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ESSAY/PERSONAL REFLECTIONS

Psycho-oncology: Searching for practical wisdom?

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ABSTRACT

The debate is vigorous in psycho-oncology about whether *spiritual*, *existential*, and *psychosocial* are the most comprehensive terms for academic research discourses investigating meaning and purpose. A call-to-action email from the International Society of Psycho-Oncology included the term *soul*. The current essay highlights the historical and contemporary uses of "soul" to suggest that the re-emergent *soul* signifies a tacit quest for an "intangible" that seems missing in current constructs of clinical domains reflected in the vigor of the debates. It is suggested that the re-emergence of the pre-Medieval meaning(s) of the notion of *soul* affirms a growing need for integrative paradigms on "being human" to guide psycho-oncology practitioners and their research. As a paradigmatic example, a clinical support group entitled *Soul Medicine* is described as employing the term *soul* to open up the more marginal discourses about experiences of illness arising from philosophical reflection, arts, humanities, and spirituality within a clinical oncology context. A link between *soul* and *wisdom* is suggested for further exploration with the view that *phronesis* ("the virtue of practical wisdom"), an emerging concept in health professional education research, is of ultimate value to the people psycho-oncology seeks to serve. This group holds that garnering wisdom from the expertise of those living with cancer should be a central aim of our field.

INTRODUCTION

In a 2006 letter to the editor of *Psycho-Oncology*, Pär Salander asked us to reflect on whether "spirituality" is a meaningful concept in the psycho-oncological discourse. He also argued that existential discourses are more appropriate for discussing how meaning and purpose are experienced in the psycho-oncological context (Salander, 2006, p. 648). In a letter to the same journal, Brennan (2006) expressed concern about conflations of the concepts *spirituality* and *existential*. Salander (2014) subsequently asserted that the question of whether spirituality is a meaningful concept remains open. These letters, as well as other conceptual and perspective articles (Breitbart, 2002; 2009; Lazenby, 2010), have contributed to the rigorous academic debate about the meaning, definition, and potential conflation of such terms as "existential," "spiritual," and "psychosocial," as well as appeals for inclusion of "spirituality" in healthcare as an integral dimension of human life, especially pertinent during illness (Puchalski et al., 2014). Wein's (2014) recent letter responding to Salander's challenge ("Spirituality: Psyche or Soul?") added the term "soul" to the mix. "Soul" also appeared in a May 14, 2014 email from the International Psycho-Oncology Society (IPOS) with the appeal to "help us put ***body*** and ***soul*** at the heart of cancer care."

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

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

A SEARCH FOR "PRACTICAL WISDOM"?

Until such a new paradigm and language truly emerge, a potential guiding principle for psycho-oncology's investigations into "what helps?" when living with the impact of cancer could be drawn from recent research on Aristotle's notion of phronesis, or "the virtue of practical wisdom," in practitioner and research practices (Kinsella, 2006; 2012*a*; 2012*b*; Polkinghorne, 2004). Kinsella (2012*b*) suggested that phronesis "emphasizes reflection (both deliberative and that revealed through action) as a means to inform wise action, to assist one to navigate the variable contexts of practice, and as directed toward the end of practical wisdom" (p. 35). Are patients perhaps best served by researchers and clinicians working together to elicit such practical wisdom from the crucial experts, who are those living with the impact of cancer, rather than debating about which conceptual spaces have been occupied by which academic research disciplines (Salander, 2014, p. 1)?

IS PSYCHO-ONCOLOGY ON A "SOUL QUEST"?

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

With cancer rates on the rise (Statistics Canada, 2014) and its impact touching us all deeply, both professionally and personally, a new psychology healing the Cartesian split of mind and body becomes deeply compelling. Engaging in this uncomfortable interaction might well be our crucial contemporary challenge. Indeed, a bio-psycho-spiritual model of care has been explicitly suggested (Sulmasy, 2002). Yet, this model, as well as the term, is a building-block approach to the separated parts of biomedicine and the psychiatric/psychological/spiritual domains. So far, this proposed concept has not generated the necessary paradigm shift and ensuing conceptual transformation for a truly integrative approach within oncology. In clinical teams, these "parts" still tend to remain separated into clinical disciplines, each with their own specialized discourses with varying domains of power and influence within the medical institutions where oncology is practiced.

