From Anaesthetic to Aesthetic in the Clinic

An Arts, Practice-Based Inquiry into Everyday Aesthetic Experience for Healthcare Practitioners.

Document I - Written section of Thesis

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Contents for Document I - Written thesis

Contents for Document II - Portfolio of practice

The portfolio of practice (PoP) is presented in the second document and is collated from the following sections that accompany each chapter as numbered respectively:

Acknowledgments

I am deeply grateful for the supervision and experience of working with my two supervisors, for inspiration and dialogues about imaginal thought with Emerita Professor Shelley Sacks in the field of Social Sculpture and for guidance, patience and knowledge from Professor Ray Lee, Sonic Art and Postgraduate Tutor. In addition, for the support from my Special Advisor, Emeritus Professor of Psychiatry and Philosophy, Bill Fulford and the opportunities he has introduced me to. It has been a privilege and a rare and special opportunity to work and think with them and link different modes of thought to explore areas of medicine outside the objective evidence base and create a new way of working called 'Connective Aesthetics in Medicine.'

I am thankful to participants in the research practices from both fields of the arts and healthcare who so generously and enthusiastically gave their time, heartfelt comments and valuable feedback whilst engaging in the practice-based processes I have designed and to all those who have attended presentations with interest and feedback during the development of this PhD. I extend my thanks to my online PhD academic writing group who have been a source of great support through solitary hours in lockdown and to my family and partner for endless patience and listening whilst I have engaged in this project alongside my clinical work. I am thankful to those who have read drafts and helped with IT.

From all the above, I value their comments about human connections that maybe so easily suppressed yet are deeply felt, central to humanity and at the heart of healthcare practice.

My father, a transplant surgeon who died just before my PhD submission, also believed that the humanities were crucial in broadening the knowledge of medical practitioners. I wish I could have told him this PhD was finally complete.

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Abstract

Medical practice is replete with emotive images and processes in everyday small interactions as well as issues of life and death. Practitioners can be moved in aesthetic ways. The capacity for, and attention to, personal lived aesthetic experience is easily suppressed in clinical practice where the objective evidence base has primacy. Aesthetic experience has been linked with values in different contemporary fields and could thus be important in healthcare.

In this research, 'aesthetic' refers to sensory perception and the imaginative dimension. 'Aesthetic experience' relates to the latter including emotions, the tacit, haptic, pre-reflective and the embodied. To articulate this rich internal complexity, an arts and practice-based approach was employed that was inspired by connective practices from the field of Social Sculpture.

The research aims were to explore and describe the nature of a type of aesthetic experience relevant to the everyday work of health care practitioners; to develop and design new participatory processes that activate this for them to observe, describe and reflect on and to evaluate the success of the emergent methodology and design.

The background experience of the researcher in both clinical medical and arts-based practice was combined with aspects of practice and theory from other relevant disciplines to create an emergent methodology that was a hybrid of methods synthesised in new practice-based ways. Experience arising directly from practice retained primacy in this research.

Practice-based methods were initially developed to explore and describe aesthetic experience in non-clinical settings and then related to clinical examples. The research was then expanded to scoping and pilot studies with participants who were healthcare practitioners, workers in allied fields and postgraduate artists. For these, new experiential processes were designed and tested to activate aesthetic experience in relation to the everyday clinical work of health carers. Participatory immersion aimed to allow participants to explore and describe experience at the time. Ultimately a series of six contemplative experiential participatory processes was finally developed for groups of healthcare workers. Poetic interventions were incorporated to draw attention to sensory and imaginative details of aesthetic experience during participation. Methods of documentation and analysis were designed and developed from first-person reflective practice and participant feedback as the research progressed.

A resulting description of aesthetic experience relevant to the everyday work of healthcare practitioners was built and found to be rich in multisensory detail that gave rise to expansive imaginative detail. The latter contained a complexity of components and had the potential for connecting with deeper insights, wider issues and values relating to humane health care. A prototype for a teaching model was given.

Practice was an integral part of the research and a portfolio of practice made transparent the details of creative design and evidenced the findings as the research progressed. Whilst these offered a representation, the depth of experience came from participation in the processes themselves.

Aesthetic experience in the clinic has not been described in this way before. The emergent methodology called 'Connective Aesthetics in Medicine' extends traditional qualitative ways of knowing by awakening awareness to aesthetic experience during participatory practice. This contributes to: connective aesthetic practices in the field of Social Sculpture, incorporating aspects of human connection with self, other

and the environment related to clinic work; the field of Contemporary Aesthetics by describing everyday aesthetic experience of sensing and the arising imaginative dimension in the clinic from empirical findings; offers a simple practical adaptation of aesthetics from models for aesthetic appreciation of nature and landscape; adds to the field of aesthetics in mental health and wellbeing within contemporary aesthetics; extends Values-based practice in healthcare offering participatory processes for reflection on values in caregiving and contributes a new application to Abraham's framework of the functions of the imagination. In the latter, participant feedback in this study demonstrated different components of the imaginative dimension. Drawing these out during reflective inquiry demonstrated the potential of expansive imagination and divergent thinking to bring deeper insights and creative possibilities. This suggests that rather than suppression, awareness and appropriate reflection on aesthetic experience could be a resource. This research also contributed to the field of arts-based research extending into healthcare. It also offered an example of online working in experiential connective processes.

Introduction and chapter summaries

The aim of this research was to explore and describe the nature of a type of aesthetic experience that is relevant to the everyday work of health carers; to develop and design new participatory processes that activate this for them to use as an enhanced reflective tool and to evaluate the success of the emergent methodology and design.

Healthcare practitioners can be moved and respond in aesthetic ways. However, there is a risk that bureaucracy, technology, heavy workloads and the positivistic objective evidence base may leave little space for noticing the subjective, aesthetic dimension in care. Yet, the latter could offer a valuable resource for enhancing quality and connectivity in the human encounter alongside objective knowledge.

In this research, the definition of 'aesthetic' is taken from its Greek origin and refers to sensory perception and the imaginative dimension. 'Aesthetic experience' relates to the latter including emotions, felt sense, the tacit, haptic, the pre-reflective and the embodied. To articulate this rich internal complexity, an innovative arts and practice-based methodology was developed in which new participatory processes were designed for healthcare workers. Poetic strategies were incorporated to activate awareness of multisensorial detail and stir the imagination of aesthetic experience so that participants could explore this directly. Reflection in and on experience revealed deeper insights and links with practice beyond the processes themselves.

The arts-based research was inspired by the connective practice approach from the field of Social Sculpture. Aspects from other fields where subjective experience was at the core were also combined and synthesised into new practices and grounded in the researcher's practice-based experience in the arts and medicine.

Chapters one to seven in document I form the written section of the thesis and include the reflective commentary. The Portfolio of Practice forms document II where practice-based evidence accompanying these chapters is given respectively. The contents of both documents are entwined and the reader is guided in the text when to turn to the respective portfolio section. Document III shows slides from the presentation given to participants and the examiners.

Document I

Chapter One - Research background and context.

The starting point for this research was a recurrent type of aesthetic experience that I have had throughout 40 years of medical practice and wished to investigate. A background of substantial experience in clinical work and arts-based practice provided appropriate theoretical sensitivity for combining these and drawing on aspects of other relevant fields to explore aesthetic experience in the clinical setting. Whilst taking a practice-first approach, the following five main areas of existing practice and theory that resonate with the core concept of aesthetic experience were drawn upon and discussed in this chapter: (1) connective aesthetics and the 'connective practice approach' in the contemporary field of Social Sculpture; (2) Goethean observation, a phenomenological approach; (3)Mindfulness-informed practice; (4) Contemporary aesthetics including aspects of environmental aesthetics and (5) the role of the imagination. All of these include the importance of awareness of subjective experience at their core. Other areas mentioned throughout the thesis are (i) reflective practice as

inquiry including experiential learning and (ii)Values-Based practice in healthcare. Brief reference is made to the expanding field of Arts in Health.

Chapter Two - Early practice-based work and initial description of aesthetic experience: 'Experiments in Close Noticing'

This chapter describes initial arts-based experiments used for observing aesthetic experience arising in a series of small actions in non-clinical settings. Using innovative first-person approaches called 'experiments in close noticing,' examples are given with reflection on practice. An early description of aesthetic experience to be explored in this study is given. These starting points raise initial research questions about how to investigate the nature of aesthetic experience by paying close attention through a series of artistic strategies. Closely noticing such multisensory detail opens up the arising imaginative dimension. This has the potential to link with values and wider issues beyond the specific experience. Nine exploratory examples are given.

Chapter Three - Relevance of aesthetic experience in the clinic.

Building on chapter two, this chapter discusses how this type of aesthetic experience is relevant in clinical settings. Several examples are given and a description of aesthetic experience in relation to the clinic is developed.

Chapter Four - Scoping studies.

Two experiential participatory processes are discussed. Practice details are given in the portfolio accompanying this chapter. These studies expand the research to test out if newly designed experiential participatory processes activate aesthetic experience for others working in healthcare and allied professions. Postgraduate artists were also involved. Aesthetic experience was successfully activated for participants. Feedback and discussion of experience showed that this was a relevant, meaningful and valuable way of working. Both scoping studies were deeply involving and highly evocative generating expansive multisensorial and imaginal detail of aesthetic experience defined in this study.

Chapter Five - Overall methodological approach. Format of reporting and recruitment.

This chapter discusses the rationale for development of an emergent methodology that employed an arts, practice-based approach. Summary tables are given to show the overall structure for describing and reporting methods used in the development of an innovative series of six experiential participatory processes that were ultimately for use with healthcare practitioners and allied professions. Postgraduate artists were also involved in the development. For the final series of experiential participatory processes, methods used in common are also given in this chapter as a further table. This chapter also discusses overall methods of analysis that developed as the processes were delivered, particularly to reveal greater detail contents of the imaginative dimension. The detailed reports from first-person explorations through to final design of each of these processes follows in chapter six. Recruitment methods for the final series of participatory processes are given. An 'Artist's Introductory Talk' that was presented to recruited participants before they took part in these processes is described.

Chapter Six - Methods used in six final experiential participatory processes

This chapter is a detailed report of the development of six experiential participatory processes from researcher first-person explorations to pilot studies with postgraduate artists and finally with healthcare groups. Methods of design, delivery, documentation, analysis, reflection and progressive refinement to create the final processes were reported. An emergent methodology called 'connective aesthetics in the clinic' was developed. The accompanying portfolio of practice for each process evidences this work. Methods used in the final group processes for health carers included practice-based participation with guided contemplation and space for 'close noticing' aesthetic experience in issues relevant in everyday healthcare, feedback of experience as reflective inquiry, and group discussion. Poetic interventions were incorporated to activate, stir imagination, raise curiosity and awareness and closely notice personal aesthetic experience of multisensorial detail and imagination. Methods of analysis were refined throughout to reveal the emergent content of the expanding imaginative dimension.

