an emergent space.

Paying attention to the whole person

Jack (a student) describes another dimension in the *wpmbe* where you are paying attention to a multidimensional person. Again, noticing and being curious brings the whole person into your focus. Jack describes finding a deeper connection within the

biographical and clinical story. It has the effect of seeing the person as not split mind or body and holding the connection between.

Paying attention to their condition as whole now that was something different I haven't experienced. Being in your own profession, where you just focus on your own profession in training. I haven't actually had that kind of image of a persona as a whole. Previously my impression was professions work with the body or the oral health. It was kind of like slicing or cutting a person in pieces and only focussing on the pieces. I think this whole body focus has more balance. I really notice this very deeply after the people came. When I really pay attention to this, I notice a lot of other interconnection that actually helps my own profession. In psychotherapy we might deal with trauma, developmental issues, and mental things. But how about the relationship between my client and his body, we don't actually pay attention to it. We don't explore the relationship between poor health and other health. I feel that if I was a client that is as a big part of me but you didn't notice.

Maybe there are three components to this not noticing and not wanting to explore, One component would be the boundary, I should actually step in, I shouldn't cross the border, the second thing might be lack of knowledge; it could be very complicated and I would have no idea what they are talking about, for instance when our whaiora was talking about their condition its almost alien to me and I am trying to grab a sense of why someone cant for instance go up the stairs. Even if I was alone with the client when they told me I still wouldn't understand. Thirdly, I think maybe there is avoidance, because if I focus on this 'thing' it will slow my own progress in the session.

So now what I do when trying to take a whole person approach I don't focus on the physical symptom itself but on how will I address it exactly. I try to notice the symptom and let my client know that I notice and I hold that pain or hold that struggle and focus on the connection between the mental and the physical. I use that connection to explore the mental side. Instead of completely pushing it away and never bringing it up again. You just talk about it. (Jack)

Jack describes how he is now taking a different approach. What was once alien or over the border to include seems now quite natural. Jack could now grab a sense of what this means to the whaiora. It came to Jack's attention that he had previously been slicing people up. He can see now that as a person this would feel awful as if you were not

noticed. Now he can see a mindbody connection. Now he has a way of managing both the physical and the mental together, in fact he can connect one with and even through the other. He notices the connection and no longer dismisses it. The symptoms do not get in the way anymore. Jack describes three possible barriers to whole person practice. Firstly, being limited by knowing and wanting to keep your boundaries. Secondly, not being comfortable with the feeling that you lack knowledge. Thirdly, you may have a feeling that if you attend to this other thing that comes up, you cannot attend to your 'real' job at hand and it will make it slow everything down. He describes making space for the other thing to come up, not pushing it away anymore. The *other thing* is talked about it and given some meaning as a part of the whole.

Jill (whaiaora) also describes an experience of being embraced as a whole person in the *wpmbe*. She had a deep yearning to be understood as more than her illness.

I just loved this approach, there was a vibrancy and liveliness to it all. Just to think it was happening for 'new'; HcP was just fantastic. Superb for future outcomes, for the next generation for people who are unwell. Reading the words on the flyer (invitation) I wondered how it could come about, I thought I can't believe this, it sounded so good. There are people here who are going to embrace the whole person – you were a person at the end of the day. I wondered why more people aren't drawn to this. We were all quite different people. But we weren't all stereotyped. It was like there are different ways to know you and to get well. It was extremely kind without ridiculously sounding touchy feely with a level of fun. We shared our names and we were all remembered.

For them to understand that you are more than your illness, I just love the approach. It was suburb. There are different ways to get better not just going to your GP or physio appointments. Combined with this, what was extremely noticeable was that I experienced an understanding that they wanted to understand how we felt as patients. They were wanting to be more encompassing and see me as not a diagnosis that feeling that they wanted to do something different, you know? I felt so lucky.

*I still often find that sometimes you get a HcP that is purely , medical or drugs or so far a certain way that It's hard to get someone who just comes up the middle and embraces both the purely medical and alternative in a good way while still getting a highly trained HcP. They either do the medical thing or the alternative thing. In this *wpmbe* you are still getting very skilled trained professionals, but you are also*

getting them the HcS to see it from another perspective. They seemed to grasp what is needed to help a person who is not well.

I was so pleased it was available because the health system needs to be more than someone just fronting up for a knee replacement. (Jill)

Jill felt so lucky to have come across this way of encompassing both medical and other perspectives together, embracing both in a good way, in a way that was not separated. It was a meeting in the middle. It was a feeling of others wanting to understand, wanting to feel how she felt and see her as something more and do things differently. She was remembered for who she was. Considered as different people, as individuals, not stereotyped. These students, with their already existing skills, were encouraged to take a look from another perspective.

Broom (2012) talked about the nature of whole person experience in healthcare where the subjective story is considered to be a full and meaningful component carrying as much weight as the medical story. It is still commonly dismissed in healthcare encounters as it has no meaning in the physico-materialist notion of medical practice (Broom, 2012). In Jill's story, she had a deep sense that this subjective story is a part of her whole picture.

The environment

Jack (a student) is distressed as he recounts a story of a patient not being cared for as a person despite all the best medical input. He feels the *wpmbe* is a distinct contrast to this experience as it allows and encompasses caring as though it matters and is integral to health.

I had an experience in ED last week that highlighted this to me. I work as a mental health volunteer. In New Zealand we are supposed we have the four wall Māori model of health, but in my experience it doesn't actually have that.

We had someone come and talk to us about that four walled house. In ED. We have a family room. We have chapel and we have the mental support (like me) and of course the physical side, the doctors and nurses. They are speaking about it like everything matters, but what I

saw was a patient lying in front of me in the bed with no pillow, for 6 hours! This seems the most obvious caring, give her a pillow.

I think for the patient they would be nervous, the environment would feel cold, and it would be hard to rest. It would be even harder without a pillow. You wouldn't know how long you are going to be there and the staff are talking about all these brilliant things they are going to do to help you but the basic need of having a pillow hasn't been achieved. The most obvious thing to make them comfortable.

In the wpmbe there were those caring touches (it was like they mattered) actually going out to the door, greeting the whaiora, and sending them away and really chatting with them on the way out, giving them food, helping them get food and coffee. Even that small touch, it builds up and builds up to a certain level where they actually sense the feeling of care. This is lacking in our medical system. Even me as volunteer, I couldn't even find a pillow, it's a really basic thing and they make excuses about sanitising etc., it like an excuse but it just keeps happening.

If it was me I would just feel cold, with all the medical care I don't even have a pillow, literally that cold environment and cold in the people. A person should sleep with a pillow. Without a pillow for 6 hours you are not treating me as a person. (Jack)

Jack describes a heart-breaking feeling; he feels the system is failing his patients. The system subscribes to a belief where all dimensions are attended to but even the basic human caring is lost. He wonders how this must feel for the patients who would feel this 'coldness'. All the best medical care is being offered and WPC is being discussed. All the walls (mind, body, spirit, and whanau) are represented and Te Whare Tapa Wha model of healthcare is talked about, but it is just like lip service, or voices in the distance, if you are uncomfortable and cold. He noticed in the *wpmbe* these caring touches were considered important and a part of the whole package. I think Jack is witnessing how far medical care has become removed from the person.

Broom (2007) talked about this disconnection from the person in clinical practice. I feel that what we believe matters generates our behaviour, and that this over commitment to

the medical part of healthcare separates us from the inherent task of healing and attending to others.

Unfortunately, medicine has come to be based almost entirely on what science can 'see' resulting a dead-matter view of the person. The task of medicine is to bring healing, and healing encompasses far more than the structural aspects of humans. Therefore, it is not legitimate for medicine to fail to see meanings which happens because of its ideologically driven over-commitment to the scientific natural attitude. (Broom, 2007, p. 101)

A changing landscape – environment having meaning

For Sarah (student) it felt good to be in an environment where she could experience the unfolding of being allowed to be the way she had always wanted to be as a healthcare professional and not being swayed from the reasons she came to healthcare:

Looking back, I would say that being a part of the wpmbe programme was one of my best clinical learning experiences. It showed me a different way of considering my role as a HcP. There are certain ways of being this particular HcP (Physio - not identified) and fitting in to that role is quite a stressful thing. I don't think anything in your normal life really prepares you for it. It's just something you have to learn. By being in an environment where you know human qualities, like being nice to people, like listening and being open and just being with people and their struggles it reminded me that that was one of the reasons I wanted to become a HcP (Physio) in the first place. It was nice being in that wpmbe environment that allows that to unfold, it was showing me the way that it could unfold. And still be like within your role as a HcP, although the role was blurred a little bit.

It was the ability to say my role doesn't have to be confined to this narrow way of working that doesn't actually address the real problems. It felt good to be in an environment that allowed me to express the better parts of my clinical practice like you know being with people and expressing empathy. Just being able to have that (empathy) as something that has a place, it isn't just ignored. I guess that was what it was like, really. (Sarah)

In this story, Sarah is saying how comfortable it was to be able to practice this way. It was the way she always wanted to practice, no longer confined to a narrow way which does not address the real problems. This was a way of practising where listening, just

being with people and their struggles and having an empathic connection was integral to the encounter. It was showing *the way that these things could unfold* still within your role.

Reflection

The findings in this chapter link the lived experience of being known and the path of the struggle by looking closely at the level playing field, the marketplace of reciprocal exchange and the nature of the engagement. This chapter frames the landscape where the *wpmbe* meeting essentially occurs. In the *wpmbe*, these participants talk strongly about a different intention which became a compelling part of the framing or scaffold. But it becomes more profound as one uncovers what was exchanged, what was contributed. What was grasped and was now within reach was the interconnection between life story and illness; through this deep whole person acknowledgement, the truth of the struggle emerged.

Through co-witnessing and permitting a whole person engagement the *wpmbe* creates an emergent and organically occurring intersubjective space. The whaiora and these HcS became present to one another. The creation of this seemingly intangible magic space led to the exploring of the experience of illness and pain (the struggle) together and allowed a move towards a discovery of what is meaningful.

By paying attention to all aspects of multidimensional personhood through this time of exploration in the *wpmbe* meant the whaiora felt no longer split by their illness. They were able to arrive through this door to wholeness via a reintegration of self in community with others. No longer split and reduced by a mechanistic experience in healthcare encounter, whaiora were satisfied. Here they were known and had a place to share their deepest struggles, the things they had told no-one before they now experience together in relationship. This had a powerful effect on their healing trajectory.

Reflection – Poem*The Marketplace at Dawn*

A mist hangs over the marketplace
Slowly arriving, the light of dawn brings with it the chatter of voices
Colour, shape, smell and sound boisterously arrive
Alive and reverberating
An exchange of life
Organic and emergent
Curiosity creating this prairie space
The dancefloor opens up
Where
Life makes its arrival
In
The in-between space
Janette Tolich

CHAPTER SEVEN

A Returning to Self (wholeness)

The art of healing at its core is a loving transaction of some sort... and the task of the healer is to have loving intention, to create a space where a person can feel that intention, can feel safe with it, and flourish inside it. None of this is incompatible with the inclusion of biomedical treatments. (Broom, 2015, p. 118)

Introduction

This chapter draws the findings of this hermeneutic phenomenological journey together. It takes the groupings of findings and looks at how each story makes up a part of the unified (whole). Placing the stories together in this way, in relation to one another, forms a holographic image by way of reflection. In other words, it points to something. The aim of discussion in this chapter is to create a coherent and accessible forum that elucidates my path in the drawing of conclusions by further contextualising my findings. It will place the themes in context with what is already known and understood in related literature on this topic and point to what could be relevant for future healthcare encounters. This is the chance to explore more deeply how the findings of the lived experience of the *wpmbe* can enrich our knowing about whole person encounters in the healthcare system. Understanding the dynamic, emergent, and powerful nature of these *wpmbe* encounters, where meaning and inter-subjectivity enter and collide more consciously, forms part of an essential longing to connect the human story of illness and healing in healthcare. It is a chance in our clinical encounters to open up more creative and inclusive possibilities.

I have shared my own pre-reflective journey and the experience of writing the stories and capturing the essence of my participants' experiences of this *wpmbe*. I have presented what I came to see as the themes of meaning (van Manen, 2001) of the phenomenon by the grouping of these stories. This research process of hermeneutic interpretation, recognising, identifying, and grouping the stories, and seeing themes emerge, revealed a pathway of an experiential emergent process of meaning-making which lies in parallel to the core and the emergent phenomena of the *wpmbe* itself.