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

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

Broyard exemplifies in this quote how soul, as a term, is functioning as a subtle courier for the intangible dimensions of human life and experiences of illness.

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He is describing a "soul loss" as an aspect of the cancer experience that clinical interventions still seem unable to reach.

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

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

SOUL MEDICINE: A PARADIGMATIC EXAMPLE ILLUMINATING "WISDOM-IN-ACTION"

Commencing in 2009, some 10 support groups with an explicit focus on eliciting individuals' personal and practical wisdom on "What helps me to live with this cancer in daily life?" have been facilitated deliberately utilizing this term—*soul*. The groups have been given the name *Soul Medicine*, and they explore what "medicines" for this intangible dimension—*soul*—might mean in the daily lives of participants. Each group runs in 1.5-hour sessions for six weeks. *Soul* is engaged using Hillman's later articulation of its meaning(s) (Moore, 1989):

> First, *soul* refers to the *deepening* of events into experiences; second, the significance *soul* makes possible, whether in life or in religious concern, derives from its *special relation with death*. And third, by *soul* I mean the imaginative possibility in our natures, the experiencing through reflective speculation, dream, image, and *fantasy*—that mode which recognizes all realities as primarily symbolic or metaphorical. (p. 21)

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

The benefits perceived by the participants in the first six groups were presented at two international conferences (Battler, 2010; 2011). Doctoral research began in 2013 focusing on the notion of phronesis: practical and embodied wisdom gleaned through the group process exploring "soul medicine(s)" in day-to-day life. Hermeneutic phenomenology is the chosen methodology due to its focus on illuminating

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intangibles within lived experiences (Finlay, 2011). Participants are encouraged to be their own investigators seeking lived experiences, rather than conceptual definitions, that best source a sense of hope, peace, balance, strength, and connectedness in the day-to-day, as well as discover their uniquely personal meanings for these concepts. The groups also provide a means to give voice, if needed, in story, art, and tears, to the painful feelings of despair and hopelessness, and the struggle for meaning in life. Expressions of lament or mourning are given equal value as "soul medicines," as well as silence and wordlessness, lest a subtle "tyranny of positive thinking" (Holland & Lewis, 2000) and pressure for verbal forms of expression forms tacitly. The group sessions provide a place to return and share stories of their findings gleaned from day-to-day life. Group sharing may or may not include discussions on spiritual matters or beliefs; rather, it is driven by *stories* as sources of wisdom and therapeutic healing of distress (Frank, 1995; Mehl-Madrona, 2007) from living with cancer. Each participant, through the telling of their discovered "soul medicines," contributes to an imaginative "wisdom epistemology" of word and image about "what helps in the day-to-day," gathered cumulatively throughout the six weeks.

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

Inner Wisdom as "Navigator" or Compass

Smythe et. al. (2008) once suggested that "techne [know-how] that predefines a 'way' has silenced lived phronesis, the wisdom-in-action that knows in the moment and finds the way day-to-day" (p. 1390). "Use your inner wisdom" was highlighted in Back and colleagues' (2014) research as a statement and concept highly valued by patients at crucial points in their illness trajectory. From women living with the acute uncertainty provoked by an ovarian cancer diagnosis, the current research aims to elicit such inner wisdom. Most specifically, it aims to investigate in their lived experience(s) how *phronesis*, the virtue of practical wisdom, *functions* in their daily lives as an inner navigator for living in the here-and-now, as Vos (2014) recently discussed within his philosophical framework for meaning and existential givens in psycho-oncology (pp. 9–10).

CONCLUSION

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

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CONFLICTS OF INTEREST

The author states that she has no conflicts of interest to divulge.

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