Chapter Seven - Evaluation, discussion, key findings, implications, beneficiaries and further research.

This chapter restates the research aims and evaluates the extent to which each of these was achieved. This is followed by an overall evaluation of how the study was conducted including restating links with existing practices and theories. A summary of key findings is given followed by the contributions these make to knowledge. Implications of the research and beneficiaries are discussed including areas for future research development. Paying attention to everyday aesthetic experience in this research aids articulation of complex experience in only a few minutes without participants requiring extensive training. This has the potential to be developed as an enhanced reflective teaching tool for healthcare workers and a teaching model is proposed.

Document II

Portfolio of practice.

A portfolio of practice-based work is given that accompanies each chapter. This includes sketches, diagrams, photographs, excerpts of writing from reflective journals, descriptions of the presentation of work and examples of participant feedback and analysis. The practice is a central part of the research and evidences the work reflected on in the text of the above chapters and practice-based findings retain primacy and shape the next steps of the research as it progresses.

Document III

Presentation of the Artist's Introductory Talk for participants was also given to the examiners May 2022

Chapter One - Research Background and Context

Chapter Introduction and Outline.

The aim of this research was to explore and describe the nature of a type of aesthetic experience that is relevant to the everyday work of health carers; to develop and design new participatory processes that activate this for them to use as an enhanced reflective tool and to evaluate the success of the emergent methodology and design. The core concept of this research resonates with five main areas of existing practice and theory that are listed below. These are discussed in detail and drawn upon in innovative practice-based ways. A further three areas also linked are mentioned. This research takes a practice-first approach and also draws on these areas throughout. Other relevant literature in relation to the developing practice is added throughout this thesis.

Background and rationale for the approach to the contextual review.

The starting point for this research was a recurrent type of aesthetic experience that I have had throughout 40 years of medical practice and, I believed was also relevant and had meaning for other colleagues. Arts, practice-based methods were designed to explore aesthetic experience through direct immersion in participation and the findings were the 'data' that arose directly from this.

Nelson points out the centrality of practice as evidence in arts-based research. Whilst the contextual review seeks ‘links and resonances’ between research and existing literature, the practice and arising reflections retain primacy. (Nelson, 2013). He states that the arts practice is a ‘key method of enquiry,’ and is ‘submitted as substantial evidence of the research enquiry’ and that ‘the practice has primacy’ as data. He calls inherent knowledge arising from this practice ‘knowing-doing', stating that this ‘is at the heart of the enquiry and evidences it.’ In her practice of the expanded art field of Social Sculpture, Sacks (Sacks, S, 2010ab) sees questions as starting points, as drivers or ‘forces’ from which creative connective practices are developed, in turn bringing deeper research questions, exploration, discoveries and insights. In this PhD research, existing practices and literature were drawn upon for comparison, contrast and to contextualise this study throughout the development of new practice-based methods. Some of these included practice-based aspects adapted from existing practices and literature.

In my research, the initial research questions, practice and approach to this contextual review were grounded and informed by years of professional practice-based experience in medicine, specialising in mental health and psychological treatment methods. This was coupled with postgraduate experience in practicing within the contemporary arts, particularly Social Sculpture as taught by Sacks. This background therefore gave me relevant ‘theoretical sensitivity’ to explore the type of recurrent aesthetic experience from clinical practice that I wished to investigate. Aesthetic experience was the core concept to be explored directly as it arose in practice using an arts-based approach. This led to the development of an innovative emergent arts, practice-based methodology including the design of new processes that activated aesthetic experience for participants' observations and a description of aesthetic experience in relation to the clinical practice of healthcare practitioners.

Five areas of existing practice and theory.

Five main areas with which the core concept of this research resonates are discussed. For each of the following areas, I give a brief introduction, state the extent of my experience, give an outline of the key points

that inform my research and show how I have interpreted, adapted, applied these and synthesised them in new ways.

1. **Connective Aesthetics and the 'Connective Practice Approach'** are discussed including the term coined by Suzi Gablik to the approach in the contemporary field of Social Sculpture taken by Shelley Sacks.
2. **Goethean observation.** A method of phenomenological observation based on Brook's description of stages of Goethean observation is outlined.
3. **Mindfulness-Based practice.** Informal mindfulness-based practice is used as a method to explore the detail of experience as it occurs. Key aspects in this contemporary field of healthcare, wellbeing and resilience are outlined.
4. **Contemporary and Environmental Aesthetics**. Everyday aesthetics described by Saito and Brady's model of the Integrated Aesthetic are outlined.
5. **Imagination** - the role of imagination in relation to a five-category framework proposed by Abraham is discussed.

Three further areas are mentioned briefly:

1. **Reflective practice and enquiry**, based on the Schön (Schön, 1983) and Kolb (Kolb, 2015)
2. **Values – Based practice,** in medicine Fulford (Fulford, Peile and Carroll, 2012)
3. **Arts in Health** – WHO review (Fancourt and Finn, 2019)

Additional links with the literature are also included throughout the body of the thesis as it develops through practice. I found myself working across various disciplines throughout.

1.Connective Aesthetics and the Connective Practice Approach.

Connective Aesthetics

The term 'Connective Aesthetics' was coined in the 1990's by the American artist and art critic Suzi Gablik. She became interested in a paradigm shift in art. In 'The Re-enchantment of Art,' she promoted art that moved away from the elitism of the gallery, capitalism, consumerism of the private collector and 'impenetrable' art works that may have lacked any feeling of responsibility (Gablik 1993). In her work, the meaning of 'aesthetic' related to sensibility and awareness of deep connections perceived in inter-relationship with each other, community, society, ecology and involvement in world issues. She promoted artists who conveyed this felt connection and who took on a moral responsibility for highlighting key issues of the time, such as democracy, humanity, sustainability, climate change, etc. Her art consisted of participatory processes shaped by shared experiences and understandings arising from this inter-relatedness. It became art that invited and welcomed seeing through the eyes of others – an empathic art that aimed to discover a wider world-view than that of the ego of the artist alone (Gablik, 1993, p. 113). She talked about the 'ecological imperative of art', and of 'making art is if the world mattered.'(Gablik, 1993, p. 96)[1] She said, 'At this point we need to cultivate the connective, relational self… the interdependent… the listening (embodied) self…art that is grounded in the realization of our interconnectedness and inter-subjectivity – the intertwining of self and others' (Gablik, S 1993b). She warned, 'Today, remaining aloof has dangerous implications.' She advocated for artists finding

[1] She sites examples for instance the work of Ukeles (Gablik, 1993, pp. 69–73).These are not discussed further here.

new 'sensitive forms' that link personal creativity with social responsibility for 'emphasizing our essential connectedness' (Gablik, 1993, p. 5)

In this PhD, I propose that adapting this concept of connective aesthetics in arts-based practice may be a useful way for exploring the experience of the human encounter, connectivity and inter-relatedness in the clinic. More than ever, work that deepens human connection through understanding each other's perspectives, empathy, compassion, kindness (Ballatt and Campling, 2011), retention and sustaining staff [2] is needed to keep the human at the heart of the clinical encounter at a time when healthcare is in crisis.

The Connective Practice Approach in the Contemporary Field of Social Sculpture

This connective meaning of 'aesthetic' is similarly used in the approach of Shelley Sacks in the contemporary field of Social Sculpture. She calls the processes she has developed the 'Connective Practice Approach'. (Sacks, S, 2021). She has extended the 'expanded field of art' stemming from Joseph Beuys in the 1970's. Sacks explains Beuys' saying that 'anyone can be an artist' to mean that everyone can employ imaginative processes for creating a more humane, democratic, ecological and sustainable world in whatever field they work. Underpinnings for Beuys' work came from Goethe, Steiner, Schiller, Kandinsky amongst others. Sacks continues to 'carry the flame' of his work by developing 'connective practices' that are arts-based creative strategies and methods. The work in my thesis is inspired by and is related specifically to the work of Shelley Sacks rather than the wider field of Social Sculpture. Beuys' work is not reviewed in this PhD nor does my research relate to the linked field of Steiner's anthroposophy. In my work, I relate connective aesthetic practices to my experience in traditional medicine.

Sacks' extensive practice-based work can be found on websites that she has composed for her works. Each work extends over several years. Examples include Exchange Values (Sacks, S, 2016), University of the Trees including 'Earth Forum' as one module within the latter (Sacks, S, 2018) and development of the Social Sculpture Research Unit at Oxford Brookes University in 1998 (Sacks, S, 2012) where she also taught and researched as Professor on the Masters and Doctoral programmes. Now Professor Emerita, her recent practice continues including curation of an exhibition of Beuys work in Kassel to mark the centenary of his birth (Sacks, S, 2021).

In her work, Sacks creates new forms using connective practices. These aim to deepen the human capacity for noticing inner experience of sensing and arising imaginal thought i.e. aesthetic experience to discover new insights and understandings to enhance more democratic, humane and sustainable living. Whilst a review of individual works in contemporary Social Sculpture is not given in this PhD, I will discuss how my arts-based practice has been informed by principles from Sacks' teachings of connective practices at Oxford Brookes University whilst I was a masters and doctoral student in the School of Arts. I will discuss how I have interpreted and applied connective practices from her work and how I have adapted these to explore the type of aesthetic experience I am investigating in clinical practice. I have called my work 'connective aesthetics in medicine.'

My practices were developed and designed primarily for healthcare practitioners and postgraduate artists were involved in the design. Furthermore, the practices would also have relevance to anyone who has

[2] This research commenced before the Covid crisis. These issues were relevant then and remain even more pressing.

experienced healthcare settings and sharing of experience in exchange could be valuable. In this research I believe that feeling heard may contribute to sustainable practice for health care workers by deepening connections with the self and fellow humans in the clinical encounter.

My Practice-based Experience in Social Sculpture.

I began adapting and incorporating connective practices from Sack's taught module (Sacks, S, 2010aa) into my major project of the Masters in Interdisciplinary Arts (Fox, 2011). I thought that methods and strategies applied from her connective practice approach had the potential to bring new ways of seeing to the field of medicine particularly to the sensing and the imaginative dimension of aesthetic experience as defined in this PhD. These areas of personal experience are often suppressed. Furthermore, awareness of aesthetic experience may offer an untapped resource. My Masters work showed that through carefully designed embodied arts processes, imagination could be stirred to reveal new insights outside habitual thinking. This in turn could also reveal what was sometimes set aside, ignored or even dismissed. Following this, I decided to extend my research inquiry in this PhD as informed by and adapted by the processes she has developed in her approach to Social Sculpture.

How has my research been inspired and informed by the Connective Practice Approach?

In this section I outline various principles from the Connective Practice Approach of Sacks as I have interpreted them and as they have inspired my research. The following account emerges from Sacks' direct teachings and supervision. I will show how my research has been informed by the following points in relation to her work.