Attending to discovering the very essence of *wpmbe* has been my intention. By telling such an interpretive story of a lived understanding and considering its resonance with

the experiences written about by others (in literature and healthcare), the essence, which is already there, is available to be uncovered. A hermeneutic phenomenological study's inherent nature is to raise questions and open up further possibilities. Reading between the lines, what is already there and uncovering the many layers of experiencing in such a study surely gives it its unique characteristics. This I hope will identify the particularities of the *wpmbe* making it easily and clearly identifiable and thereby more readily translated into clinical practice.

It may take a shift in worldview to channel this whole person encounter sensibility into everyday healthcare practice, as it is a perceptive change. To complete the discussion, I suggest opportunities for further research that could assist with change. At the very end of this chapter, in my reflections, I will briefly discuss how my own understanding has deepened and been renewed.

Emergent themes of the *wpmbe*

The emergent themes of this *wpmbe* are interwoven already and form parts of each other. Firstly, the theme of experiencing (being with) the struggle in *wpmbe*; secondly, being known and acknowledged as a person through being accompanied in the *wpmbe*, which tells of the importance and role of the accompanied journey; and thirdly, the environment, the emergent landscape of the *wpmbe* that allows an organic space in order to be with the struggle. Together, these themes merge and expand as they tell the story of the encounter. I will situate them in the context of the known related healthcare literature and ponder out loud what is represented in the findings.

Part one - the appearance of the struggle as integral to the *wpmbe*

In all three findings chapters, the participants spoke of experiencing a struggle or tussle. Being with this struggle was described in the stories as being able to be with the horrible messy side of life and was connected with the experience of illness and healing. The *wpmbe* shone a light on the struggle and tension of being in this horrible place (in illness) allowing what whaiora called the most desperate thing to bubble up to the surface. Something that had been hidden was being uncovered. An unconscious awareness was making its way to a shared conscious intersubjective awareness. This reflects literature encouraging physicians to be willing and available to hear their patients' lament, allowing this pain or lament to surface as a valid and valuable part of the encounter. Attending to this in the clinical encounter, whilst acknowledging its important benefits to well-being is an area of keen debate. A realisation is growing that

being with the suffering other remains at the heart of medicine, and it is imperative to re-integrate this to advance well-being. Tate and Pearlman (2019) make the call explicit,

Intention, sustained presence and the act of recognising the patients suffering are the end to be achieved, even if the relief of suffering is not attained ...it is hard to keep returning to the suffering patients' bedside day after day and yet the calling of the clinician is to return, to sit, to stay and ultimately one can hope to heal. (p. 107)

Choosing to listen for and allow the patient's lament to surface in encounters has been acknowledged in literature as transformative and a significant part of the healing process (Bub, 2004). This point of maximum pain or the patient's lament is a term used in psychotherapy to describe the surfacing of an unconscious pain. It is not a term so commonly used in the physical therapies, which essentially are seeking to minimise or control pain through appropriating meaning. It is important to identify what is thought of as pain in different healthcare disciplines, as it does not hold a common language, it is an area that lies across the mindbody divide, despite it being known as a subjective experience. The patient's lament in the body is a soul feeling linked to the experience of a feeling brain (Arnaudo, 2013; Damasio, 2003; Edwards, 2013; Frankl, 2004).

Naming the struggle – shining a light in the cave of suffering

In the *wpmbe*, the struggle was described as that dark place where you do not want to go. There was a tension in going there. It is usual in healthcare for the clinician to decide and focus on what is considered the presenting problem. The presenting problem in a biomedical consultation generally equates with the actual situation or difficulty that is seen as the reason for the consultation itself. In the *wpmbe*, this struggle was something quite different. Whaiora found themselves facing loss, the new diagnosis, the loss of normality (e.g., after a stroke or life-threatening illness, or ongoing relentless pain or chronic disease). Their self-identifying place in their world as they knew it had been disrupted. Medical phenomenologists have sought to define and describe this life disruption and its concurrent suffering. Svenaeus (2000) expressed it as an unhomelike feeling of being in the world after a life changing event is compatible with a process of separation from a comfortable self-knowing, caused by the illness itself; the suffering person appearing as other to themselves, an alien presence. This alienation from self and life as one knew it is further augmented by the objectified scientific gaze of the health professional. Merleau Ponty called it the body of Others (*le corp d'autrui*) the physical body, the object of medicine what has become diseased as opposed to the lived body

(*lieb* or *corps propre*), which experiences illness from the inside. The now naked body (person) exposed to examination (Merleau-Ponty, M. 2002).

Our body, which holds our sense of the experiencing self-when unencumbered, has now become the encumbered body with a sense that disease is the intruder. Van Manen (2016) expressed this break in unity of existence as,

We discover the object like nature of our body when the unity of existence in our world is broken, disease disturbs our well-being, serious illness changes everything, our sense of time and priorities, our experience of space and our felt relations with each other, our sense of self. (van Manen, 2016, p. 330)

Separation from self and its constituent suffering has become even more pronounced by the disconnection of the mind and body through dualist practice. The *whaiora* are seeking a reclaiming of this sense of self. A return to the passed over in silence body (*le passe vous silence*) and a return to a homelike feeling in the world is what is most sought (Carel, 2015). I wonder if there are two objectifications happening here. The person who suffers is desperately longing to return to their unencumbered previous sense of self but remains hindered by *illness separation*. This is further exacerbated in biomedical consultations by the objectified gaze, extended to *even hiding myself from the view of others*.

Participants in the *wpmbe* are accompanied in relation to others to recovering a liveable relation to themselves, a term used by van Manen (2016). According to Tate and Pearlman (2019), in their analysis of the phenomenon of suffering and its relationship to medicine, a “persons sense of self is relational and in a significant way given to them by others ...the sense of self is formed and sustained through discourse” (p. 102). The sense of self is determined by relationships (to others), roles, and one’s self-narrative. By denying subjectivity a place alongside and integral to physicality, we slow or prevent the recovery of this liveable relation (van Manen, 2016).

Tate and Pearlman (2019), in their critique of Cassell’s (1998) model of suffering, sought to provide a more grounded conceptualised pathway for clinicians providing an ‘inroad into the mist’. Their conceptualisation closely aligns with the *wpmbe*. Firstly, they place importance on (*merely*) recognising the presence of suffering. They go on to recommend seeking to understand the patient’s lived experience by “paying particular attention to the loss of relationships, roles and narratives and identifying avenues of

conversation that achieve a shared understanding, through actively listening and exploring their words and stories” (Tate & Pearlman, p. 106). They also make the point that it is what seems simple in practice but is frequently forgotten. They point out that the clinician’s words and acts are “not benign” but that this *new* clinician relationship is very significant to the role of alleviating suffering. The findings in the *wpmbe* also point to simplicity and meaningful everyday significant connections.

Tate and Pearlman’s (2019) critique relates even more directly to *wpmbe* in that they see Cassell’s model as limiting because it looks only at subjective meaning. Patients remain marginalised by the disease and its diagnostic labels, they are experiencing (Tate & Pearlman). They point out the limits of a view of the nature of suffering as a threat to personhood and its being *corrected* by a subjective meaning-generated lens by the individual. Cassell’s anecdote to suffering being largely the re-narrating of the story. Tate and Pearlman see Cassell’s model as “fixing the capacity for meaning making to the person and (*the*) disease to the biological body. Cassell, ironically, dissolves the holism he is so intent on maintaining” (Tate & Pearlman, 2019, p. 98).

Cassell (1998) resisted the objective view of suffering, that this limited notion was dualist and not in line with a phenomenological approach which “shows that human suffering is inseparable from human embodiment” (Moran & Jensen, 2013). Tate and Pearlman (2019) recognised that there is a need to look further into the relationship between objective and subjective suffering in line with the phenomenological view of the ill body and the experience of illness as suffering includes a radical shift in one’s embodiment³.

Weaving the components of being with the struggle

Facing this disintegration of a previous known life though was not the struggle; the struggle was with something else. It was the thing no-one had asked them about. This *no one ever asked about struggle* had not been the focus before. The medical condition

³ Note: the sense of loss is further accentuated by the belief that advancement of medicine can “protect us from the vagaries of ill-health which is an illusion harboured by modern man” (Carel, 2015, p. 107).

or the actual illness situation had previously been the focus. Throwing light on the struggle brought something else into focus. It was something other than the situation itself or adjusting or accepting this situation. Could it be that the *wpmbe* was opening the envelope of suffering? Was it suffering being addressed adding to the tension and discomfort? Being accompanied to engage with the struggle and going into that uncertain and unknown *cave* in the *wpmbe*, seemed pivotal to making sense of the disaster that has befallen them. Being with the struggle was getting to the crux of the matter, getting to *what matters*, as one student said *this* was facing the *real* problem. The affective *feeling of suffering*, with its constituent pain from the loss of connection to self by disruption of harmonious stability (that comes with illness), finds its place at the forefront of the encounter, rather than the problem or condition that needed to be fixed. The *wpmbe* pushed away the problem-based, fixing approach. It turned the encounter around; here you could struggle together and tackle what mattered, tackling what emerged head on. The struggle became a companion and quite possibly a container to the suffering itself, *the struggle to be with* the suffering for oneself and with others. The question to ask here, is what is it that is difficult to *face* in our usual medical encounters, that was *faced* here in the *wpmbe*, and why is it hard to surface? It was a pathway that took courage and was likened by whaiora and HcS to walking a tightrope, facing your fear and balancing a fine line of vulnerability. In the *wpmbe* vulnerability was given permission to emerge.

The struggle in the *wpmbe* a reflection of itself

The *wpmbe* created a reflection of itself, the tension created tension, the struggle emerging was conversely a struggle to be with. Both whaiora and students were expressing that *wpmbe* took them to the edge, it was painful, but it was a liberating pain. Pain and tension allowed growth. Being allowed to get down and get dirty while still accompanied was described as similar to having a good parent. In the depth of intimate relating, this safe environment was creative, and the experience was simply enough to allow recovery.

This is significant for healthcare practice since the experience of this kind where one's story is heard and one experiences being accompanied was identified as the healing part of the encounter; this is the nature of encounter, the art of medicine and the missing link. It is the *splinting/support* in and through relationship, over time, that supports the growth and healing. The limbic mirroring and regulation of oneself in relationship is

health giving and absolutely necessary for the reorientation of self in rehabilitation and wellness: “Limbic attractors thus exert a distorting force not only within the brain that produces them but also in the limbic networks of *others* - calling forth compatible memories, emotional states and styles or relatedness in *them*. (Lewis, Amini, & Lannon, 2000, p. 142). One’s whole past story can never be fully known by another; but as one comes alongside another, self becomes reflected in another. This is important because it is missing in healthcare encounters. It is the love quotient referred to in the findings that makes the difference and changes practice from a fast medicine ‘tick box’ approach toward a slow intentional attending to others (Damasio et al., 2003; Sweet, 2018).

This love quotient has power to form and reshape our identity and stretches beyond the moment. All of us, when we engage in relatedness, fall under the influence of another’s emotional world. Limbic transmissions render personal identity malleable (Lewis et al., 2000). “In a relationship one mind revises another; one heart changes its partner; this astounding legacy of our combined status as mammals and neural beings is limbic revision; the power to remodel the emotional parts of the people we love” (Lewis et al., 2000, p. 144).

Lewis et al. (2000) cites a poem from E. E. Cummings, painting a picture of the lover’s power to render identity:

*your homecoming will be my homecoming-----
my selves go with you, only I remain; a shadow phantom effigy or
seeming
(an almost someone always who’s no one)
a no one who, till their and your returning, spends the forever of his
loneliness
dreaming their eyes have opened to your morning
feeling their stars have risen through your skies*

Truth emerging from the struggle

The truth began surfacing in the *wpmbe* as connections were made with life story. More than one whaiora acknowledged that the *wpmbe* was an experience of returning to the truth of who they were. HcS referred to this as being able to discover themselves inside their therapist role. Murphy (2013) tells about this experience and its importance in the healing journey for himself as a mindbody clinician, “By coming into life – giving

contact I learnt (how) to embody the truth of who I am, the first step in healing and integration” (p. 56).

Being on the receiving end in the *wpmbe* has significant resonance with the writing of Barhava-Monteith (2018) who described the whole person approach:

It was unsettling and painful, destabilising and distressing, being confronted with the possibility that my own life story might have something to do with my illness... And yet it felt very right. It felt right because the WPMB practitioner asked me in that first meeting what no other medical practitioner had asked me before, he asked me the most crucial questions about my history, it was in answering those crucial questions (in a very safe environment he created) that I realised that my history and my life’s story had to be connected ...it was as if entering a long, very dark and quite scary corridor into the unknown. (Barhava-Monteith, 2018, p. 21)

A meeting with a whole person practitioner was a disturbing, distressing experience for Barhava-Monteith—it had the effect of connecting with the painful truth. Barhava-Monteith’s description bears a strong resemblance to the stories told by the *wpmbe* participants of entering a cave and the feelings of uncertainty.

The environment of this safe relationship, along with a veracity to find a connection between illness and personal storied experience, allowed the truth to be found. These *crucial questions* allowed the connection with this *life* experience of illness to a life experience with meaning to emerge. Meanings and meaningful connection was made. These connections were also experienced in the *researched wpmbe*. These *wpmbe* encounters were not longstanding relationships with experienced clinicians; they were simple interactions with a different intention. An intention that allowed the person and the self to emerge, story itself being already there. Compassionate accompaniment, along with the role of the enquirer expanding and allowing larger view, created an environment where deeply felt experiences of illness were heard together. Fear and anguish bubbled up to the surface. Whaiora speak of this when they said, they asked me what *no one else had asked before*.

Utilising the intersubjective space is essential in allowing the exploring of meaning making in illness (Broom, 2007). It is a hurdle and challenge to practice in this way as it requires one to have a different mind-set or system of beliefs from our current system. One of the biggest challenges in seeing disease and illness as connected to one’s story,

is that it is seen to be blaming oneself or others for one's circumstance. A clinician's ability to be present, concerns emotion, self-belief, and styles of intimate relating. A meanings connection is possible if the clinician has the capacity to safely hold and accompany a person; thereby, creating an emergent space for the sometimes painful truth to appear and be seen together in relationship (Broom, 2007; Mearns & Cooper, 2018).

Notable here is Schore's (2016) outstanding work in forging a link in the fields of psychoanalysis and neurobiology furthering our insight into brain and mind/body changes. Affective neuroscience and regulation theory, and its wide-ranging applications for personal neurobiological models of emotional and social development have relevance to this intersubjective experience for the patient and therapist alike. Remaining ignorant of interactive personal dynamics in healing and repair is not benefitting a return to well-being as Schore stated, "in relationally oriented therapeutic contexts that optimise intersubjective communication and interactive regulation, deficits in internal working models of the self and the world are gradually repaired" (p. 36). It is expedient now that we give consideration to the whole range of human experience in our therapeutic alliances, allowing whole person care to advance healing and repair.

Part two - An experience of being known (in relationship) in the *wpmbe*

Being known in and through the presence of another

Wholeness does not come from simply adding the parts. We are stirred or called forth into wholeness through meeting the other as an individual. This suffuses our meeting the world with aliveness, unknowing and vulnerability. Through meeting the other our, our being comes into presence. (Murphy, 2013, p. 46)

I identify with Murphy's account and explanation of his journey towards integration of mindbody practice through his connection with the existential philosophy of Buber. Murphy (2013) used the term, a radically intimate field of mind, body, and spirit to explain the place of meeting within personal encounter. It is a good term to explain the nature of the experience that whaiora and students were being called to in the *wpmbe*, explaining what happens when *being comes into presence*, in meeting the other. In regular healthcare encounters, we do not think of ourselves as practitioners as being there as a person/s—ourselves—meeting another. The student participants in the *wpmbe* found that they were stirred and called to this unique *meeting* experience, it was an

uncertain, undefined organic space. Participants struggled with this uncertainty, keeping safe (professional and emotional) boundaries, and experiencing their own vulnerability. Murphy identified this vulnerable space as the “place where we ourselves are born” (Murphy, 2003, p. 46). Selves being born is a theme right throughout the findings chapters. The *wpmbe* brings about this birth or re birth *into self-hood*; this happens in an interpersonal space that is multidimensional, in other words it pervades personhood (Broom, 2007).

Becoming (and being) known through this relational experience meant those suffering, seeking wellness were able to make small islands of meaning, and re-mind map their overturned world. Neuroscientific studies are now focussing on this mind mapping which assists good rehabilitation. These components of meaning making are vital in assisting with this *feeling brain* reconstruction. The rational mind making sense through the processing of the *feeling brain* (Damasio, 2003; Schore, 2016; Sternberg, 2010). In the *wpmbe*, participants made sense and became re-known to themselves accompanied *by another*. Embracing an existential and relational love reality was referred to in the *wpmbe* as the missing X-factor. The *wpmbe* has assisted whaiora in returning to a vital life, no longer an illusion of returning to their pre illness state they are now becoming a new version of themselves (Chiozza, 1999). Being invited to consider all aspects of personhood as having meaning links to the returning self, to agency and to reigniting a capacity to engage again in a meaningful life.

By taking a relational view of persons in our therapeutic encounters, whole persons are brought forth through encountering the other. Here, in the famous words of an existential philosopher, Buber and Smith (2006) call it being encountered by grace; grace is the capacity to encounter the other:

The YOU encounters me by grace - it cannot be found by seeking ...the YOU encounters me. But I enter into direct relation to it. Thus the relationship is election and electing, passive and active at once... The concentration and fusion into a whole being can never be accomplished by me, can never be accomplished without me. I require a YOU to become; becoming I, I say You. All actual life is encounter... the present -not that which is like point... but the actual and fulfilled present - exists only insofar as present-ness, encounter and relation exist. Only as the

YOU becomes present does present-ness come in to being. (Buber & Smith, 2006, p. 62)

Being known as a passageway to wholeness and vitality

Murphy (2013) beautifully articulated becoming fully known in the clearing as being a 'passageway' to wholeness; the clearing, being a Heideggerian concept (Harman, 2007). Even more, Murphy talked about the capacity to remain here: "The clearing is one path to wholeness. We reach the truth of what is, and what is emerging together, by turning to the experiential openness of the moment" (p. 44). Whole person healthcare is a learning to trust that the whole is already present in any one of its parts, particularly in the story and symptoms of the whaiora. This *is a learning to remain* in the clearing by developing a trust that what the patient (in a clinical encounter) gives and says in their symptoms and words *is sufficient*. The whaiora experience this in the *wpmbe* but even more so the HcS who identify the challenge of remaining in a clearing space that is here by not pushing for more information (Broom, 2007; Murphy, 2013). The rush to cover up the story and move on to the next pressing agenda is like treading on the leaves that have been laid on the path, instead of looking at them; it is sweeping the treasure of the story away as if it did not matter, the personal storied subjective experience treated as inconsequential. The treasure of the story is lost and the moment of connection hard to recover. Whaiora described this as a feeling of being dismissed. In contrast, in the *wpmbe* the experience itself *is sufficient*. The whaiora and students begin to get a sense of *this being with as being enough*. It was enough to remain with the struggle, and acknowledge the suffering, no longer intent on fixing up everything.

Identifying the skillset required to remain in the clearing is challenging in healthcare as it is closely aligned to a belief. This belief that the story is enough is "having a holographic faith in the sufficiency of what is" (Murphy, 2013, p. 49). It is a *faith* that requires we see the person before us as not just as a body but a subject-body, both physical and subjective from the beginning (Broom et al., 2012). This is a move from the Cartesian paradigm where the machine-body is *extrinsic* to the essential self (Leder, 1984). The *wpmbe* is an encounter with a multidimensionality and multi-potentiality of a lived-body, where physicality and subjectivity are honoured and considered as having meaning together in the same space.

The notion of the Cartesian body and its pragmatic separation of soul and subjectivity was significant in promoting the advances of medicine as we know it. However, now it

is time that this emphasis, which led to negligence of the life-context, the impact of subjectivity and mindbody connection in illness and healthcare is addressed. We have much more access to the knowledge and understanding of these connecting systems through advances in neuroscientific, biological, and psycho-neuro-immunological theory. It is becoming apparent that these neglected pathways have a distinct role in the disintegration of self and the perpetuation of illness and disease. The next challenge, as described by several of the participants in Chapter Six, is to bring the notion of the lived body back into the realm of the patient encounter (Broom et al., 2012; Leder, 1990). Participants described an invitation to remain with rather than move quickly past the uncomfortable moments. It involves a journey of encouraging one another in a moment by moment dynamic dyad to be with vulnerability, the feeling of suffering, the suffering affect (Tate & Pearlman, 2019).

Being known through being accompanied

Whaiora experienced being accompanied to that painful place where persons in relationship feel the ache together. This theme of both sides sharing a lived experience is threaded through the research findings. What stands out in the *wpmbe* was that permission was given to accompany another; empathic attunement became the vehicle to the loneliness of suffering. Whaiora and HcS enter the abyss together, no longer alone but accompanied.

Colquhoun (2011) called this being with the ache. It is not doing nothing. He talks about the art of medicine is in part the art of the encounter, requiring the ability to come alongside the other.

The art of medicine is in part the art of encounter. It requires the ability to come alongside another human being and then provide space for magic to result. This (being with the ache) is not doing nothing, ache recognises ache – (it is) a being in the same space, sharing the same fire... we might need to admit we are in the abyss with them so they are not alone... Ache is important in medicine because it is pounding on the door. (Colquhoun, 2012, p. 142)

Colquhoun is not the only writer of medical literature who invites those in clinical encounters to embrace this space of the suffering other. When reading the literature, it is apparent we avoid this place and there is a strong call to return to it, it is the missing ingredient in our encounters (Epstein, 2017). Through simply being acknowledged as

more than one's diagnosis, and being accompanied into the abyss, the whaiora became reintegrated. In the *wpmbe* sitting by the fire together was given its own importance and it was enough.

Being known in the *wpmbe* as being protected in relationship

The lived experience of being protected enough was entwined in the *wpmbe* with being known and accompanied in order to grow. Being splintered and held safely in a therapeutic relationship to allow healing and a returning is an established role of the therapeutic alliance in psychotherapeutic literature on working relationally. This sheltering protection in the *wpmbe* became part of finding the *new me* after a life changing experience. Chiozza (1999) spoke about the illusion of returning after illness as the deepest pitfall in rehabilitation. After illness one can never return to one's previous state; we become a new creation, our previous innocence never recovered. The metaphors in the *wpmbe* for this experience of being protected, were spoken about as the parent child relationship. It was being allowed to get down and get messy; playing in the dirt and being allowed freedom to do this *like a child growing up* in a safe relationship. The feeling was protected enough to shed some onionskins together. This protection provided an ability to show the true self in the *wpmbe*. This lived experience of authenticity stretched across all the findings (Mearns & Cooper, 2018). The *wpmbe* allowed whaiora to experience growth through this protected space.

Part three – the emergent landscape

The *wpmbe* was linked together by the emergent landscape which has three main characteristics. Firstly, that of a *reciprocal arrangement*, the market place where each contributed to the relationship, no longer as a spectator; secondly, jointly co-witnessed a lived experience together; they did this by thirdly, allowing an emergent, organic space which was underpinned by a willingness, generosity, and open curiosity.

The *wpmbe* experience of two persons being in relationship was described as a level playing field—a shared contribution—emotional availability allowed self-expression. The whaiora came to be known and the HcS reported this too; they were integrating

themselves and their knowing, this emergent landscape was the space of becoming known.

The *wpmbe* an experience of my story being listened to – telling the real story

Whaiora began to hear their own story. As if it was being played back to them, they heard the story in themselves. Participants talked of being listened to in such a way that they were able to tell the *real story*. This experience deeply connected them to their real life, which they experienced in relationship within a shared vulnerability. Their stories of the unshared and at times un-shareable fears had a place here to be heard; here the oft unspoken was voiced and it was listened to. This story connected them to their own lived experience. Through this encounter of enduring care with a daily life element, an experience which was about *just life*, it brought the whaiora to a wholeness, and more than one whaiora reported an experience of finding the new me.