'Invisible materials.'

The materials Sacks works with include 'invisible materials' as well as those that are tangible and physical. Inner mental experience can be thought of as 'invisible material', as 'substance' that has 'form' or shape. Examples include lived experience such as thought, questions and the sensed dynamic as 'forces' that drive them, inner impulses, values, sensory perceptions, images, imagination, sensing the gesture, or the essence of things and inter-relational connections. Connective practices include strategies that bring awareness to inner experience by connection through deepened attention. This invisible material can be 'gathered' through processes of individual reflection or shared with others in experiential participation and collective reflection. Processes can be created, sculpted and brought to tangible forms to enable this and may bring transformative, creative new insights and understandings. For instance these may reveal what has been missed, 'hidden, denied or ignored.' (Sacks, S, 2010ab).

In parallel in my research, the 'invisible material' is the recurrent inner experience that I have had throughout my career in everyday clinical practice. This is the phenomenon I wished to investigate. By using a first-person introspective approach, I explored its nature in more detail in the 'inner workspace' of my mind as will be shown in Chapters two and three. I explored sensory perception and imaginal thought through deepened attention and this revealed that it was an experience full of multisensorial and imaginative detail. It is this that I have defined as 'aesthetic experience' in this study. It had an expansive form that I could draw out as a tangible diagram. This form had a flow and dynamics that revealed where my research questions lay, discussed in chapter 3. Working in this way, I developed practices to connect with and explore this experience closely and

further questions unfurled. Furthermore, from clinical experience, I believed that some of my colleagues may have this type of aesthetic experience. Yet, in medicine, personal experience or imaginative thought may be deemed too subjective in the workplace. This experience could easily be ignored, taken for granted or suppressed. Not taking notice of, or not validating one's inner aesthetic experience may lead to a state of numbness or 'anaesthesia.' However, this aesthetic experience could be a potential resource if skilfully reflected on and I believe, also enhance vitality in practice. Being aware of this inner experience could lead to deeper insights and values that could steer actions that are more humanely connected, for instance as an important component of empathy, compassion and Values-based practice (Fulford, Peile and Carroll, 2012).

The territory: The 'Poetic Continent' and aesthetic mode.

In her Social Sculpture practice, Sacks refers to the 'inner workplace' as the 'territory' in which 'inner work' actively takes place through connective practices that are both reflexive and reflective. These bring awareness to the 'I-sense' during participatory experience, whilst observing this, at a reflective distance. She describes this 'internally active' way of working as 'aesthetic' and 'enlivened' as opposed to a lack of such awareness or numbness as 'anaesthetic'. It is a poetic, (also see the section on 'Imagination' below) artistic mode and the inner space in which it takes place has also been called the 'poetic continent.' (Sacks and Zumdick, 2014).

In parallel in my research, I start by connecting with the recurrent inner experience I alluded to above. Starting points included both reflexive and reflective inquiry in a first-person approach. Through introspective exploration, I became more aware of the detail and nature of the type of aesthetic experience I wished to investigate. Sacks' use of 'aesthetic' also resonates with James Hillman's terms 'aisthesis' (sensing and imagining) and 'anaesthesia' ('psychic numbing') (Hillman, 1992, p. p107,125). This is how I have used these terms in this PhD. This is further described in chapter two.

'Inner' and 'outer' work.

In her Social Sculpture practice, Sacks explains how 'inner work' leads to, and is connected with, 'outer work' in the world. Connective practices are processes used to bring this dialogue between 'inner' and 'outer' work into form. For example, the artist may be exploring an experience in their own mind that they then wish to convey and share with viewers to discover their views, insights or understandings. The artist may communicate their experience through a process that generates an experience for others to be participant in. Collective feedback and discussion will in turn lead to the artist's further reflection and shaping of the process as needed. The dynamic of this movement between inner and outer worlds can be represented in a diagram of a lemniscate form. Sacks uses this to show the form of a dialogic process of perpetual 'oscillation,' between in inner (Sacks, S, 2021) and outer work in the world. In this way the artist may share their own inner experience by conveying it to other participants through a process created to activate it for them so they can comment on their own perspectives. Such a connective process may be used, for instance, to bring new insights and deeper understandings in relation to more humane, democratic and sustainable living.

Similarly, my research expanded outwards from inner work to tangible forms in outer work for my own reflection and ultimately by developing processes that involve others. Examples of tangible outer forms included free writing, drawing and small actions. I found that pieces of free writing emerged as short poetic transcripts that captured and articulated the sensibility of the event and stirred imagination further. Also, initial simple drawings emerged as tangible forms that showed the expansive shape and the dynamics of the experience

(Portfolio of Practice for chapter one - PoP1) including where further research questions lay. In these ways, inner introspective work began to move outwards into form. In this way a connection and dialogue between 'inner' and 'outer' work began. The outer work helped me connect more closely and vividly by further raising awareness and observation of my inner experience. This generated further research questions thus 'gathering' further 'substance' in my research. From this, the work expanded outwards to others through works in progress, pilots, scoping and ultimately in creating processes that activated aesthetic experience for healthcare workers. Thus, findings from starting points of 'inner' first-person explorations were extended to 'outer' work not only for my own exploration but also to convey and share this with others through experiential participatory experience to activate this experience and discover if this was relevant to them. The overall research form took a spiral iterative path of ongoing connection between awareness of inner experience (perceptual and imaginative thought) and creating outer work to share with others. Here, the experience conveyed and activated is related to small everyday actions that may occur in the everyday practice of healthcare workers as will be discussed in chapter three.

The ability to respond: 'Response-ability.'

In her Social Sculpture practice, Sacks also indicates that the ability to respond with awareness of perceptual and imaginal thought brings a 'response-ability' and feeling of 'what needs to be addressed.' This brings a moral dimension where one may choose to act for the better good as an 'agent of change' through actions and planning that shape the world in more democratic and sustainable ways (Sacks, 2021). Connective practices involve creative strategies and methods that aim to raise awareness to this ability to respond. Similarly, in my work, research practices aim to bring awareness to the ability to sense and imagine i.e. aesthetic experience, and that this 'response-ability' may also bring feelings of what's needed in terms of human connection in the clinical encounter.' Thus, awareness of aesthetic experience also has moral implications.

Imagination

In her Social Sculpture practice-based approach, Sacks aims to 'mobilise imagination'. Working with imaginal thought is a key component in Social Sculpture. Creative practices include poetic interventions that render a familiar situation slightly 'strange' are used to draw curiosity, attention and disrupt habitual thinking. Sacks refers to Brecht's 'making strange' (Sacks, S, 2011) In this way, transformative new insights and understandings beyond fixed pre-existing concepts may emerge. These may otherwise be hidden, denied or ignored.

In my research, I became interested in using poetic interventions as a creative strategy to defamiliarize habitual ways of thinking to draw attention to sensory perception and imaginal thought of aesthetic experience in relation to clinical situations. This was to stimulate deeper understandings and new insights. To achieve this in my research, poetic interventions were designed in. These took the form of a slightly unusual twist to familiar, routine everyday clinical situations. Kumagai also discusses the action of 'making strange' for bringing new insights in medical reflection. (Kumagai and Wear, 2014). Similarly, Bachelard, citing Minowski. talks about images that reverberate at the edges of imagination. (Bachelard and Jolas, 1994, p. xvi)

An interdisciplinary field

Sacks describes the contemporary field of Social Sculpture as a 'framework for looking at the world,'… 'an interdisciplinary field (Sacks, S, 2010c) that can include any kind of practice that brings awareness to sensory perception and imagination through paying deep attention' to comprehend the world with

different modes of knowing including imaginal thought and reflexive practice. Two examples of fields she includes as connective practices, and of relevance in my research are the imaginal thought of James Hillman and Brook's description of the stages of Goethean Observation (Brook, 1998) References to James Hillman's writings are interspersed throughout the body of my text. Brook's description of Goethean observation is discussed in the next section.

In my research, I draw on different disciplines to explore the imaginative dimension that could arise directly out of closely noticing multisensorial detail. I have also drawn on James Hillman's writing on 'image sense,' where he says, 'stick with the image…the image tells all' (Hillman, 2000, pp. 170–185). I have adapted his term 'close noticing' into new arts practice-based research methods to explore images that arise in the aesthetic experience in detail, discussed in chapter two. I have also designed practices based on an adaptation of Brook's stages of Goethean observation to describe sensory perception and the arising imaginative dimension. As my research develops, I draw on additional fields to explore the imaginative dimension arising from sensing in aesthetic experience These are described in further sections of this chapter.

Summary

Inspired specifically by the connective practice approach of Sacks from the contemporary field of Social Sculpture, and because of the complexity of aesthetic experience, I thought that aspects of her practice-based approach could offer ways to connect with and explore aesthetic experience that also extended beyond the verbal, and in relation to everyday clinical situations. I have described key aspects from her approach and shown, in outline, how I have interpreted and applied these into my arts-based research. Samples of slides given in a presentation of this can be seen in PoP1[3].

I thought that developing practices that aimed to connect practitioners with an awareness of aesthetic experience, coupled with conscious, skilled and appropriate reflection for the situation at hand, could be a way of contributing deeper human connection needed at the heart of healthcare practice. As in the connective practice approach of Sacks, the capacity for becoming aware of inner aesthetic experience and the ability to respond, or 'response-ability' by 'feeling what needs to be addressed' brings a moral dimension to that could enhance practitioners to become 'agents of change' and act with more connected humane care.

In specialist fields of psychotherapy, the therapists' awareness of perceptual and imaginative experience is an important component of treatment however this requires lengthy training[4]. This experience is generally not a major focus of everyday clinical practice in other areas. However, from discussion over the years, I came to think that the recurrent experience I am exploring in this research was also familiar to many of my peers from medical school to current work colleagues no matter what medical discipline they worked in. Yet, this was not often spoken about. I thought this needed to be addressed as it seemed possible that this awareness could validate the inner world of the practitioner thus bringing interest and enlivenment to practice. This may include enhancing personal sustainability. After all, many of my peers entered the profession to work with deep human connection. The latter is of great importance at a time when many healthcare practitioners are leaving the field as mentioned at the start of this section.

[3] A shortened version of this account was presented online with images in a public exhibition in Kassel (Fox, H, 2021). Slides shown in PoP 1

[4] e.g. Transference, counter transference and projective identification, transference cognitions. These are not further discussed here.

The research in this PhD is concerned with exploring how 'connective aesthetics' could contribute to more 'connected' healthcare. I have called the emergent practice-based methodology 'Connective Aesthetics in Medicine.' Becoming aware of the sensory and imaginative detail of aesthetic experience may bring deeper connection not only with the self but also lead to deeper connection with fellow humans and healthcare settings. This research is inspired by, applies and extends the connective practice approach employed by Sacks into the field of medicine and healthcare in innovative ways.