Corradi Fiumara (1995) wrote extensively over many years about the philosophy of listening within a tradition of questioning. She, along with Orange (2011) explained a hermeneutic sensibility in one's listening posture. Gadamer is the philosopher most closely linked with this listening posture:

The art of winning every argument, dialectic, as the art of asking questions is able to persist in the questioning which involves being able to persevere his orientation towards open-ness ...As such it could be said that "the willingness to keep alive this orientation towards openness is the genuine basis for every question. According to Gadamer, the close relationship that exists between question and understanding gives the hermeneutic experience its true dimension... The sort of logic that underlies our culture does not seem to allow for a more authentic openness that may sustain a revealing dialogue.
(Corradi Fiumara, 1995, p. 33)

For Orange (2010) being fundamentally open, is a true posture of listening and without this kind of openness to one another there is no genuine relationship (Orange, 2010).

Orange (2011) articulated this openness more fully when describing Gadamer's hermeneutics:

Gadamer provided philosophical hermeneutics to free us from our enslavement to a natural-science model of understanding in the human sciences and thus showed us an alternative to tempting reductionisms.

Here we turn precisely to his hermeneutics - and especially to his emphasis on readiness to listen to and learn from the voice of the other - as a clinical philosophy. (p. 15)

Those listening in the *wpmbe* were encouraged to have an open dialogic listening posture and it was linked to their intention. It was noted by the whaiora in several stories that here, in the *wpmbe*, there was a different style of listening.

The *wpmbe*, the experience of a different intention

Being acknowledged, becoming known and being seen as a person (with an illness), and accompanied in this *wpmbe* was linked by the intention. The intention in the *wpmbe* was an obvious intention, it was deliberate. It was as though the caring intentions in the *wpmbe* had a clear and forceful direction, a clear mandate that simply in an uncomplicated fashion collected up all the fragmented components of a person and brought them together, allowing the life story (of illness) to find a place of cohesion.

This *wpmbe* had a different nature and intention. From my interpretation of the data it seemed that here in the *wpmbe* was no judgement. It was a call to a somewhat challenging encounter, one where you are forced to be honest with yourself. It caused tension. It was uncomfortable. Even described as frightening and even tiring.

This experience of a loving intention was held within professional boundaries but walked the fine line of vulnerability in relationship. Signs of this caring was felt as *warmth in the heart*, the caring extended to life outside the encounter. It also extended beyond the physical symptom, to the actual daily life element of the person as inside the encounter.

Participants identified this different intention, as one where they felt others wanted to understand them and this was formed, in part, from being comfortable about not knowing the answer which created an opportunity to look harder, listen, explore, and discover. A healing intention provides the space for the cultivation of intentional focus on the whole person when it considers all the components of their experience (of illness). Walking together in an existential landscape and claiming our divinity is a change to inclusion of our consciousness. Healing works *as between people*; it is not done to you; it is already there. When people ask you questions, they are searching for

meaning. According to Jonas and Crawford, 2003 doctors most often give a biological answer to these meaning questions.

Jonas and Crawford (2003) ask how can we language our answers in a way that is acceptable to the mainstream, can we do healing by presence rather than doing? The studies of Jonas and Crawford (2013) found common characteristic components in healing to be love and good intention. Love, being one and being mandatory provided the power. Love though, on its own, was not sufficient. Love also needed good intention – being the force of direction. Intention directs the healing.

At some point, everything converges if we pay attention to the whole person. We need to listen for the hidden variable, the mystery. For the components to show up we have to provide a space that people seeking healing can ‘show up in’. Jonas and Crawford (2003) identify a need to create an environment where this can happen, where love and positive intention is the vessel. Creating of a collective environment where you and your patients *can show up for each other* (Jonas & Crawford, 2003).

We need to change the dialogue in all of us to allowing what is meaningful and what matters to be integral to our healthcare encounters. No longer saying this means that but finding out what matters. We are always, already who we really are (our consciousness continues). It will take a culture shift to how to walk this healing journey to find out what matters. Exploring what can happen when time, space, intention and belief combine whilst privileging whole person viewing allows a return to meaningful existence.

Biology comes and goes and we do what we can as health professionals but spirituality is at the core of being well because it alone can alter our story and give us the ability to make sense of whatever befalls us. It reminds us that whatever shape we end up in we are not just human beings. (Colquhoun, 2012, p. 143)

The *wpmbe* – a co-witnessing reciprocal arrangement; the marketplace – a contributing emergent landscape

Here in the *wpmbe* two lived experiences combine to create something new away from preconceived, predetermined, prescriptive encounters. Here, two authentic vulnerable persons appear before each other. A co-created arrangement that was the level playing field of the *wpmbe* takes away the power separation of (knowledge) expert versus patient. The relationship in this *wpmbe* was of person to person relating with a fallible

attitude. Orange (2011) particularly promoted this level playing field as the place where transformational healing experiences happen in therapeutic relationship.

Part four – a summarised integration - why does any of this matter

If you can deeply appreciate that somehow your patient is sacred, and deep, and emotionally and spiritually full of resourcefulness, energy and potential, then he or she will quickly sense this, and then you have a healing relationship... this language is counter current within the dominant biomedical discourse. (Broom, 2015, p. 103)

Understanding and exploring the nature of encounter matters if we think of it as pivotal to healthcare. It affects the practices of medicine, the health and well-being of patients, and the health and wellness of those who practice (bio) medicine. Since the *wpmbe* sits within the biomedical encounter, the reasons we meet matter, including our expectations of this actual meeting, especially in our current age where computerised pre-formulaic meetings are proliferating and close becoming the norm.

Carel and Cooper (2013) remarked that specific study of the philosophy of medicine has really only made a recent contribution to the study of medicine itself. In the 1970s, for instance, there were barely a handful of articles looking at the lived experience of illness. More recently, in the last decade, it has become a study in itself (Carel & Cooper, 2013).

I myself would defend the concept of medicine that stresses the meeting of health care professional and patient in an interpretive attempt to help and treat the ill and the suffering one, whereas others would rather look at the essence of medicine in its application of medical knowledge in its attempts to understand and alter the biological organism. (Svenaeous, 2013, p. 97)

Svenaeous (2013) emphasised meeting as a pivotal component in healthcare. Where medicine takes us will depend on whether we choose to integrate these two aspects of care—meeting and the application of knowledge in a complementary fashion. It depends what we choose as the essence of healthcare. As a phenomenologist, Svenaeous encouraged us to look with a phenomenological eye which “address (es) everyday life matters which consider the experience of illness itself as pivotal” (p. 97). These

concepts do not need to be mutually exclusive and could be brought into dialogue. We do have a choice here.

It also matters because healing lies in the potency of being known in relationship. In whole person healthcare, the relationship between life experience, meaning and illness matters as the healing happens in relationship between the patient and the clinician. We need “to work with it and give new meaning to it as it is where much of healing lies” (Broom, 2015, p. 102).

Linking the lived experiences of the *wpmbe*

The lived experiences that were linked in the *wpmbe* brought about an integrated sense of personhood, wholeness, and self-integration. This was experienced in relationship where there was a different intention. By creating a safe, relational space, creativity flourished *whaiora* and student could ‘see’ (experience) their own physical and subjective life story and its interconnections. They were able to experience their own struggle of the experience of illness in the company of another. They had felt a dislocation and separation in illness in their own personhood which had been further exacerbated by the objectifying gaze of dualist practice. Meaning in life had been disrupted and fractured. The *wpmbe* was an experience of themselves as whole persons with a meanings connection.

In summary – the *wpmbe* – a way of returning

The experience of becoming known in the *wpmbe* comprised a healing journey for participants; a way to enter a radically intimate field. In this field they were in relation to a healthcare practitioner in a way that was unexpected. This relational space was a whole person mindbody space; in it they could bring their deepest held truths and their deepest fears. This experience was not one they had been used to in previous healthcare experiences. It was an experience of a simple yet complex human connection in the *wpmbe*, its simplicity was remarkable. The simplicity of acknowledgement as a whole person with a story to match and a connection to being known in the presence of another formed the landscape of the *wpmbe*. The *wpmbe* itself created an emergent and dynamic space where listening with a heart capacity, a loving intention and being seen with a phenomenological eye was apparent. Being seen in this whole person way had the effect of *whaiora* experiencing a return to self and a sense of wellbeing. Encountering each other in this whole person way, in a safe relational space, meant a new image or mind map where sense and meaning making after experiencing

personhood disintegration due to injury, illness or a life changing event became a way of returning to a homelike being in the world.

My personal reflection

My own view of the *wpmbe* has expanded, developed, and consolidated through this journey. For me, it has been an experience of validation and one of experiencing (for myself) again the potency of this differently ordered relational dynamic of the *wpmbe*.

My strongest drive to write this thesis was to make a further contribution to the generosity of the mindbody community that created a safe relational and ‘belief’ space for me to look at and uncover the essence of what I saw as ‘basic’ good healthcare practice. I was hearing and seeing additional suffering in healthcare, brought on by the system itself and the way we view the body mind problem. This whole person mindbody was for me of hitting the mark, no longer missing the mark. Not wasting time in mindbody (substance) dualism but now providing a way to go to directly to what matters and what is meaningful. In my opinion, to practice in this way is not only expedient, but transformative, powerful, and possible. You need to be willing, generous, and curious.

Unpacking the experience of the *wpmbe* has been not dissimilar to the journey for the whaiora and student participants themselves. It was like going down into the cave with them to be with my own struggle and the struggle of biomedicine itself. My own struggle has been to make this *wpmbe* visible, vital, necessary, and valid to ongoing healthcare. When you know that what you are tackling is strongly underpinned by belief systems, societal and cultural norms, and what you are looking at is the way people experience their world, you realise that what needs to change belongs to the perceptual realm.

Conclusions

The listening relational dynamic in the *wpmbe* is what whaiora want to be commonplace and every day in healthcare; as one whaiora said, the system is broken but the people in it do not want it to be. Healthcare has become so far removed from whole person caring that people no longer even expect it. One of my personal practice challenges has been just this, not wanting to judge the efforts and the caring of others as not good enough. What drives and sustains me, and has become more apparent through this study, is the ease, simplicity, and innate humanness that contribute to bringing whole person

healthcare about. Whole person healthcare is happening but in small pockets all over the healthcare system.

I think we are at a crossroads, where the mindbody connection is currently gaining traction. Whole person healthcare it is being approached from many sides but most strongly from the area of palliative care always at the forefront in my view, always and already leading the way, and PCC, both contributing toward changed perspectives. We need to work together continuing with openness and fierce minds (and of course bodies) to bring sustainable changes to healthcare practice.

My own reading of mindbody literature and popular literature that is exploring these matters has been significant, validating, and strengthening. I am extremely grateful to those who have penned their ideas, experiences and collected these ideas and personal accounts together in written form. The recent expansion in the last two decades of knowledge in the understanding of mindbody brain connection, and the powerful insight into the neurobiological science places us at a pivotal point in mindbody integration. Furthering the understanding of conscious awareness and the awareness of consciousness, how we know we are what we are and how we experience ourselves is the next wave of science discovery, extremely exciting and will bring with it ongoing challenges to continuing to practise the way we do.

Recommendations

Research needs to be undertaken in a shared discipline fashion combining separate mind and body dimensions. Combining differing specialities in research and in everyday practice, will provide opportunity to discover the realities of co-emergent illness experience and the healing potential of nondualist practice. Continuing in biomedicine as we are will further increase growing dissatisfaction in healthcare by HcP and healthcare consumers alike. Gaining insight into our own being and relating along with the skills and permission to approach clinical practice from an ontological perspective

will promote a more expansive view of our authentic humanness in our clinical encounters.

Recommendations- Summarised

For education

- Provide healthcare students with increased exposure to clinical practice opportunities that promote the development of listening capabilities. Be explicit in acknowledging therapeutic space for personal story to be heard and acknowledged as meaningful (allow subjectivity and physicality in the same therapeutic space). Promote a culture of acceptability for integrated whole person care.
- Provide undergraduate and postgraduate healthcare students with self-development educational opportunities that prioritise building personal capacity to be in relationship with others.

For practice

- Pilot an interprofessional project which can further show case the effectiveness of whole person integrated care model as part of a standard biomedical care pathway.
- Provide educational opportunities that explore and recognise that healthcare professionals bring with them their own philosophies of practice. Promote in depth exploration of theories, models, frameworks, and their effect in mind body connection or conversely their division in healthcare.
- Identify and use explicit language to explain the integration of actual lived experience of illness as meaningful to illness story in therapeutic encounter, to make this more apparent in clinical notes and easily identifiable to clinicians, patients and whaiora.
- As recommended an expansion of philosophical understandings of our own discipline specific being and relating, essentially our ontological assumptions will enable growth of skills in relating, an ability to be with the suffering of others and will bring with it permission to approach a clinical practice which discovers and experiences whole person knowing in relationship.

For research

- Collaborative research to be undertaken in a shared discipline fashion, which combine the mind and separate body dimensions in clinical practice. Combining differing specialities in research and in everyday practice will provide

opportunity to discover the realities of co-emergent illness experience and the healing potential of nondualist practice.

How are we going to put this all together? One of the keys, stated clearly in this research, is that we become whole ourselves in clinical encounter through calling each other forth as whole persons. The way we view and allow others to experience illness brings us all to wholeness. We find meaning in our experience of illness, through accompaniment in our encounters. When we find others, we also find ourselves. Then we become whole and wholly experiencing persons.

I would like to finish with a quote from Sweet (2017). In this quote, the persons have arrived, able to be here with one another. It captures the profound simplicity of relational healing, an experience of becoming known as whole persons as in the *wpmbe*.

I began to realise something strange was going on. After I had learned all that, figured out all that (referring to intensive medical training and other searching into path of human nature & healing) what was wrong with the patients and what was not wrong with the patient and removed as best I could what was in the way...done everything I could think of to do...

...**Then suddenly there we were**, the patient who seemed after our long acquaintance, just another person, like myself. There he was in his predicament and me in mine. He knew me about as well as I knew him; my flaws and weaknesses, my virtues and strengths, **when I would “just sit with him”, he was also sitting with me.** (Sweet, 2017, p. 248)

There is power and simplicity in our call to be whole.

References

- Abram, D. (1996). *The spell of the sensuous: Perception and language in a more-than-human world*. New York, NY: Pantheon Books.
- Arnaudo, E. (2013). Pain as illness. In H. Carel & R. Cooper (Eds.), *Health, illness and disease: Philosophical essays* (pp. 143-157). Durham, United Kingdom: Acumen.
- Banks, C. (1995). *Rumi, selected poems*. London, United Kingdom: Penguin Books.
- BarHava-Monteith, G. (2018). *The difference between being looked and being seen: An in-depth consideration of experiencing the Whole Person Therapeutic Approach for chronic illness* (Unpublished Doctoral dissertation). Auckland University of Technology, Auckland, New Zealand. Retrieved from <http://hdl.handle.net/10292/11773>
- Bolletino, R. C. (2001). A model of spirituality for psychotherapy and other fields of mind-body medicine. *Advances in Mind-Body Medicine*, 17(2), 90. <http://www.advancesjournal.com/>
- Bredlau, S. (2019). On perception and trust: Merleau-Ponty and the emotional significance of our relations with others. *Continental Philosophy Review*, 52(1), 1-14. doi:10.1007/s11007-016-9367-3
- Briere, J., & Scott, C. (2013). *Principles of trauma therapy: A guide to symptoms, evaluation, and treatment*. Thousand Oaks, CA: Sage.
- Bright, F. A. S., Boland, P., Rutherford, S. J., Kayes, N. M., & McPherson, K. M. (2012). Implementing a client centred approach in rehabilitation: An autoethnography. *Disability and Rehabilitation*, 34(12), 997-1004. doi: 10.3109/09638288.2011.629712
- Broom, B. (1997). *Somatic illness and the patient's other story*. London, United Kingdom: Free Association Books.
- Broom, B. (2000). Medicine and story: A novel clinical panorama arising from a unitary mind/body approach. *American Psychological Association*, 16(3), 161-207. doi: 10.1054/ambm2000.0186
- Broom, B. (2007). *Meaning-full disease: How personal experience and meanings cause and maintain physical illness*. London, United Kingdom: Karnac Books.
- Broom, B. (2017). Meaning and medicine. In L. Mayes (Ed.), *Beyond the stethoscope* (pp. 101-114). Castlemaine, Australia: Heart Works Press.
- Broom, B. (2018). *Whole person healthcare*. Retrieved October 28, 2018, from

<https://wholeperson.healthcare>

- Broom, B. (Ed.). (2013). *Transforming clinical practice using the mindbody approach: A radical integration*. London, United Kingdom: Karnac Books.
- Broom, B., Booth, R. J., & Schubert, C. (2012). Symbolic diseases and "Mindbody" co-emergence: A challenge for psychoneuroimmunology. *Explore*, 8(1), 16-25. doi: 10.1016/j.explore.2011.10.005
- Bub, B. (2004). The patient's lament: Hidden key to effective communication: How to recognise and transform. *Medical Humanities*, 30(2), 63-69. doi:10.1136/jmh.2004.000164
- Buber, M., & Smith, R. G. (2006). *I and thou*. Edinburgh, United Kingdom: Hesperides Press.
- Carel, H. (2008). *Illness: The cry of the flesh*. Stocksfield, United Kingdom: Acumen.
- Carel, H. (2015). Conspicuous, obtrusive and obstinate: A phenomenology of the ill body. In D. Meacham (Ed.), *Medicine & society, new perspectives in continental philosophy* (pp. 105-123). Dordrecht, The Netherlands: Springer. doi:10.1007/978-94-017-9870-9_7
- Carel, H., & Cooper, R. (2013). *Health, illness and disease: Philosophical essays*. Durham, United Kingdom: Acumen.
- Carruthers, R. (2013). *Being holistic in practice: A hermeneutic phenomenological study*. (Unpublished Masters thesis). Auckland University of Technology, Auckland, New Zealand. Retrieved from <http://hdl.handle.net/10292/5540>
- Cassell, Eric, J (1976). *The healer's art: A new approach to the doctor-patient relationship*. Cambridge, MA: Lippincott.
- Cassell, E. J. (1991). Recognizing suffering. *The Hastings Center Report*, 21(3), 24-31. doi.org/10.2307/3563319
- Cassell, E. J. (1998). The nature of suffering and the goals of medicine. *Loss, Grief & Care*, 8(1/2), 129-142. doi:10.1300/J132v0801_18
- Chiozza, L. A. (1999). *Why do we fall ill? The story hiding in the body*. Madison, CT: Connecticut Psychological Press.
- Clarkson, P. (2003). *The therapeutic relationship*. London, United Kingdom: Whurr Publishers.
- Colquhoun, G. (2011). The therapeutic uses of ache. *English in Aotearoa*, 74, 7-12 <https://www.nzate.co.nz>
- Colquhoun, G. (2012). *Jumping ship and other essays*. Wellington, New Zealand: Steele Roberts.

- Corradi Fiumara, G. (1995). *The other side of language: A philosophy of listening*. London, United Kingdom: Routledge.
- Coulehan, J. (2009). Compassionate solidarity: Suffering, poetry, and medicine. *Perspectives in Biology and Medicine*, 52(4), 585-603. doi: 10.1353/pbm.0.0130
- Coulter, I. (2001). Genomic medicine: The sorcerer's new broom? *Western Journal of Medicine*, 175(6), 424-426. doi: 10.1136/ewjm.175.6.424
- Crowther, S., Ironside, P., Spence, D., & Smythe, L. (2017). Crafting stories in hermeneutic phenomenology research: A methodological device. *Qualitative Health Research*, 27, 826-835. doi: 10.1177/1049732316656161
- Dahlberg, K. (2006). The individual in the world - The world in the individual: Towards a human science phenomenology that includes the social world. *Indo-Pacific Journal of Phenomenology*, 6, 1-9. doi.org/10.1080/20797222.2006.11433932
- Damasio, A. R. (2003). *Looking for Spinoza: Joy, sorrow, and the feeling brain*. Orlando, FL: Harcourt.
- Dorrestein, M. (2015). *The lived experience of teaching mindfully. A hermeneutic phenomenological study* (Unpublished Masters thesis). Auckland University of Technology, Auckland, New Zealand.
- Driver, C., Crawford, S., & Stewart, J. (Eds.). (2013). *Being and relating in psychotherapy: Ontology and therapeutic practice*. New York, NY: Palgrave Macmillan.
- Durie, M. (1998). *Whaiora: Māori health development*. Auckland, New Zealand: Oxford University Press.
- Durie, M. (2001). *Mauri Ora: The dynamics of Māori health*. Melbourne, Australia: Oxford University Press.
- Eckersley, R. (2006). Is modern Western culture a health hazard? *International Journal of Epidemiology*, 35(2), 252-258. doi: 10.1093/ije/dyi235
- Edwards, L. (2013). *In the kingdom of the sick: A social history of chronic illness in America*. New York, NY: Walker & Co.
- Elfred, M. (2013). The healing relationship. In C. Driver, S. Crawford, & J. Stewart (Eds.), *Being and relating in psychotherapy: Ontology and therapeutic practice* (pp. 9-21). New York, NY: Palgrave Macmillan.
- Epstein, R. (2017). *Attending: Medicine, mindfulness and humanity*. New York, NY: Scribner.
- Frankl, V. E. (2004). *The doctor and the soul: From psychotherapy to logotherapy*. London, United Kingdom: Souvenir Press.

- Frankl, V. E. (2006). *Man's search for meaning*. Boston, MA: Beacon Press.
- Gadamer, H.-G. (2013). *Truth and method*. London, United Kingdom: Bloomsbury
- Gadamer, H.-G., & Bernasconi, R. (1986). *The relevance of the beautiful and other essays*. Cambridge, United Kingdom: Cambridge University Press.
- Gertler, P. (2019). *The healing time*. Retrieved August 6, 2019, from <http://www.pauljhowell.com>
- Glasgow, K. (2018). *Re-negotiating the boundaries: A grounded theory study*. (Unpublshed Masters thesis). Auckland University of Technology, Auckland, New Zealand. Retrieved from <http://hdl.handle.net/10292/12225>
- Goldenberg, M. J. (2010). Clinical evidence and the absent body in medical phenomenology: On the need for a new phenomenology of medicine. *International Journal of Feminist Approaches to Bioethics*, 3(1), 43-71. doi: 10.1353/ijf.0.0067
- Goulding, J. (2013). Training troops for a mindbody revolution. In B. Broom (Ed.), *Transforming clinical practice using the mindbody approach* (pp. 275-298). London, United Kingdom: Karnac Books.
- Griffith, J. L., & Griffith, M. E. (1994). *The body speaks: Therapeutic dialogues for mindbody problems*. New York, NY: Basic Books.
- Groddeck, G. (1977). *The meaning of illness selected psychoanalytic writings by Georg Groddeck, including his correspondence with Sigmund Freud* (Trans. G. Mander) Oxford, United Kingdom: International Universities Press.
- Hansen, E., Walters, J., & Howes, F. (2016). Whole person care, patient-centred care and clinical practice guidelines in general practice. *Health Sociology Review*, 25(2), 157-170. doi: 10.1080/14461242.2016.1170625
- Harman, G. (2007). *Heidegger explained: From phenomenon to thing* (Vol. 4). Chicago, IL: Open Court.
- Heidegger, M., & Stambaugh, J. (1996). *Being and time: A translation of Sein und Zeit*. Albany, NY: State University of New York Press.
- Hotchkies, L., & Hudson, N. (2013). Living with mortality. In C. Driver, S. Crawford, & J. Stewart (Eds.), *Being and relating in psychotherapy: Ontology and therapeutic practice* (pp. 107-118). London, United Kingdom: Palgrave Macmillan.
- Hutchinson, T. A. (2011). *Whole person care: A new paradigm for the 21st century*. New York, NY: Springer.

- Hutchinson, T. A. (2017). *Whole person care: Transforming healthcare*. Montreal, Canada: Springer, Cham.
- Jonas, W. B., & Crawford, C. C. (2003). *Healing, intention, and energy medicine: Science, research methods, and clinical implications*. New York, NY: Churchill Livingstone.
- Jonathan, F., Luis J, F., Ross E G, U., & Maya J, G. (2014). Renaissance or reformation for evidence based medicine? *British Medical Journal*, 349, 4902. doi:10.1136/bmj.g4902
- King, M., & Llewellyn, J. (2001). *A guide to Heidegger's Being and time*. Albany, NY: State University of New York Press.
- Kövecses, Z. (2000). *Metaphor and emotion: Language, culture, and body in human feeling*. Cambridge, United Kingdom: Cambridge University Press.
- Kramer, K., & Gawlick, M. (2003). *Martin Buber's I and thou: Practicing living dialogue*. New York, NY: Paulist Press.
- Lakoff, G., & Johnson, M. (1999). *Philosophy in the flesh: The embodied mind and its challenge to Western thought*. New York, NY: Basic Books.
- Leder, D. (1990). Clinical interpretation: The hermeneutics of medicine. *Theoretical Medicine*, 11(1), 9-24. <https://link.springer.com/article/10.1007/BF00489234>
- Lewis, T., Amini, F., & Lannon, R. (2000). *A general theory of love*. New York, NY: Random House.
- Loughlin, M., Bluhm, R., Fuller, J., Buetow, S., Upshur, R. E. G., Borgerson, K., . . . Kingma, E. (2014). Philosophy, medicine and health care - where we have come from and where we are going. *Journal of Evaluation in Clinical Practice*, 20(6), 902-907. doi: 10.1111/jep.12275
- Mayes, L. (2017). *Beyond the stethoscope*. Castelmaine, Australia: Heart Works Press.
- McDougall, J. (1989). *Theaters of the body*. New York, NY: W.W Norton and Company.
- Mearns, D., & Cooper, M. (2018). *Working at relational depth in counselling and psychotherapy* (2nd ed.). London, United Kingdom: Sage
- Merleau-Ponty, M. (2002). *Phenomenology of perception*. London, United Kingdom: Routledge.