2. Goethean Observation.

Personal practice experience.

I was first introduced to the Goethean way of seeing in the Social Sculpture module of the Masters in the Interdisciplinary Arts as mentioned above. Guided by Isis Brook's paper on reading a landscape with Goethean Observation (Brook, 1998), we practiced a shortened form as an example of a connective practice. I describe Brook's paper below. In my own arts, practice-based processes I have also interpreted and adapted a simplified version of Brook's paper and attended workshops on Goethean observation run by Axel Ewald. (Ewald, 2016). In Chapter three, I discuss how this type of observation may also be related to close noticing in the clinic. Whilst not a scholar in Goethean Science, I was interested in exploring this rigorous method of empirical and direct observation for closely noticing sensory detail and the arising imagination that Brook discusses. My application of this method is a basic, practical interpretation that ultimately plays a part in adapting new shorter processes designed for use by healthcare workers who are pressed for time. Importantly, in Goethean observation, it is the development of the imaginative component that arises directly from closely noticing sensory detail and that brings a sense of dynamism and a more holistic appreciation of the thing explored.

Brook's description of methods of Goethean observation.

In an early passage from J.W. Goethe's 'Italian Journey' in 1786 (Goethe, 1970), he says that he wishes to directly and closely observe using his own powers of perception to see with 'clear fresh eyes.' Brook discusses this way of seeing that Goethe called 'delicate empiricism'. Brook has described stages of Goethean observation in relation to reading a landscape (Brook, 1998). She also says this can be applied to items from nature or the study of a relationship or social group or other phenomena (Brook, 2009, p. 33). Writing from the Western tradition of philosophy, a central point is a way of perceiving phenomena for ourselves through detailed participatory observation and noticing the arising imagination, rather than relying on pre-existing concepts alone. Brook has significant training[5] in Goethean Observation. In her papers, she sets out her method clearly in a way that is accessible to the reader who wishes to try this for themselves. I found her paper gave a structure that allowed me to follow this practice compared to the more theoretical text of Bortoft (Bortoft, 1996). The next section gives a brief overview of Brook's application of Goethe's method. This is drawn from both Brook's papers above.

[5] From the 'Life Science Trust' which was set up to study Goethean science across disciplines and founded by the late Margaret Colquhoun. Goethean science was also the subject of Brook's PhD (Brook, I, 1994)

An item to be studied is firstly chosen by a feeling of being ‘drawn’ to it and a curiosity to understand it more deeply. The preliminary stage involves noticing and setting aside first impressions, personal responses, pre-existing theory and preconceptions in order to ‘clear the workspace’ and consider the phenomenon anew. This is akin to ‘bracketing out’ in phenomenology. Then, in stage one, careful observation of the chosen phenomenon is made to describe it as objectively and exactly as possible with all the senses (not just vision), as if it had never been 'seen' before. This is called ‘exact sense perception’. She suggests that detailed writing or drawing can deepen attention and close noticing. In ‘New Eyes for Plants’ examples of drawings can be seen (Colquhoun and Ewald, 2004). Brook also explains that drawing from memory demonstrates the connection between object and observer when an image of the phenomenon is absorbed through the senses and imprinted in the mind. Brook describes how a ‘felt’ sense of the way an organism changes over time may arise in imagination through this careful observation. She describes this process of becoming aware as the second stage called ‘exact sensorial imagination’. She points out that it is important to stick closely with the imagination that arises directly from the phenomenon (‘in the style of’ it) rather than let the mind wander randomly into ‘overly human attributes.’ She points out that it is this adherence that brings awareness and connection with the phenomenon in a ‘rigorous way’ by ‘schooling imagination.’ For example, by viewing sequential parts of the plant as it grows upwards one can bring its progressive development together in imagination and sense it, ‘as if from inside.’ Here, I think of the kind of image in mind that modern day time-lapse photography can show. The overall process of this close observation and the arising imagination of dynamic change is called ‘delicate empiricism.’ This moves into stage three where this process deepens as one may become aware of sensing a ‘gesture’ of the whole phenomenon. This is called ‘seeing in beholding.’ My understanding here is that this occurs through paying deep attention to stages one and two and through this one may become aware of sensing a ‘feel’ of the phenomenon as it presents itself in its potential for dynamic change or wholeness. Brook says this is as if the phenomenon is ‘speaking’ and alludes to the ‘human inspiration’ that this may bring. I understand this as the ‘taking in’ of something from the phenomenon as it becomes felt and imprinted within mind and body through a process of imagination. Brook implies that it is this connection through sensing and the arising imaginative dimension that may then bring new insights and meanings. To me, this feeling the plant’s dynamic, appears to be an empathic move. Stage four is when an overarching idea or theory emerges as a result of the previous stages in an intuitive way and by ‘being one with the object’, its type of object and even going beyond to wider realisations.

In summary, Brook concludes that working through these stages of Goethe’s methodology can bring direct connection with the phenomenon itself. Closely exploring sensory detail can lead to awareness of the imaginative dimension arising from this. This resonates strongly with the type of aesthetic experience I wish to investigating in this PhD. In this way, one may come to imagine a felt sense, or gesture of the phenomenon as dynamic rather than only seeing is at one instance in time and thus be able to imagine more holistically. Brook calls this participatory process ‘being with’ or ‘being one’ with the phenomenon. She refers to the writings of Merleau-Ponty and I understand this relates to the connectivity of the ‘intertwining’ (Merleau-Ponty, 1968) thus challenging a dualistic approach in which the onlooker takes a disconnected, objective stance as a separate entity.

I have interpreted and tried out Brook’s stages on several occasions. For example, I experimented using an acorn. As I held it in my hand I noticed closely, by describing sensory perceptions to myself in some detail, I

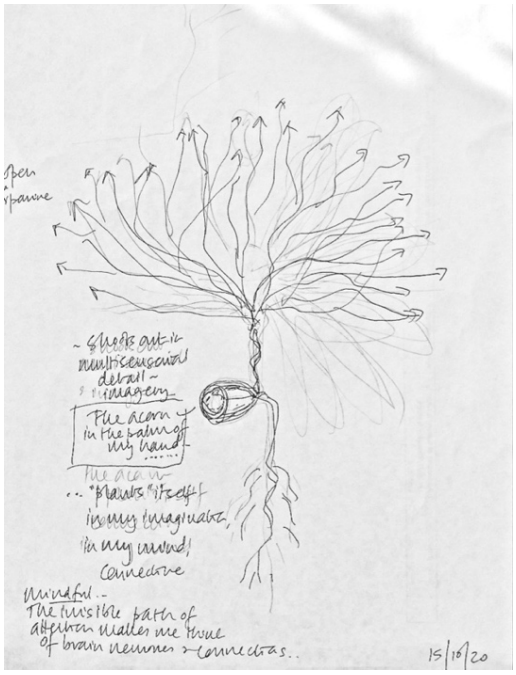
was able to imagine its potential root, shoot, branches branching, progressively unfurling then falling leaves through the seasons. My imagination expanded to visualise these. I felt a sense of the tree's life cycle, of growing upwards, unfurling, opening, falling, shrinking back down, reabsorbing, even whilst writing this text, revisiting the memory, imagining again. Moreover, the expanding root and branch system was mirrored in my own mind as an expansion of imagination from sensory perception in the same archetypal form shown in the sketch below. In turn, this brought reflection on wider issues and values e.g. how seed is successfully dispersed, the needs of the tree, concern for it, the privilege to have this tree on my allotment, the importance of trees, plants nature, ecology and so on. Thus, through paying attention to sensory detail and the arising imagination, the acorn and its potential became part of me and impacted on wider thoughts about the importance of this acorn, of trees and their preservation etc.

Brook explains that her stages may overlap in reality. Also, the process she describes extends over several days. In my experiment above, I have described a much briefer process. Brook's description of Goethean methodology shows how awareness of sensory perceptual detail and the arising imagination can be noticed in a rigorous way. It is this that resonates with the type of aesthetic experience in this PhD project. I think this also resonates with the close noticing of 'sticking with the image' as described by Hillman in his essay on 'Image Sense' (Hillman, 2000)

I have adapted Brook's stages into methods in my research for becoming aware of sensory perception and the arising imagination in relation to phenomena in traditional medical work. I have adapted and applied a simplified version of her stages and applied them in a way that can be used in everyday practice alongside the objective evidence base. I have designed short contemplations that guide participants through similar stages from closely noticing sensing to the arising imaginative dimension and ultimately to values and issues beyond what is observed. I describe these methods in chapter six.

Goethean observation involves being mindfully aware of what arises in inner experience during moments of participation. Mindfulness-informed practice is discussed in the next section.

Drawing from observation of an acorn. The form of how this is imprinted in me and my expanding imagination mirror the root and branch pattern.



3. Mindfulness-based practice.

Personal and professional experience of practice.

Following a Certificate in Cognitive Behavioural Therapy, I developed a personal mindfulness practice over the last 10 years by attending teachings at the Oxford Mindfulness Centre[6]. I participated in an initial 8-week course of Mindfulness Based Cognitive therapy for the general public followed by sections of the pathway for teacher training of formal Mindfulness-Based Programmes[7] (MBP). These have included a week-long intense teacher training retreat; attending regular teacher training masterclasses; teacher training for shorter courses for use in non-clinical groups based on 'Mindfulness: Finding Peace in a Frantic World (Williams, Penman and Kabat-Zinn, 2011) and Sustaining and Deepening Practice based on Ancient Wisdom meets Modern Psychology (Feldman and Kuyken, 2019); a face-to-zoom series on Sustaining and Deepening practice (Kuyken, 2020)and from the ongoing zoom programme for mindfulness teachers; 'Mindfulness Frame by Frame' (Williams, 2021).

Within my clinical work I have applied this experience in adult general psychiatry both as personal practice and in paying mindful attention in my clinic as well as guiding some groups of hospital staff and other non-patient groups. My use of mindfulness awareness is grounded in participatory experience of formal MBP. Within the arts, I have also applied aspects of mindfulness as a way of 'close noticing' during my Masters in the Interdisciplinary Arts with further developments in this PhD. As mindfulness practice is an approach for directly observing and exploring experience as it occurs, I have used this as a method to explore aesthetic experience in this PhD. Whilst I have some experience in guiding formal mindfulness-based programmes, in this PhD I use mindfulness in an informal and applied way, not as part of a treatment programme.

Development and use of secular formal Mindfulness-Based Programmes (MBP)

A definition of Mindfulness[8] of experience is, 'the awareness that emerges through paying attention on purpose, in the present moment, and non-judgmentally to things as they are.' (Williams, 2007, p. 47) Formal Mindfulness-based practice is described fully in key texts elsewhere. An outline is given here. In 1982 Jon Kabat-Zinn originally adapted Buddhist principles for use in secular settings for patients with chronic pain and the associated stress of suffering as the Mindfulness Based Stress Reduction (MBSR) programme taught in group format over 8 weeks (Kabat-Zinn, 2011b). Williams, Teasdale et al (Williams, 2007) extended this programme by coupling it with techniques from cognitive behavioural therapy to create a treatment for relapse prevention in depression as Mindfulness-Based Cognitive Therapy (MBCT). Since then, the Mindfulness movement has expanded and MBP's are now used on a global scale in areas of mental and physical health and wellbeing in various different populations. There is a robust and scientific body of evidence for the outcomes of formal MBP to relieve stress and suffering as part of treatment for a variety of health conditions. Formal programmes have also been adapted for non-clinical groups to enhance well-being, resilience and attention. Examples are, for the general public, in the workplace, for teachers and school children and in Parliament. More recently the programmes of Mindfulness Based Practice for Life programme and Sustaining and Deepening practice[9] have been developed to build flourishing and resilience, reduce stress, and enhance appreciation, joy

[6] www.oxfordmindfulness.org
[7] Taught by Oxford Mindfulness Centre
[8] Other definitions can be found in (Feldman and Kuyken, 2019)
[9] Mindfulness-Based Practice for Life Programme as taught by Kuyken and Yiangou 2019, Oxford Mindfulness Centre

and gratitude in normal populations. In addition, shortened forms of MBP may be learned using self-help books and Apps.

Kuyken and Feldman (Feldman and Kuyken, 2019) list areas in which MBP's have been developed and include the essential features of learning secular formal mindfulness practice. Citing Crane et al (Crane, R.S., and Brewer, J. 2017), these essential features include: a theoretical underpinning linking aspects of Buddhist contemplative practice with western science and based on a model of human experience; the aim of relieving the experience of human distress by learning to focus and sustain attention in the current moment on a chosen area of experience such as the breath, rather than being waylaid by negative thoughts and ruminations; approaching experience in an exploratory new way with an attitude of curiosity, equanimity, acceptance, compassion and reflective inquiry to deliberately choose a wise response rather than automatically reacting to difficulty. Mindfulness is cultivated through ongoing practice.(Feldman and Kuyken, 2019, p. 134) Kuyken[10] describes a funnel shaped map of how different intensities of mindfulness-based programmes are related. Pollack (Pollak, Pedulla and Siegel, 2016, p. 3) also describes a range of practices ranging from informal mindfulness practice that can be woven into daily work by the clinician to inform and bring insight, through to teaching formal MBP's. My research here is aligned with a more informal practice of mindful awareness that may be practiced during everyday clinical work rather than part of a formal mindfulness-based treatment intervention.

Aspects of mindfulness-based practice related to this research.

These are outlined next showing how I have applied and adapted methods of mindfulness in comparison and contrast.

Paying attention, breaking habitual thinking and closely noticing detail

In MBP, awareness is cultivated by paying attention to current moment experience. In this 'being' mode of mind, it is possible to notice much more experiential detail than when engaged in tasks in 'doing' mode, or when thoughts are elsewhere in 'automatic pilot' when the richness of the current moment may be missed or ignored. Paying attention to current moment experience can reveal more of the detail of what is sensed, felt, thought or pictured and can be a transformative discovery. Mark Williams' (Williams, 2021) analogy of becoming aware of current moment experience 'frame by frame' is as if looking at a photo-burst of images and deliberately choosing to explore the detail in each frame in each moment. Strategies such as 'habit breakers' may be used to shift beyond usual patterns of thinking to paying attention and awareness to detail. For example, making small changes to routines such as sitting in a different chair or walking a new route to work can shift one out of habitual ways of thinking thus enabling noticing of new things.

In my research, the practice of mindfulness helps me turn towards and sustain attention on what I experience in the current moment to explore and notice detail more closely. In addition, I designed research processes that invite participants to become aware of their own aesthetic experience by paying mindful attention to sensory perception and the arising imagination during actions related to daily clinical practice. Spoken guidance led participants through this. As in MBP, shifting into a 'being' mode of mind is relevant for exploring aesthetic experience, as it occurs. Being 'in' participatory practice brings the opportunity for direct observation as experience happens rather than only thinking 'about' issues conceptually. As in mindfulness, greater detail

[10] In spoken teaching

may be closely noticed that could otherwise be missed, ignored or suppressed. This may bring greater connectivity with self, other and environment and serve as a resource for mindfully choosing the best actions for care. Even paying attention to aesthetic experience in brief moments and small actions could bring an opportunity for deeper connection. For example, whilst taking a pulse in a busy clinic, just noticing the touch with another's skin may be transformative in bringing one to a sense of connection with the humanity of another and lead to making eye to eye contact or a smile. As in mindfulness, being aware of one's sensing may also bring vitality to clinical work. And by not being aware in this way, much may be missed. The research processes revealed the richness of what can be noticed in this way in even brief and routine aspects of everyday clinical practice if one only notices beyond the habit level. Furthermore, in my research, a poetic intervention or 'twist' is incorporated into the design to facilitate shifting out of 'automatic pilot' to activate awareness of aesthetic experience. Poetic 'twists' are akin to 'habit breakers in MBP and aid noticing something slightly out of the ordinary, to break habitual, fixed ways of thinking and lead to seeing anew by using a method of defamiliarisation. Additionally, the poetic twists were designed to make a piece intriguing, to deliberately draw attention and importantly to stir imagination in relation to aspects of clinical work familiar to most healthcare practitioners.

Focussed attention and open awareness

In MBP, attentional control is cultivated to direct attention to a chosen experience, by placing and sustaining attention on this to explore detail, then choosing to shift away to another chosen focus. For example, one may choose to focus attention on the sensations of the breath, other body area, a content of mind, or a focus outside the body. Choosing and focussing attention deliberately can act to steady the mind for instance attending to an area of deliberate choice, such as the breath, away from negative mental states. A further component of learning to control attention in this way, is bringing the mind back to this chosen focus when it becomes distracted in 'mind wandering.' The chosen focus of attention is used as an 'anchor' for grounding the mind when waylaid or overwhelmed by ruminating on difficult emotions and feelings, as in depression or other mental states. This 'de-centring' from difficult experiences allows a space to choose a deliberate response rather than an immediate automatic reaction. It also allows one to choose when one is ready to explore difficulty in a deliberate mindful way.

The research processes here are not a treatment method but an exploration of all that is sensed and imagined. In contrast to MBP, mind wandering into the imagination that arises out of noticing sensory perception is encouraged. If attention is then paid to deliberately notice these contents of imagination, I suggest this could be a similar process to Brook's 'schooling' of imagination described in her stages above. In my research aesthetic processes, an open awareness to whatever comes to mind in the imagination is also noted as wider connections may emerge though less obvious at first[11] as in free association used in psychodynamic therapy. So, in the aesthetic processes, as well as a more schooled imagination arising out of noticing sensory perception, awareness is also open to any or all that arises in imagination at the time. This is further discussed in relation to Brady's 'imagining well' (p27) in the section below (Brady, 2003a). However, if what is noticed in imagining is too disparate between participants, it may be that the design of a particular aesthetic process has not been 'sculpted' with enough precision to stir aesthetic experience related to the clinical issue in question. In the

[11] In psychoanalysis, 'free-association' may be connected with the unconscious. This is not ruled out here.

aesthetic processes, the idea is to turn towards the contents of the imagination to explore them. These are also contents of mind that can be turned toward in exploration, just as with negative thoughts and images that are eventually turned towards in MBP's. The content of the imagination may include recall of past experiences either real or fictional and imagine future possibilities and creative thought. Whilst past and future are not of the present moment, re-experiencing the past or predicting the future can all occur in mind in the present moment. Thus, the capacity of the imagination to time travel, bringing past and future content into current moment imaginings is included in my research. This is discussed further in the section on the imagination below.

In MBP, attention may be also deliberately paid in 'open awareness' to all that arises as it comes to consciousness from the mind-body complex. Open meditation or open awareness has been linked with divergent thinking in creativity (Calzato LS, Ozturk A and Hommel B, 2012). Focussed and open meditation are linked with different networks in the brain. This is further discussed in the section below on imagination.

Paying 50:50 attention

MBP also teaches, a '50:50' practice of paying attention to an external focus, for instance such as attending to another person in a conversation, at the same time as maintaining an awareness of one's own internal experience Awareness of both can be held in mind simultaneously.

In this research, the participatory processes take place in time set aside from clinical tasks when it is possible or appropriate to explore aesthetic experience in some depth. It is possible that the awareness activated in the research processes could act as an exemplar for what could be noticed at an appropriate time for reflection. Professional skill is needed to decide this. As the processes are designed to relate to common everyday clinical actions it is possible in some situations to practice a 50:50 way of paying attention. For instance, being aware of the need to maintain human contact with another whilst performing clinical tasks in covid times despite wearing gowns, masks, head shields and gloves, a nurse may describe how they mindfully take care to convey a smile through their eyes to retain the human connectivity of the Duchenne smile.[12]

Mind-body interaction

In MBP, awareness of the mind-body interaction is a core feature in MBP. A key practice includes becoming aware of and paying attention to bodily sensations and their link with mental events as the 'mind-body' complex.[13] In addition, one may become aware of bodily, physical sensations as pre-reflectively heralding emotions or other mental events that subsequently arise in consciousness.

In this research, the definition of aesthetic experience includes the felt sense, the tacit beyond words, the pre-reflective that which may be held in body and not yet fully come to consciousness. In each process, noticing of all bodily sensation is also embraced.

Attitude of practice

In the aesthetic processes, an attitude of openness, curiosity and exploration with non-judgment is encouraged. However, rather than being actively brought to attention as in MBP, these are implicitly and deliberately embodied in the artist's actions through care taken in the design, delivery and guiding of sessions whilst facilitating exploration, offering attentive listening and also fostering this in participants.

Throughout, MBP an attitude of non-judgemental curiosity is encouraged with acceptance of all that is

[12] In the Duchenne smile the whole of the face is involved and is genuinely more heart-felt than a grimace of lips alone.

[13] As opposed to a dichotomy of mind separate from body

sensed in any particular moment. This is thought of as a 'coming home to one's sensing' (Kabat-Zinn, 2011a) thus validating them as they are, rather than supressing or criticising them.

Reflective inquiry

In MBP, following mindful awareness of experience, there is time for sharing of experience if wished and reflective inquiry after each practice based on Kolb's experiential learning model (Kolb, 2015). Similarly, space for inquiry is also designed into the research processes in a similar way and followed by discussion and collective reflections.

Training and delivery of practice

Formal MBP's are taught by approved, trained teachers, who have undergone a set pattern of teacher training and supervision following guidelines[14]. MBP's are delivered in a set sequential pattern of learning stages.