- Miles, A. (2015). From EBM to PCH: Always predictable, now inexorable. Editorial introduction to the 2015 evidence based medicine thematic issue of the Journal of Evaluation in Clinical Practice. *Journal of Evaluation in Clinical Practice*, 21(6), 983. doi: 10.1111/jep.12525
- Moran, D., & Jensen, R. T. (2013). *The phenomenology of embodied subjectivity*. Heidelberg, Germany: Springer.
- Murphy, M. (2013). An intimate field. In B. Broom (Ed.), *Transforming clinical practice using the mindbody approach* (pp. 43-58). London, United Kingdom: Karnac Books.
- Nicholls, D. (2018). *The end of physiotherapy*. Abingdon, Oxon: Routledge.
- Nicholls, D., & Gibson, B. (2010). The body and physiotherapy. *Physiotherapy Theory and Practice*, 26(8), 497-509. doi: 10.3109/09593981003710316
- Orange, D. M. (2010). *Thinking for clinicians: Philosophical resources for contemporary psychoanalysis and the humanistic psychotherapies*. New York, NY: Routledge.
- Orange, D. M. (2011). *The suffering stranger: Hermeneutics for everyday clinical practice*. New York, NY: Routledge.
- Pinto, R. Z., Ferreira, M. L., Oliveira, V. C., Franco, M. R., Adams, R., Maher, C. G., & Ferreira, P. H. (2012). Patient-centred communication is associated with positive therapeutic alliance: A systematic review. *Journal of Physiotherapy*, 58(2), 77-87. doi: 10.1016/S1836-9553(12)70087-5
- Schore, A. N. (2016). *Affect regulation and the origin of the self: The neurobiology of emotional development*. New York, NY: Routledge.
- Smythe, E. (2011). From beginning to end: How to do hermeneutic interpretive phenomenology. In G. Thomson, F. Dykes, & S. Downe (Eds.), *Qualitative research in midwifery and childhood: phenomenological approaches* (pp. 35-58). Hoboken, NJ: Taylor and Francis.
- Smythe, E., & Spence, D. (2012). Re-viewing literature in hermeneutic research. *International Institute For Qualitative Methodology*, 11, 12-25. doi: 10.1177/160940691201100102
- Sontag, S. (1990). *Illness as metaphor*. New York, NY: Picador.
- Sternberg, E. M. (2010). *Healing spaces: The science of place and well-being*. Cambridge, MA: Belknap Press of Harvard University Press.

- Stolorow, R. D., Atwood, G. E., & Orange, D. M. (2002). *Worlds of experience: Interweaving philosophical and clinical dimensions in psychoanalysis*. New York, NY: Basic Books.
- Svenaeus, F. (2013). What is phenomenology of medicine? Embodiment, illness and being-in-the world. In C. Carel & R. Cooper (Eds.), *Health, illness and disease: philosophical essays* (pp. 97-111). Durham, United Kingdom: Acumen.
- Svenaeus, F. (2000). *The hermeneutics of medicine and phenomenology of health: Steps towards a philosophy of medical practice*. Dordrecht, The Netherlands: Kluwer Academic Publishers.
- Sweet, V. (2017). *Slow medicine: The way to healing*. New York, NY: Riverhead Books.
- Tate, T., & Pearlman, R. (2019). What we mean when we talk about suffering—and why Eric Cassell should not have the last word. *Perspectives in Biology and Medicine*, 62(1), 95-110. doi: 10.1353/pbm2019.0005
- Thomas, H., Mitchell, G., Rich, J., & Best, M. (2018). Definition of whole person care in general practice in the English language literature: A systematic review. *British Medical Journal Open*, 8(12), 1-12 doi:10.1136/bmjopen-2018-023758
- Thomson, G., Dykes, F., & Downe, S. (2011). *Qualitative research in midwifery and childbirth phenomenological approaches*. London, United Kingdom: Routledge.
- Thomson, G., Dykes, F., & Downe, S. (2012). *Qualitative Research in Midwifery and Childbirth*. Abingdon, United Kingdom: Routledge
- Toombs, S. K. (2001). *Handbook phenomenology and Medicine*. Dordrecht, The Netherlands: Kluwer Academic Publishers.
- Tudor, K., & Worrall, M. (2006). *Person-centered therapy. A clinical philosophy*. Sussex, United Kingdom: Routledge.
- Van Manen, M. (1997). *Researching lived experience: Human science for an action sensitive pedagogy*. Walnut Creek, CA: Left Coast Press.
- Van Manen, M. (2016). *Phenomenology of practice: Meaning-giving methods in phenomenological research and writing*. New York, NY: Routledge.
- Wilber, K. (1999). *The marriage of sense and soul: Integrating science and religion*. New York, NY: Broadway Books.
- Youngson, R. (2012). *Time to care: How to love your patients and your job*. Auckland, New Zealand: Rebelheart Publishers.

Appendices

Appendix A - Ethics Approval



Auckland University of Technology Ethics Committee (AUTEC)

Auckland University of Technology
D-88, Private Bag 92006, Auckland 1142, NZ
T: +64 9 921 9999 ext. 8316
E: ethics@aut.ac.nz
www.aut.ac.nz/researchethics

21 September 2018

Josie Goulding
Faculty of Health and Environmental Sciences

Dear Josie

Ethics Application: **17/166 The lived experience of a whole person mindbody healthcare encounter for Whaiora and healthcare students: a hermeneutic phenomenological study.**

On 17 July 2017 you were advised that your ethics application was approved.

I would like to remind you, that it was a condition of this approval that you submit to AUTEC the following:

- A brief annual progress report using the EA2 Research Progress Report / Amendment Form, available at <http://www.aut.ac.nz/research/researchethics/forms>, or
- A brief Completion Report about the project using the EA3 form, which is available online through <http://www.aut.ac.nz/research/researchethics/forms>. This report is to be submitted either when the approval expires on 17 July 2020 or when the project is completed;

It is also a condition of approval that AUTEC is notified if the research did not proceed or any adverse events occurring during the research. If there has been any alteration to the research, (including changes to any documents provided to participants) then AUTEC approval must be sought using the EA2 form.

To enable us to provide you with efficient service, please use the application number and study title in all correspondence with us. If you have any enquiries about this application, or anything else, please contact us at ethics@aut.ac.nz.

Yours sincerely

Kate O'Connor
Executive Secretary
Auckland University of Technology Ethics Committee

Cc: Janette Tolich; Liz Smythe

Appendix B – Verification of Māori Consultation



School of Clinical Sciences Verification of Māori Consultation

This document provides verification that the research project named below was discussed with the School of Clinical Sciences Mātauranga Māori Committee, Auckland University of Technology. Specific comments and recommendations are indicated below.

Research Title: The lived experience of a Mindbody encounter		
Researcher(s): Janette Tolich, Josie Goulding, Liz Smythe, Brian Broom		Date: 7/6/2017
Discussion Areas	Addressed	Comments/ Recommendations
Whakapapa: Relationships		
Researcher experience in field	X	C1
Consultation with local stakeholders	X	C3
Consenting process		
Clarity of data usage		
Dissemination of findings	X	
Benefits to participants	X	C3, R2
Tika: Validity of the research		
Clear purpose of project	X	C2
Relevance to Māori	X	C3,8 R1,2,3,4
Likely outcome for participants, communities, other stakeholders	X	R2
Participant recruitment methods	X	C7 R3,4,5,6
Māori involvement in project (participants, researchers, etc)	X	C3 R3,5,6
Manaakitanga: Responsibility and respect		
Participants' access to appropriate advice		
Participants treated with dignity and respect	X	
Privacy and confidentiality	X	
Whānau support	X	R6
Transparency of research process	X	
Mana tangata: Power & Authority		
Reciprocity (acknowledgements, compensation, gifts)		
Risks of participation identified		
Ownership of outcomes		
Informed consent process		

Comments

1. Janette is a clinical educator based in Akoranga Integrated Health (AIH). She has a strong drive for interprofessional practice and is interested in how to integrate this into standard health practice. The project will form her Master's thesis.
2. The goal of project is to determine the experience of students and patients who have participated in the Mindbody programme offered through AIH. The whole-person approach used in the programme may be a different experience for the students, in particular, and it would therefore be informative to gauge their views of this.
3. Janette consulted with Margaret Morice and Maria Rameka prior to setting up the Mindbody programme to ensure that it was grounded in the Te Whare Tapa Whā model of health, particularly the spiritual component. The design of the current project has also aimed to take this model into consideration. While it would be considered mainstream according to the Te Ara Tika view of research, the findings may inform other ways of practicing healthcare that are pertinent to Māori. It may also be found that Māori student practitioners enjoy working with the model as it fits with their culture and they are more able to be themselves.
4. Current patients in the programme have experienced a life-changing event and are not progressing in their recovery or not where they would like to be. The programme is advertised through the clinic database and in flyers at the clinic, so only involves current patients.
5. The students involved in the programme are interdisciplinary. The programme uses a relational approach where the students are with the patients, forming relationships during the sessions, but without performing an "intervention" as such. There is a 2:1 ratio of students:patient for the initial sessions, followed by a group session where the concept of wellness is discussed together.
6. Most of the patients have a physical presenting condition (e.g. stroke, rheumatoid arthritis, heart failure) but may have associated mental health conditions.
7. Two 6-week programmes have been run to date. The project participants will be students and patients involved in these two programmes. There will be another programme run in August and possibly another one in another location.
8. The committee asked the percentage of students and patients who were Māori and would therefore be available to participate in the project. Janette thought there may have been 1 Māori student in one of the programmes.
9. Janette clarified that both the students involved in the programme and the patients would be interviewed individually. There are likely to be 4 student and 4 patient participants.
10. It was questioned how the interviews would encompass the Te Whare Tapa Whā model if the participants were not familiar with the model or did not have a context to place it in. Janette indicated that, as part of the analysis, she would determine if the emergent themes were congruent with the model, rather than specifically referring to the model in the interview.
11. There was a suggestion of recording some of the sessions within the programme, which could provide data in addition to that obtained in the interviews. It was determined that the project methodology was not congruent with this and was more about uncovering the story in an open process.

Recommendations

1. Te Whare Tapa Whā was the most appropriate and simplest model of health to use. However, there is not necessarily a generic interpretation of the model, particularly in relation to the spiritual component. Consideration should be given to the age of the participants, as young Māori may not understand the spiritual component or interpret it the same way as older Māori.
2. The project will be beneficial in that it will determine how non-Māori students experienced using the Te Whare Tapa Whā model. This will provide an indication if it would be useful being implemented in a wider context.
3. It was questioned whether the programme could be run on the South Campus to facilitate Māori patient and student involvement in the future. Given that Māori dominate most of the conditions that present at the clinic, it would be appropriate to facilitate Māori involvement. Care must also be made regarding the project conclusions if the participants involved were not representative of people with those conditions.
4. It was questioned if the term “whaiora” was most appropriate in this context, given its strong association with mental health. This may restrict participation if people are put off by the term.
5. It was suggested the term “kaiaarahia”, which translates as going along the same path with a guide/mentor/navigator, could be used to describe the students involved in the study.
6. Currently, recruitment is planned on a first-come-first served basis. The committee recommends using purposive sampling instead. Of the 4 student and patient participants, it was recommended that at least one of each identify as Māori. This will ensure that sampling can more purposefully capture a diversity of rich perspectives relevant to the research question as well as reflect the context in which the approach is being used.
7. If Māori patients or students are being interviewed, it was suggested that whānau or another Māori who can speak Te Reo is present as it may help with interpretation, explanation or clarification of terms.