The research aesthetic processes are not necessarily delivered in a sequential series, although the first process is key to introducing the type of aesthetic experience in this research. Each process is designed to draw attention to aesthetic experience that could be noticed in greater detail in clinic work where appropriate. Whilst each process in a series is designed to centre round a particular way of connection with the self, others and the environment, each could stand alone. The research processes are designed to focus on the sensory and imaginal components of aesthetic experience that may occur in everyday clinical practice. Although the action in each process has been chosen and directed by the researcher, these are familiar to the practice of health carers. The contemplations are lighter and more openly scanning of all that arises than in MBP's. The research processes could be offered in a six to seven session workshop as a retreat or over one term as a teaching module called 'Connective Aesthetics in the Clinic.' Overall, there is greater flexibility of delivery than in a MBP.

Furthermore, as this PhD research develops and is shaped for realistic use in practice, the aesthetic contemplations are designed to be shorter than typical sessions in MBP's. The final designs of the aesthetic processes include contemplations of five to ten minutes duration followed by a space for reflection and discussion. Overall, each session lasts an hour and includes time for reflective inquiry based on the reflective practice discussed by Schön (Schön, 1983) and the experiential learning model mentioned above.

The aesthetic processes were designed for use by healthcare workers. Postgraduate artists were also involved in the design. However, these processes would also be suitable and relevant to members of the general public and their comments experiencing aspects of healthcare would also be valuable although this application would need to be explored beyond this PhD work. The aesthetic processes are not a treatment for relieving distress. They are practices to activate attention and awareness to the richness of aesthetic experience in appropriate moments of clinical practice and the resource this could offer for new insights and creative ideas. Being aware of aesthetic experience may offer an invaluable resource to enhance humane practice during everyday moments. The awareness raised by participating in this type of process may then be transferred to everyday practice and thus work towards enhancing quality through deepening attentive and connective care. Exchange and discussion with others may broaden perspectives and allow reflection on values in caregiving.

Whilst the design of the aesthetic processes is informed by mindfulness practice, these processes also include, in various combinations, aspects from other fields discussed in this chapter. These have been

[14] available on www.oxfordmindfulness.org

synthesised into practical arts-based methods rather than scientific ones.

As in MBP's, training would be required for a facilitator to lead the research processes in a reproducible way that are similar to the researcher's skills. The researcher's training includes professionally running psychotherapy groups & mindfulness as well as adapting these principles into the newly designed aesthetic processes for postgraduate artists and healthcare colleagues. It is possible that the guidance could be taught to colleagues who have parallel skills in facilitating groups. A training format would need to be devised for dissemination of this type of process to facilitators. This would be a further development of this research. It would be shorter than in MBP to be more practicable here.

In addition, where participants of the research processes are interested in practicing a formal and deeper mindfulness-based practice, they will be guided to one of the approved programmes above.
Unlike MBP's, the research practices are not manualised. However, scripts and audios for the research processes are available in this thesis. Designing a manual, or guidance for a teaching model would be a further research step.

Summary

The design of all the aesthetic processes includes informal mindful awareness. Artistic and poetic twists are incorporated to defamiliarise everyday actions or situations relevant to clinical work to create a shift from habitual thinking, capture attention and importantly to stir imagination arising from sensing. This is followed by space for reflective inquiry. The aesthetic processes involve informal practice rather than formal mindfulness-based programmes. Mindful awareness offers a way to explore current moment experience, of which sensory perception and the arising imagination is activated in the aesthetic processes. Participants are guided to become aware of their experience during actions that are familiar and related to daily clinical practice. In the clinic, the pressure of work can place healthcare workers predominantly in a busy 'doing' mode of mind. Preoccupied with thinking 'about' things such as multi-tasking, solving problems, thinking critically, conceptualising, focusing on the objective evidence base and completing bureaucratic tasks etc. there can be little chance to pay attention to the richness of the lived aesthetic experience they are immersed in. The capacity for the awareness of experiencing direct sensing, subjective thoughts, images, personal feelings, imagination and intuition can get pushed to the back of the mind as this 'being' mode maybe felt to be too subjective. However, the ability to hold this in mind - to be mindful - and link it with objective professional knowledge may be a useful additional and transformational resource and add to traditional reflective practice in an enhanced way. Being mindful of aesthetic experience also embraces the imaginative dimension arising from sensing.

4. Contemporary Western Aesthetics

Practical Experience

I co-convened the Aesthetics in Mental Health Group, a network within the Collaborative Centre for Values-Based practice in Health and Social Care[15] that commenced in 2014. Yearly meetings are organised bringing together professionals and academics working in various disciplines related to healthcare. This also includes acting as an editorial advisor for a section in a forthcoming Handbook[16] called 'Clinical Aspects of

[15] www.valuesbasedpractice.org
[16] Oxford Handbook of Contemporary Western Aesthetics in Mental Health (in press)

Aesthetic Experience in Care' in which the definitions of 'aesthetics' and 'aesthetic experience' are similar to this PhD and in line with the field of Contemporary Aesthetics.

In the field of Contemporary Aesthetics, Berleant's description of aesthetic experience includes both an awareness of what is experienced through sensory perception and the experience of meaning that arises from this. Explaining its complexity, he says that aesthetic experience '...harbours feeling tones, bodily stance, mnemonic resonances, associations and intimations that cannot be articulated except, in their own ways by the arts, particularly, perhaps literature and music' (Berleant, 1995). He explains that aesthetics of the environment differs from aesthetic appreciation of art[17] because the appreciator is immersed in the experience itself and not a separate observer from it. The environment is fully sensed, one is part of it. Environment and observer are interconnected, 'a living sense of the actual continuities that bind my conscious body to the places I inhabit...this is aesthetic engagement, and environmental perception can exemplify such experience clearly and forcefully.' (Berleant, 1995, p. 27) It is this participatory engagement that I am exploring in the clinic environment.
Next, I give brief accounts of additional areas of contemporary aesthetics that I have drawn upon, adapted and applied into practices for the purposes of this research. I have simplified them for practicable application.

Everyday Aesthetics

Also, from the same field, Yuriko Saito, Professor Emerita of Philosophy at Rhode Island School of Design and editor of the journal, *Contemporary Aesthetics*,[18] has written about 'Everyday Aesthetics' (Saito, 2007) and 'Aesthetics of the Familiar'(Saito, 2017). She suggests broadening the notion of Western aesthetics to include awareness of aesthetic components inherent in everyday living. She points out that whilst Western philosophic thought on aesthetics is more commonly linked with taste in fine art, music and literature etc, in other cultures, there is an awareness of the sensibility in daily living. She defines 'aesthetic' as those experiences 'gained through sensory perception and sensibility' (Saito, 2017, p. 1). She includes awareness of both 'negative and positive aesthetic textures' (Saito, 2017, p. 3) along with an aesthetic awareness gained through seeing the 'extraordinary in the ordinary' through 'defamiliarisation'(Saito, 2017, p. 15) as well as seeing the 'ordinary in the ordinary.' Her definition of 'everyday' refers to the 'typical, usually practical, attitude that people take toward what they are experiencing' in their regular everyday lives (Saito, 2017, p. 2). She explains that the key to noticing aesthetic experience is by paying attention with mindful awareness during participation. It is this type of aesthetic experience in the regular everyday-ness of health carers' practice that I explore in this PhD. Importantly, Saito gives examples of how awareness of everyday aesthetics is linked with values and care in wider issues such as moral, interpersonal, social, political, environmental and sustainable levels. In her chapter entitled 'Consequences of Everyday Aesthetics' (Saito 2017 p141-186), she argues that awareness of the 'everyday aesthetic' is thus deeply important as it can 'steer' decisions about actions taken at both personal and local levels, right through to large political and environmental issues. As in sections described above, she upholds that being aware of an ability to respond in this way thus brings a moral responsibility to act for the good in the world, a 'social responsibility' for 'world-making.'

Although the Japanese Tea Ceremony is not an everyday event, Saito uses this as an example of the awareness of sensibilities involved. For instance, the process demonstrates taking and giving care, thinking

[17] I assume he means more traditional art forms and does not include connective aesthetics here
[18] contempaesthetics.org

about the other, issues of empathy respect and gratitude that arise in participation, as well as the setting (Saito, 2017, p. 150). The importance of becoming aware of the care inherent in these actions can be transferred to everyday actions. In this way and like Dewey's writing in 1934 in 'Art as Experience'(Dewey, 2005), she broadens the view of 'aesthetic' to practical everyday actions and 'aesthetic experience' that arises in participation.

I propose that the everyday aesthetic described by Saito is also applicable to everyday aspects of working in a clinic and that aesthetic richness in regular, everyday actions may be missed yet could offer a useful resource. As Saito says, I believe that paying attention to everyday aesthetics can also be linked with values and Values-Based practice in medicine and that this relates to interpersonal connections and extends to political and environmental issues in healthcare work. Whilst the role of imagination in not a major focus in Saito's work, she alludes to the work of Brady which will be discussed next and details the arising imagination from sensory awareness.

Environmental Aesthetics

Emily Brady puts forward a model for aesthetic appreciation of the natural environment called the 'Integrated Aesthetic (Brady, 2003a, p. 146). This is based on the human capacity for awareness of perceptual sensory detail and the imaginative dimension that arises from participatory relationship with the natural environment. She contrasts her model with Carlson's 'cognitivist' approach that proposes one must be informed with pre-existing scientific factual knowledge for appropriate aesthetic appreciation (Brady, 2003a, p. 87). Brady refers to her model as a 'non-science' or 'non-cognitive' model as it embraces awareness of subjective human perception and imagination in response to what is directly observed rather than starting with reference to objective scientific facts. She argues that pre-existing knowledge is not a necessity for appreciation of aesthetic 'qualities' although factual knowledge can provide a backdrop to expand appreciation and contextualise insights from her model.

In relation to the clinical setting, the scientific objective evidence base has primacy and whilst crucial, perceived human qualities of sensing and imaginal experience may be suppressed. In the clinic, one is immersed in experiential participation, in inter-relationship with other humans and the environment where subjective encounter takes place. The different types of knowledge from both positivistic and qualitative paradigms bring different perspectives. Considered together, they could bring a more holistic understanding. As with Sacks and Saito, Brady's model of aesthetic appreciation is about the ability for the human to respond and link this with values and moral implications. Brady's model is in relation to environmental aesthetics and conservation, yet I thought that it resonated with the type of aesthetic experience that I am exploring in this PhD. I was interested to see what would happen if I interpreted, adapted and applied aspects of her model in practice-based ways for becoming aware of aesthetic experience in the clinical setting. Her clear description makes it possible to try an adaptation in practice.

In outline, Brady's model comprises of a framework of four stages or 'modes of imaginative activity' that arise from closely noticing sensory perception. She calls these modes 'exploratory, projective, ampliative and revelatory.' Later she adds 'metaphorical imagination' (Brady, 2003a, p. 153) These modes may be present in varying amounts. My account below adheres to her paper (Brady, 1998, pp. 143–145).

Exploratory imagination: the first stage arises out of exploring a chosen object or scene by paying attention to sensory detail. From this, imagination quickly begins to 'reach beyond,' extending to associations and images. She gives the example of how the bark of a tree may bring to mind an elderly man or the tree's size may bring qualities to mind e.g. sturdiness.

Projective imagination: here imagination may be projected onto, add to, overlay or replace the perceived object by seeing it as another thing. Or one may imagine 'into' a natural object such as feeling the outstretching gesture of a flower opening towards the sun. In this way the imagination allows appreciation of qualities in a more 'intimate way,' as an empathic move.

Ampliative imagination: here imagination deepens further, amplifying what is perceived or directly projected onto inventively and creatively. Brady says this is imaginative power at its 'most active mode in aesthetic experience' and can involve 'visualising and leaps of imagination that enable approaching natural objects from new standpoints.' This may bring new insights. For example, holding a pebble in my own my hand, I too can see clearly the beach it came from and survey the scene, hear the sea and feel the wind on my face. I can even feel the rocking motion of the pebble in my body as it is buffeted by the tide. In imagination, I can feel my feet moving as I walk along the shingle hearing the scrunch. I can scroll back in time to an imagined narrative of what this pebble might have been and forward to what it might become either on the shore or after being placed on my desk. Brady adds that it is through this mode of imagination that we can try out new variations, outcomes and possibilities.

Revelatory imagination: Brady describes how this may lead to discovering an 'aesthetic truth' that she calls 'revelatory'. The imagination is stretched to the point where there may be a broader realisation about a bigger picture as in Brook's last stage of Goethean Observation. Brady gives an example of aesthetic appreciation of a glacier ultimately revealing the 'tremendous power of the earth' in imagination. Thus, paying attention to what is sensed and imagined may be transformative in leading to new insights that may not be discovered if one adheres to pre-existing facts alone.

Metaphorical Imagination: (Brady, 2003a, p. 153) refers to the way the imagination may extend to another thing, to symbolise some quality or aspect of the issue studied in a novel, creative way. I give an example in chapter six.

Brady goes on to say that once sensory and imaginative detail have been perceived and explored from the human perspective, this can be compared with what is known from pre-existing scientific facts to situate the findings.

Brady also explains the need for 'imagining well'(Brady, 2003a, p. 158). My interpretation of this is of taking a balanced view, between the human subjective perspective in her model and the pre-existing objective facts along with reflecting on what is appropriate in the given situation. She also includes subjective emotions. In relation to this, she goes on to propose an adaptation of Kant's disinterestedness (Brady, 2003b, pp. 121–123) but this is not discussed further here.

In my research processes, I have adapted components of Brady's model into new participatory processes designed to activate aesthetic experience in relation to clinic issues. I have incorporated her stages into spoken guidances that lead participants from closely noticing sensory detail to the expanding imagination and then to wider links and insights with clinical practice in parallel with her model. I also relate to these in my methods of analysis discussed in chapter 5.

Like Brady, I argue that aesthetic appreciation based on human capacities for sensing and imagination also offers an additional resource for reflection on qualitative caregiving and can be linked with values and wider implications. Reflective practice would serve to skilfully decide what subjective knowledge is appropriate in a given situation alongside the objective evidence base.

Furthermore, Brady states that the complexity in nature offers an opportunity for rich aesthetic experience. The senses and imagination are triggered as they arise directly from the observer's immersion in and relationship with the natural environment or aspect of nature observed. She suggests keeping an open and flexible state of mind maintaining a 'sensitivity and 'mobility of mind' to constant change, or happenings, in the natural environment to notice the 'expressive aesthetic qualities in natural objects.' Thus, the capacity for aesthetic appreciation requires an open awareness, to what is experienced, as in mindfulness and to new perspectives and insights that emerge. This is relevant to the type of aesthetic experience I am investigating in this research in the clinic where one is immersed in the environment and the human encounter.

Brady defends a criticism that her model is too subjective and hard to evaluate in a quantifiable way. She explains that a rigorous approach comes through careful reflection in 'imagining well' thus 'knowing when to reign in the imagination' (Brady, 1998, p. 146) and skilfully find a balance between overly personal aspects and those that are related to the current situation at hand, including the views of others. This maintains enough distance to be both reflective and at the same time be sympathetically engaged. [19] A similar criticism of the risk of being too subjective and unquantifiable is often raised in medicine. Yet, qualitative aspects and reflective practice for making balanced choices in delivering best care are increasingly used such as those based on lived experience, values and collaboration.[20] A further issue also relates to how to evaluate qualitative observations. I will discuss my methods of analysis in chapter five.

Brady also defends the criticism that the role of imagination risks being an inappropriate flight into phantasy. Similar to the 'schooled' imagination that emerges by progressing through stages of Goethean observation as discussed by Brook, Brady explains that it is important to adhere to perceptions and imaginings that arise directly from the object of observation itself. This is the 'frame' that guides imagination keeping it connected to sensory experience. Wider imaginings that come to mind can be reflected on skilfully, as above, to decide which can be excluded as irrelevant and which are appropriate.

The type of aesthetic experience and awareness in the clinic that I am investigating in this study has some parallels with the model in environmental aesthetics described here. It differs from traditional aesthetic appreciation of art where an art object may be 'framed' and separate from the viewer and directed by the artist. Brady explains the natural environment is not framed or presented by the artist and her model of aesthetic appreciation, in line with Berleant's view, is participatory. For instance, there is no artist's direction when looking at a flower or landscape. Similarly, I uphold that situations in the everyday clinical work are not 'framed' by an artist and that health carers are also immersed in participation with many emotive and changing scenes and actions. The healthcare worker can also be responsive to happenings in an aesthetic way as well as

[19] In a personal communication with Emily Brady (2021), she cited Adam Smith's linking of moral values with subjective perception and imagination. 'Sympathetic engagement' is a term of Smith's and I interpret it to mean empathic engagement.
[20] themdu.com: Judgment in Montgomery v Lanarkshire Health Board [2015] UKSC 11, paragraph 87.

an objectified way. However, in this PhD, I have 'framed' instances of familiar everyday clinical issues in the design of the participatory processes as described in chapter six. Yet, I have done this to present these everyday issues for participants to experience away from the busy clinic where there may be no time for reflection. Taking time to become aware in this way may enable practitioners to be aware of such experience in subsequent practice. Awareness of aesthetic experience can work alongside the objective evidence base at appropriate times of reflection to offer a more connected and holistic approach. The aesthetic experience investigated in this PhD resonates with Brady's model in becoming aware of the imaginative dimension as it expands from sensory perception.

As Brady points out, aesthetic appreciation in this way may bring revelatory ideas and moral implications with 'response-ability' as also discussed in sections above. My interest and interpretation of Brady's work is that it may shed light on a way of also coming to aesthetically appreciate such images that are abundant in the clinic.

Aspects of Brady's and Brook's models are combined with mindfulness-informed awareness and poetic interventions to design processes to activate and become aware of aesthetic experience in relation to the everyday clinical environment.

An example of how aspects of the above models have been simplified, adapted and synthesised for practice in the design of my research processes is given in the portfolio of practice - process 1, PoP6

5. Role of the imagination

As the research design progresses and processes are tried out, the complexity of the different ways the imagination functions emerged. In this next section, I discuss imagination in more detail.

'Aesthetic' is defined in this PhD as sensory perception and the arising imaginative dimension. Above I have discussed the importance that Saito places on noticing the sensibilities of aesthetic detail in everyday experience. I have described how the imaginative dimension that arises from noticing sensory detail is included within aesthetic experience by Brook and Brady. Also, in Social Sculpture, connection with both sensory perception and imaginal thought are important in the aesthetic response. I have discussed how cultivating focused attention in mindfulness-based practice allows exploration of present moment experience rather than allowing the mind to wander. I have explained that imagination that stretches back into the past or projects forward into the future yet is brought into mind as current experience in this research arising from sensory perception is embraced and is a form of mind wandering[21]. By remembering, re-experiencing or projecting forward in imagination, these contents of mind can be brought into the present moment so can also be explored mindfully.

An outline of Abraham's framework for the imagination embraces these aspects of 'time travel' and is therefore outlined next (Abraham, 2016) as I wished to demonstrate the complexity and richness of the imaginative dimension that emerged during my newly designed processes. Participant feedback revealed that many different aspects of imagination were triggered and linked to each participatory process as the research progressed. Anna Abraham's proposed framework was useful as it provided categories for various functions of the imagination. Based on philosophical ideas coupled with current neuroscience, it was useful for thinking

[21] Intentional and unintentional mind wandering have been described but this is not discussed further here.

about the detail of findings that arose in my research processes. In scoping studies that are described in chapter four, I used broad themes from mindfulness and the life world (Ashworth, 2003) to group types of experiences reported by participants. However, later, I wanted to demonstrate the detail and richness of the contents of the arising imaginative component of aesthetic experience and devise a way of analysing these. Also, to demonstrate the potential of the imaginative dimension as a resource.

In her paper entitled 'The Imaginative Mind,' Abraham's proposed framework has five categories of different aspects of human imagination (Abraham, 2016). The framework aims to enable a common understanding of terminology for communicating concepts between disciplines for building of ideas and hypothesis testing. Additionally, in editing 'The Cambridge Handbook of Imagination', she brings together contemporary thinking from selected authors for each category (Abraham, 2020). She points out that whilst philosophical thinkers may include different components in describing the phenomenon of imagination, a central feature is the capacity for awareness of issues to be held in mind that relate to times beyond the immediate present (Abraham, 2016). She cites Stevenson's 'Twelve Conceptions of Imagination' (Stevenson, 2003) as a comprehensive descriptive classification. This is reflected in the Oxford English Dictionary definition of imagination. Moreover, Abraham's framework aims to link philosophical thinking with corresponding brain functioning shown from neuroimaging. She says that her framework is 'loosely based,' with overlap between categories in reality and that there are still many unknowns. Her categories are outlined next and the relevance of these for my research is indicated and discussed further in relation to the processes in chapter six.

Mental-based imagery. In this first category, she explains that sensory perception in real time can trigger sensory imagery that overlaps with or arises purely in imagination. The same sensory areas of the brain are activated in both. For instance, mental imagery can activate the visual cortex in those born blind and imagining sound can activate the auditory cortex. Also, more than one area of the brain may be activated by one type of image e.g. visual and auditory cortices at the same time in synaesthesia. Multisensorial imagery occurs in the aesthetic experience in my research and will be shown later.