Feedback on these comments and recommendations is to be provided by: 10/6/2018

Signature:



Date: 14/06/17

Gwyn Lewis, Representative, Mātauranga Māori Committee

Appendix C – Participant Information Sheet



Participant Information Sheet-Appendix C

Sheet provided for students from the Interprofessional living well programme at AUT university

Date Information Sheet Produced:

12/6/ 2017

Project Title

The lived experience of a mindbody encounter through the Interprofessional living Well Programme (IPLWP)

A post-programme study

An invitation to students

Kia ora my name is Janette Tolich and I am a clinical educator at AUT in physiotherapy for Breathing & Living at the Akoranga Integrated Health Clinic (AIH), AUT University. I invite you to assist me in studying your experience whilst you were a student in the Interprofessional living well programme (IPLW) at AIH.

By studying your experience I hope to understand what it is like for both students and Whaiora to be part of whole person approach to healthcare.

I have been instrumental in setting up the IPLW and am one of the clinical educators supervising students and caring for Whaiora in this programme at AIH.

The invitation to this study is happening after the programme has been completed so there is a clear separation between your experience in the programme and your participation in the study. This is to ensure your experience in the programme is not impacted adversely by this research.

My hope is that this study will also enable more discussion and discourse about these approaches with healthcare education colleagues and further enhance the teaching of our AUT healthcare students whilst improving care for Whaiora.

Your participation in this post programme study will assist me in completing my thesis towards a Masters in Health Science in Mindbody Healthcare.

What is the purpose of this research?

In gaining a greater understanding of this unique healthcare encounter, and uncovering the experience of students, my hope is that it will reveal what this approach does to the therapeutic relationship and the healing journey and the effect on students who are invited to work in this way.

This could inform future healthcare practice by encouraging and allowing this whole person experience within the clinical encounter to become visible and understood. It in turn could also lead to the whole person mind body approach being more accessible to future health care practitioners.

How was I identified and why am I being invited to participate in this research?

You are receiving this information sheet about this post programme study and are being invited to participate as you were either a student or Whaiora in the Living Well Programme at Akoranga Integrated Health. If you wish to participate you will be included on a first come first served basis.

How do I agree to participate in this research?

If you wish to participate in this study you are welcome to contact me directly using my details below.

I have also attached a consent form for you to complete and return to the receptionist at what was Akoranga Integrated Health and is now called

AUT Integrated Health at Northmed, 3 Akoranga Drive, Northcote.

You can either personally hand the consent form to Jane Galle at AUT Integrated Health reception

OR use the self-addressed envelope to return this to Jane Galle.

I will then arrange an interview at your convenience, most likely in the coming few months.

Your participation in this research is *entirely voluntary* (it is your choice) and whether or not you choose to participate will neither advantage nor disadvantage you. You are able to withdraw from the study at any time. If you choose to withdraw from the study, then you will be offered the choice between having your data removed OR allowing it to continue to be used. However, once the findings have been produced, removal of your data will not be possible.

What will happen in this research?

I will arrange an interview at the AUT Integrated Health Clinic at a time that is convenient to you. This interview will ask you about your experience in the living well programme. You are welcome to bring a support person or whanau to this. It will take approximately 1 hour. You may be asked to return for a further interview to expand on your ideas but this will be totally at your own discretion. The interview will be audio taped and it will then be transcribed (written down word for word). Once all the interviews are conducted I will reflect on the shared information and stories and write about them in the thesis. At this point any personally identifying information will be removed.

What are the discomforts and risks?

I do not expect the interview to cause you discomfort or risk to your physical health but you may feel other discomforts as you will be sharing your experiences and feelings, along with your own deeply held beliefs about healthcare.

How will these discomforts and risks be alleviated?

If over the course of the interview you feel uncomfortable in any way you are allowed to stop participating at your request and no questions will be asked. If you experience any discomfort at all or have ongoing feelings of discomfort or uncertainty in any regard after the interviews you are entitled to have free access to our health and counselling service at AUT. I am able to organise this for you through our receptionist, see the details below

AUT Health Counselling and Wellbeing is able to offer three free sessions of confidential counselling support for adult participants in an AUT research project. These sessions are only available for issues that have arisen directly as a result of participation in the research, and are not for other general counselling needs. To access these services, you will need to:

- drop into our centres at WB219 or AS104 or phone 921 9992 City Campus or 921 9998 North Shore campus to make an appointment. Appointments for South Campus can be made by calling 921 9992
- let the receptionist know that you are a research participant, and provide the title of my research and my name and contact details as given in this Information Sheet

You can find out more information about AUT counsellors and counselling on <http://www.aut.ac.nz/being-a-student/current-postgraduates/your-health-and-wellbeing/counselling>.

If you feel that participating in this post programme study could compromise your ongoing study you are welcome to decline this offer to participate at any time before or during the study.

What are the benefits?

You may personally benefit by participating in this research as it may allow time for a one on one reflection of your experience of health care for yourself and others. It may also assist your future learning as it may extend your own perceptions and individual practice initiatives.

The benefits I may gain from this view of how students are experiencing this whole person mind body approach may assist decisions with regard to the adoption of this approach and its benefits across wider health care delivery. It may also help me to gain an idea about the satisfaction gained from creating space for this relationship in healthcare. Additionally it could provide a working model or framework which may encourage clinical educators to be more confident in delivering whole person healthcare education.

It will also allow me to complete my Master's Thesis in Mindbody Healthcare and possibly obtain a PhD qualification.

How will my privacy be protected?

Your privacy and confidentiality will be protected during the course of this study. Any information you disclose at the interview will be held safely in written and digital form in the AIH electronic system which is locked and confidential. It will also be stored on my own personal digital hard drive. Your name will not appear on any transcribed documents (written) and your information not shared verbally in any other context than the final written thesis.

What are the costs of participating in this research?

The cost anticipated to you will include time and travel expenses. A small Koha will be offered as a thank you in recognition of this expense.

The organisation and conducting of the interviews is anticipated overall to take about 1 and half hours, plus additional travel time.

What opportunity do I have to consider this invitation?

I would really appreciate it if you take some time to consider this invitation to participate in this study and return the signed consent as you wish within 2 weeks if possible to the AIH receptionist.

Will I receive feedback on the results of this research?

I would like to provide you with feedback about the project when it is completed. I will provide you with an online link to my thesis which will be held at the AUT library. I will also provide you with a short written summary of the findings of the project which I will send to you by post.

What do I do if I have concerns about this research?

Any concerns regarding the nature of this project should be notified in the first instance to the Project Supervisor, Josue Goulding

Jgoulding@aut.ac.nz

Concerns regarding the conduct of the research should be notified to the Executive Secretary of AUTEK, Kate O'Connor, ethics@aut.ac.nz, 921 9999 ext 6038.

Whom do I contact for further information about this research?

Please keep this Information Sheet and a copy of the Consent Form for your future reference. You are also able to contact the research team as follows:

Researcher Contact Details:

Janette Tolich Clinical Educator Physiotherapy Breathing and Living clinic

AUT Integrated Health Phone 09 921-9155 Jtolich@aut.ac.nz

Project Supervisor Contact Details: Josie Goulding

Jgoulding@aut.ac.nz Work Phone 09 921 9999

Approved by the Auckland University of Technology Ethics Committee on *type the date final ethics approval was granted*, AUTEK Reference number *type the reference number*.

Participant Information Sheet-Appendix D

Sheet provided for whaiora (those seeking wellness) from the Interprofessional living well programme at AUT university

Date Information Sheet Produced:

21/2/2017

Project Title

The lived experience of a mindbody encounter through the Interprofessional living Well Programme (IPLWP)

A post-programme study

An invitation to Whaiora (person seeking wellness)

Kia ora, my name is Janette Tolich and I am a clinical educator at AUT in physiotherapy for Breathing & Living at the Akoranga Integrated Health Clinic (AIH), AUT University. I invite you to assist me in studying your experience whilst you were a Whaiora working with healthcare students in the Interprofessional living well programme (IPLW) at AIH.

By studying this experience I hope to understand what it is like for both Whaiora and students to be part of a whole person approach to healthcare.

I have been instrumental in setting up the IPLW and am one of the clinical educators supervising students and caring for Whaiora in this programme at AIH.

The invitation to this study is happening after the programme has been completed so there is a clear separation between your experience in the programme and your participation in this study. This is to ensure that your experience in the programme is not impacted adversely by this research.

Your participation in this post programme study will assist me in completing my thesis towards a Masters in Mindbody Healthcare Practice. This in turn will enable discussion and discourse about these approaches within healthcare and I hope it will further enhance the teaching of AUT healthcare students and improve care for Whaiora.

What is the purpose of this research?

The purpose of the research is to gain a greater understanding of this unique healthcare encounter. In particular the experience of Whaiora and students in the IPLWP. My hope is that it will reveal the therapeutic relationship and the healing journey during the IPLWP.

This could inform future healthcare practice by encouraging and allowing this whole person approach within the clinical encounter to become visible and understood. It in turn could also lead to the whole person mind body approach being more accessible to future health care practitioners.

How was I identified and why am I being invited to participate in this research?

You are receiving this information sheet about this post programme study and are being invited to participate as you were either a student or Whaiora in the Living Well Programme at Akoranga Integrated Health. If you wish to participate you will be included on a first come first served basis.

How do I agree to participate in this research?

If you wish to participate in this study you are welcome to contact me directly using my details below.

I have also attached a consent form for you to complete and return to the receptionist at what was Akoranga Integrated Health and is now called

AUT Integrated Health at Northmed, 3 Akoranga Drive, Northcote.

You can either personally hand the consent form to Jane Galle at AUT Integrated Health reception

OR use the self-addressed envelope to return this to Jane Galle.

I will then arrange an interview at your convenience, most likely in the coming few months.

Your participation in this research is *entirely voluntary* (it is your choice) and whether or not you choose to participate will neither advantage nor disadvantage you. You are able to withdraw from the study at any time. If you choose to withdraw from the study, then you will be offered the choice between having any data that is identifiable as belonging to you removed or allowing it to continue to be used. However, once the findings have been produced, removal of your data may not be possible.

What will happen in this research?

I will ask you to come to an interview at the new AUT Integrated clinic at a time that is convenient to you. You are welcome to bring a support person or whanau to this. This interview will ask you about your experience in the living well programme in a relaxed unstructured way. It will take approximately 1 hour. You may be asked to return for a further interview to expand on your ideas but this will be totally at your own discretion. The interview will be audio taped and it will then be transcribed (written down word for word). Once all the interviews are conducted I will reflect on the shared information and stories and write about them in the thesis. At this point any personally identifying information will be removed.

What are the discomforts and risks?

I do not expect the interview to cause you discomfort or risk to your physical health but you may feel other discomforts with regards to your general wellbeing or possible uncertainties with regards to your future care or study.

How will these discomforts and risks be alleviated?

If over the course of the interview you feel uncomfortable in any way you are allowed to stop participating at your request and no questions will be asked. If you experience any discomfort at all or have ongoing feelings of discomfort or uncertainty in any regard after the interviews you are entitled to have free access to our health and counselling service at AUT. We can organise this for you through our receptionist, see the details below

AUT Health Counselling and Wellbeing is able to offer three free sessions of confidential counselling support for adult participants in an AUT research project. These sessions are only available for issues that have arisen directly as a result of participation in the research, and are not for other general counselling needs. To access these services, you will need to:

- drop into our centres at WB219 or AS104 or phone 921 9992 City Campus or 921 9998 North Shore campus to make an appointment. Appointments for South Campus can be made by calling 921 9992
- let the receptionist know that you are a research participant, and provide the title of my research and my name and contact details as given in this Information Sheet

You can find out more information about AUT counsellors and counselling on <http://www.aut.ac.nz/being-a-student/current-postgraduates/your-health-and-wellbeing/counselling>.

In order to mitigate a possible conflict of interests with regard to your study or your care at AIH I will be asking for your participation after the programme is completed.

if you feel that participating in this post programme study could compromise your ongoing care at AIH you are welcome to decline this offer to participate at any time before or during the study.

What are the benefits?

You may personally benefit by participating in this research as it may allow time for a one on one reflection of your experience of health care for yourself and others.

The benefits I may gain from this view of how those seeking wellness experience this whole person mind body approach may help with decisions on the adoption of this approach across wider health care. It may also help to gain an idea about the satisfaction from focussing on this relationship in healthcare. It may also provide a working model or framework which may encourage clinical educators to be more confident in delivering whole person healthcare education.

It will also allow me to complete my Master's Thesis in Mindbody Healthcare and possibly obtain a PhD qualification.

How will my privacy be protected?

Your privacy and confidentiality will be protected during the course of this study. Any information you disclose at the interview will be held safely in written and digital form in the AIH electronic system which is locked and confidential. It will also be stored on my own personal digital hard drive that will be password protected. Your name will not appear on any transcribed documents (written) and your information will not be shared verbally in any other context than the final written thesis where any personally identifying information will be removed.

What are the costs of participating in this research?

The cost anticipated to you will include time and travel expenses. A small Koha will be offered as a thankyou in recognition of this expense.

The organisation and conducting of the interviews is anticipated overall to take about 1and half hours, plus additional travel time.

What opportunity do I have to consider this invitation?

I would really appreciate it if you take some time to consider this invitation to participate in this study and return the signed consent form as you wish within 2 weeks if possible to the AUT integrated health receptionist.

Will I receive feedback on the results of this research?

I would like to provide you with feedback about the project when it is completed. I will provide you with an online link to my thesis which will be held at the AUT library. I will also provide you with a short written summary of the findings of the project which I will send to you by post.

What do I do if I have concerns about this research?

Any concerns regarding the nature of this project should be notified in the first instance to the Project Supervisor, Josue Goulding

Jgoulding@aut.ac.nz

Concerns regarding the conduct of the research should be notified to the Executive Secretary of ATEC, Kate O'Connor, ethics@aut.ac.nz , 921 9999 ext 6038.

Whom do I contact for further information about this research?

Please keep this Information Sheet and a copy of the Consent Form for your future reference. You are also able to contact the research team as follows:

Researcher Contact Details:

Janette Tolich Clinical Educator Physiotherapy Breathing and Living clinic

AUT integrated health clinic Work Phone 09 921-9155

Jtolich@aut.ac.nz

Project Supervisor Contact Details: Josie Goulding

Jgoulding@aut.ac.nz Work Phone 09 921 9999

Approved by the Auckland University of Technology Ethics Committee on *type the date final ethics approval was granted*, ATEC Reference number *type the reference number*.

Appendix D – Consent Form



Consent Form-

For use when interviews are involved.

Project title: **The lived experience of a mindbody encounter**

Project Supervisor: **Josie Goulding**

Researcher: **Janette Tolich**

- ☐ I have read and understood the information provided about this research project in the Information Sheet dated 23/05/2017.
- ☐ I have had an opportunity to ask questions and to have them answered.
- ☐ I understand that notes will be taken during the interviews and that they will also be audio-taped and transcribed.
- ☐ I understand that taking part in this study is voluntary (my choice) and that I may withdraw from the study at any time without being disadvantaged in any way.
- ☐ I understand that if I withdraw from the study then I will be offered the choice between having any data that is identifiable as belonging to me removed or allowing it to continue to be used. However, once the findings have been produced, removal of my data may not be possible.
- ☐ I agree to take part in this research.
- ☐ I wish to receive a summary of the research findings (please tick one): Yes ☐ No ☐

Participant's signature:

Participant's name:

Participant's Contact Details (if appropriate):

.....

Date:

Approved by the Auckland University of Technology Ethics Committee on 17th JULY 2017 AUTEK 17166-15062017

Note: The Participant should retain a copy of this form.

Appendix E – Indicative Question Guide

Appendix B

Indicative Question Guide

Semi –structured interview questions

Since you were a participant in the living well programmes, would you be able to tell me (or share with me) ‘what is was like for you”

OR

I am curious to hear how you experienced the wpmbe?

What do you think was the essence of your encounter?

What was your experience? If you were to reflect on the ‘nature’ and maybe impact of the encounter / how would you describe this?

OR/AND

Was there anything in particular that stood out for you as whaiora or student?

What did you experience in the wpmbe?

What did you experience over the 5 weeks and ongoing?

How would you describe the nature of your experience/

Is there anything that captivated you? Had an impact on you? Positively or negatively?

What words or emotions or stories would you use to describe the experience?

How did you experience the encounter?

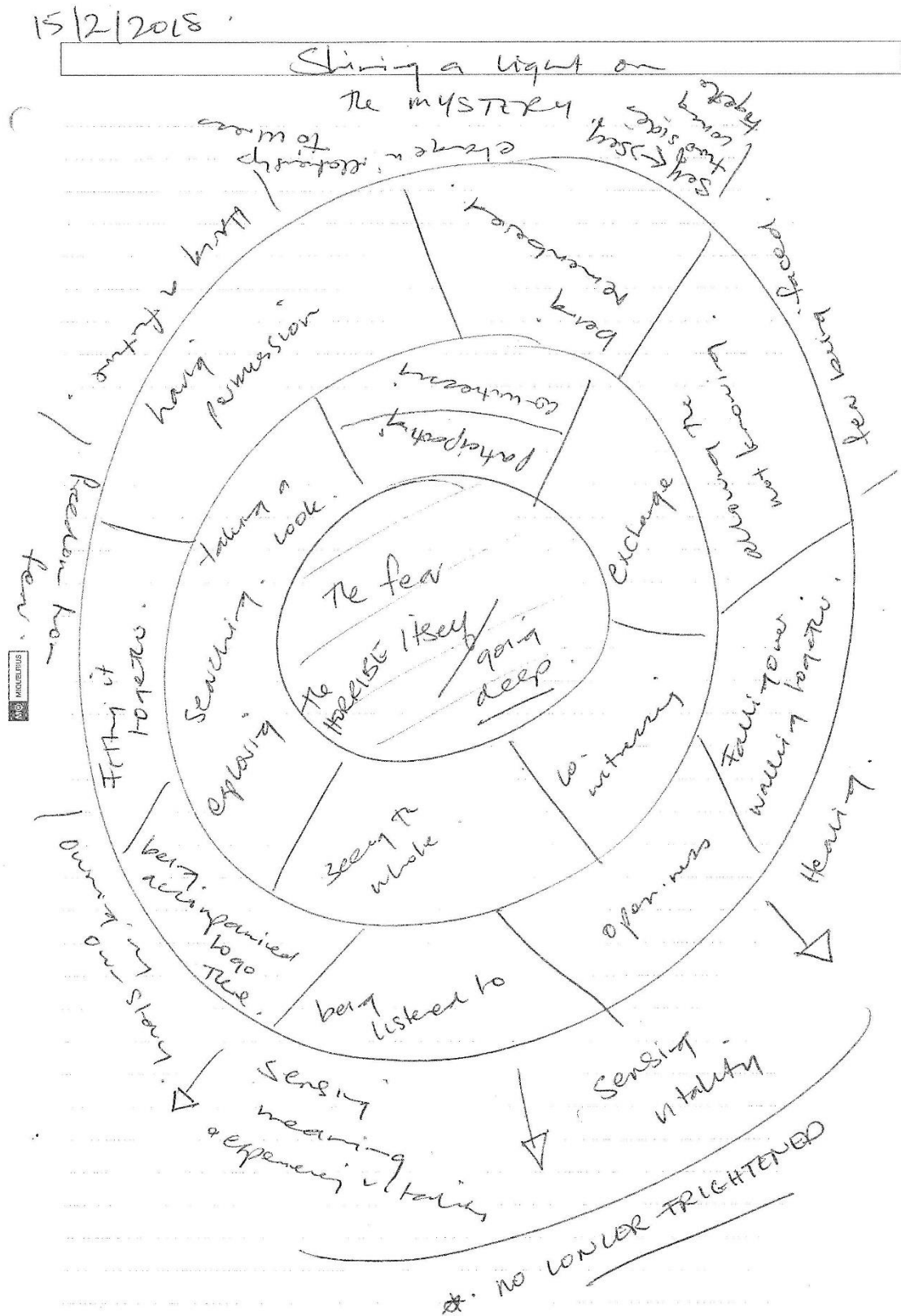
Could you elaborate?

What was the most powerful experience?

What as the most difficult experience?

What was the overall experience?

Appendix F – Working Diagram



Appendix G – Hermeneutic Analysis

overall impressions ①	
2/11/2017	
Interview 1.	
<ul style="list-style-type: none"> • felt. • heard. (really heard). • embraced. • being brought to light 	<ul style="list-style-type: none"> felt something felt like a human being. felt included felt like a member (belonging) felt some belonging felt a sense of agency felt a sense of relating felt allowed to be (in the room)
as opposed to objectified ;	
	(analysed)
being able	able to speak
to co-witness a lived experience	participate
(the students) able to be	

(2)

What is
was like P13.

"It touched them"

(more than expected)

It was a more than
expected
experience

"It touched me"

"Still feeling the feeling"

- touching something intangible

embracing
intangibles

It was like the birth of something

The intent of
the class

experience of
feet ^{being} cradled.

: being allowed
being allowed to be

* *

like all of me could be at that room.

It felt like there was more space, possibility

③

p. 5.

(It was like a feeling

I can change my relationship to

a feeling
of change.

my body, my prognosis

what is happening to me.

(It was a multifaceted feeling.

feeling scared

but

choosing to put

both feet in.

most of all "I remember how I felt".

(Feeling of 'carrying' the trepidation

a feeling of is it safe to bring all of me.

is it safe to be vulnerable?

" The joy of feeling it's ok to be

with the trepidation

• vulnerability

note bring all of me

which is so much a

part of my being."

4.

a feeling of. Something about truth

it was authentic

a feeling of speaking the truth — and the truth
being in the room.

a feeling of being glad that I

stepped through the
fear.

a feeling of being much more than
I anticipated

The experience gave me

was a feeling of being — transformed

— given hope
— appeared ability to
connect

Pg 10.

a feeling of the connection being valued.

an experience of a different ability to connect
framing of the space.

Feeling much safer and more powerful
... when I know they can encompass
space for the interview

5

When I speak about feeling a low sort of
is + relevant

"I am almost (now) taking up some
space even when I am not allowed —

It was an experience of realisation

(well he realised how much I was being
"not disabled"

It was an experience of Surrender
to reality.

relaxing

• letting that be

1913

agency

being able to speak the truth,

being with something that was new

"walking alongside in newness"

6

It was an experience of "seeing the changes"

feeling of future working.

How could this be brought into
practice.

a feeling of it making a difference

7.

①

The lived experience of a moment

as expressed by a woman,

compared to overall experience of ^(pointed to) an experience of
being felt; it was, feeling something,

feeling like a human being, feeling a

sense of belonging, ^{feeling} a sense of

agency, and a fast sense of

relating and being allowed.

It was also an overall ^{experience} feeling of
being able ^{along with being} (rather than possibly
dis-abled); whilst ^{also} co-witnessing

a lived experience with the other,
being able to speak, & participate

It was also a "more than expected
experience", which had the

effect of touching ^{of} being embraced.

8

②

and also embracing. (intangibles),
 of being cradled and
 also of a sense of newness and
 giving birth. ~~It was a novel experience~~
 being.

"It was like the birth of something"
 of being allowed & being allowed
 when "there isn't any expectation" to be.

"like all of me could be in the
 with more space & more room"
 possibility.

"being able to allow what happens to happen"

It was a feeling of changing
 in relationship to [with my
 body, my prognosis.

It was a multi-faceted feeling.

It encompassed being afraid
 a "feeling of coming to
 reproduction"

9

3

"a feeling of is it safe to
bring all of me?"

"The joy of feeling its ok to be
with the expectation when is
so much a part of my being".

It had a sense that it was
something about, truth, & the
authentic speaking of the truth.

"The truth being in the room"
It was also something that was new "like walking alongside
was new-ness."

It had a feeling of being much

more than I anticipated, a more than
expected feeling.

It was an experience of the space
being framed,

a space of feeling

"much safer with professionals
when I know they can encompass
space for Reintegrating"

It was a feeling of the space itself
allowing - "I am almost, (now) taking

10

up some space even when \textcircled{I} am
not allowed!!

It was an experience of relaxation,
made me realize how much I was
being "not disabled".

Overall it was an experience of Surrender
to reality, relaxing & letting it be.

an experience of the two sides of me —
— it was a multi-faceted experience
& an experience of "seeing the changes"
and future wondering.