Intentionality-based[22] or **recollective imagination** is the second category. Here, Abraham places processes of the imagination that engage the default mode network (hereafter abbreviated as DMN) of the brain as revealed in neuroimaging. The DMN is a connected network of brain areas that are activated in spontaneous thought that arises about something but is not related to focussing on a specific task i.e. 'task unrelated' as compared to 'task related.' It is introspective thinking and includes, for example, mind wandering, daydreaming or zoning out. The literature on this is extensive and not included in my thesis.

This category includes imagination about the past in 'autobiographical'[23] and 'episodic memory,'[24] thinking about the future in 'episodic future thinking'[25], mental state reasoning or theory of mind[26], self-referential thinking[27] and moral reasoning[28]' (Abraham, 2016, p. 4202). Whilst task-unrelated thoughts such as mind wandering can distract from the focussed attention of task related performance, they may serve a

[22] the quality of mental states (e.g. thoughts, beliefs, desires, hopes) in being directed towards something - object or issue.
[23] Personal memories
[24] Discrete episodes in one's history
[25] Imagining or simulating experiences that might occur in one's personal future.
[26]The ability to think of or infer the mental states of others, as empathic
[27] Relating external information to the self
[28] How individuals think about right and wrong and apply moral rules and guidelines

productive purpose. For instance, in 'Not all Minds that Wander are Lost' the authors, (Smallwood and Andrews-Hanna, 2013), list the following advantages of mind wandering: being able to reflect on the past; imagine future experience; the ability to mentally 'time travel' between the two; future planning; delayed gratification; creative thinking and moral reasoning. These functions of the imagination can thus act as a resource to be drawn upon in reflection and for appraising current situations. These components of imagination were found to be important in the aesthetic experience in my research processes as will be shown in later chapters.

Novel combinatorial-based imagination. In her third category, Abraham includes processes of imagination such as 'novelty, open-endedness, discovery and generativity' (Abraham, 2016, p. 4203). She says this category is when the power of imagination extends beyond 'what was', 'what is' and extends to the 'what if' or 'what might be' and involves journeying within the 'possibility space.' Through imagination exploration can reach beyond the current situation and 'combine or evaluate existing knowledge in novel ways'. The processes of imagination involve more open-endedness, freedom and 'counterfactual reasoning[29], generation of hypotheses generation and creative thinking[30] during problem exploration and solving. Also included here, and part of creative thinking is non-fixed thought that is divergent and 'non-linear combination of information' that leads to shifts in perspective and changing mental sets.'(Abraham and Windmann, 2007). This category has also been found to be important in my research processes and will be discussed later.

Whilst Abraham points out that in this third category, empirical findings from neuroimaging literature are more diverse than the second category. She presents her third category is a 'tentative case' for 'functional commonalities' of aspects of imagination, however, here she explains that the DMN is also active and connects with brain areas involved in cognitive and semantic functions allowing evaluation of 'possibilities' for their relevance and appropriateness (Abraham, 2016, p. 4204). The contribution of the DMN here depends on the degree of constraint or open-endedness of the task. This latter point is important as task orientated activity may suppress the more expansive, creative functions of the imagination.

The relevance of this to my research is the importance of becoming aware of this category in which the imagination can function in a 'possibility space' where novel thinking, new insights and understanding can freely emerge. In other words, new ideas may emerge whilst not focussing on a specific task but during mind wandering into imagination. Making space for the imagination to expand has implications for my own design process and for the type of the guidance I come to design for each the aesthetic processes. To achieve more expansive creative thinking it would be important to allow time for the imagination to emerge in this way as the DMN may be fertile soil for new ideas. I discuss this later.

Phenomenology-based Imagination (Aesthetic Engagement) is Abraham's fourth category. She points out that the psychology and neuroscience relating to the meaning of 'aesthetic engagement' here largely focus on the visual arts and music. Neuroaesthetics is a field of cognitive neuroscience that investigates the biological basis of aesthetic experience or art objects, natural objects and environment and involves a neural interaction combining an 'aesthetic triad' of sensory-motor, emotional-valuation, meaning-knowledge

[29] Thinking about alternative possibilities for past or future events other than the present reality
[30] One definition is: "the capacity to generate many different kinds of ideas, manipulate ideas in unusual ways and make unconventional connections in order to outline novel possibilities that have the potential to elegantly meet a given purpose".(Ramalingam, D *et al.*, 2020)

components of the brain linked to the reward system in the brain (Chatterjee and Vartanian, 2016). Concepts in this field are outlined in more detail by Pearce (Pearce *et al.*, 2016). However, in my research the definition of aesthetics embraces aspects of the imagination that relate to all of Abraham's categories. However, I aim for an element of beauty and fascination in the processes I design to draw people in.

Altered states of Imagination Abraham's fifth category includes the imagination that occurs in altered states of mind such as dreaming, meditation, drug induced, hypnosis and brain lesions. Whilst not all of these may be expected to occur in my research processes, the first two may be relevant if a participant falls asleep and dreams or becomes deeply involved in some forms of meditation.

Later, in my research, I use Abraham's categories to devise methods to analyse feedback from participants in the research processes. I use tables with column headings of themes adapted from the above categories and assign participant feedback words and phrases to these. I create visual maps based on these categories to show how the imaginative dimension expands from present experience including reaching back into past, projecting into future, and imagining new possibilities (chapter 5). These maps show the richness of aesthetic experience that may come into play in clinical practice, 'in real-life action' and how they may correspond with Abraham's framework demonstrating this from experiential practice rather than theory or neuroimaging. As in 'living anatomy' one may come to understand how the body may function by seeing it in action. Here I aim to show how inner aesthetic experience can be described whilst observing during participation. Mapping onto Abraham's framework also serves to position my work as well as adding an arts-based model to this framework.

Overall, I have found that Abraham's framework has aided my exploration of the complexity of aspects of the imagination at play in the aesthetic experience in my research. As my research developed, applying this framework allowed me to demonstrate themes that were more detailed than in the scoping studies. Also, my method of analysis was furthered by adapting Abraham's categories.

In summary, I have applied categories from Abraham's framework in a practicable way for analysing participant feedback of experience in my research processes. In chapters five and six, I show this in detail.

Three further areas referred to:

1. Reflective practice is mentioned throughout this thesis and refers to reflective practice described by Schön (Schön, 1983) and **experiential learning** of Kolb (Kolb, 2015) clearly described in these texts. These concepts are used in the research inquiry process. In chapter five, I add details of reflective practice in the arts that includes knowledge arising during performative practice that is haptic, tactic and embodied (Nelson, 2013)

2.Values-based Practice (VBP) is an important area for clinicians. The main focus of traditional training and appraisal focusses primarily on objective evidence-based medicine in the positivistic paradigm. However, values-based medicine that embraces relevant values and perspectives arising out of subjective lived experience for patient and clinician alike are also important. Coupled with reflective practice, values-based practice takes each person's 'unique preferences, concerns and expectations' related to the clinical encounter into account and integrates these with the objective evidence-base to enhance the quality of care. Fulford describes VBP and reminds us of Sackett's initial definition of evidence-based medicine that necessarily integrates the objective evidence base with values for delivery of best clinical practice. (Fulford, Peile and Carroll, 2012, p. 7). VBP is

fully described in their text. The research practices in my study extend the scope of VBP by offering the opportunity to reflect on values that emerge from awareness of aesthetic experience arising during experiential participatory action. Being in direct experiential participation may bring a more vivid encounter with experience and exploration of values for reflection than talking 'about' these alone.

3. Arts in Health. This expanding field incorporates a wide area of arts-based practices. It is beyond this thesis to mention all these and they are covered in a thorough and extensive recent review (Fancourt and Finn, 2019). However, the aesthetic experience of health care workers in everyday practice was not included and my research presents a contribution here.

Chapter Summary

In summary, this chapter shows fields I combine with my own background experience in medicine and the arts for exploring and designing connective aesthetics in my research. I discuss my interpretation, adaptation and application of aspects of them, newly synthesised in this study. All practices have at their core a 'being' mode of mind in which awareness arises from paying attention and closely noticing what is experienced in participation and reflection on this.

Connective aesthetics are practice-based processes designed to explore experience during participation by closely noticing multisensorial detail and the arising imaginative dimension of aesthetic experience as defined in this research, as it arises at the time followed by feedback and reflective inquiry. The imaginative dimension is complex and can hold re-collection of the past and future possibilities in mind in the present moment. This suggests that the capacity for awareness of personal sensing and the complex imaginative dimension of aesthetic experience is fertile soil for creative thought and possibility. Coupled with 'imagining well' in reflective practice, awareness of aesthetic experience could be a resource that could be extend VBP and be integrated with objective evidence.

Chapter Two

Early practice-based work & initial description of aesthetic experience: Experiments in 'Close Noticing'

Introduction.

I have defined 'aesthetic' and 'aesthetic experience' in the introductory chapter. In this study, the imaginative dimension of aesthetic experience includes components of inner mind that arise from sensory perception. In this chapter I begin to explore these directly by designing arts, practice-based methods to closely notice experience as it arises in participation.

Following this, chapter three relates aesthetic experience to clinic work. Chapters four to six describe how the research is expanded to design new experiential participatory processes for others. Overall, an emergent practice-based methodology is developed called 'Connective Aesthetics in Medicine.'

Chapter outline.

Initial practice-based explorations of everyday aesthetic experience in non-clinical settings are described and reflected on in this chapter. New arts and practice-based methods were designed and used experimentally to investigate, observe and describe aesthetic experience by paying deep attention. I called these methods 'close noticing,' a term adapted from then late James Hillman (Hillman, 2000, pp. 170–185). The use of this term in this research is described. Examples are given of arts-based small actions where experience was closely noticed along with connections this brought with self, other, the environment and wider issues. Using a first-person practice-based approach and small group processes, experiences that arose during participation were explored, reflected on and reported. An initial description of aesthetic experience was compiled, and further research questions emerged. Five examples of presentation slides to show practice are included here. Larger views are given in the Document II, Portfolio of Practice for this chapter (hereafter abbreviated to PoP2).

What is 'Close Noticing'?

This term was adapted from James Hillman's writing on 'Image Sense'(Hillman, 2000, pp. 170–185) where he said that the process of 'sticking with an image[31]' and exploring all its possibilities through close, direct and deep attention allows the 'the image to tell all.'[32] I have adapted his term here into arts, practice-based methods used in a series of experiments to start to investigate aesthetic experience. The experience arising in each is closely noticed. In the context of this PhD, 'Close Noticing' involves: (i) noticing inner experience[33] whilst immersed in an action, image or scene; (ii) deeply attending and using all one's powers of perception for sensing this; (iii) describing this inner experience including the arising imaginative dimension; (iv) through this, becoming aware of possible new insights and links with wider issues and values beyond the initial experience and (v) an awareness of having a choice to respond appropriately i.e. 'response-ability.'

The **'**Experiments in Close Noticing' discussed here relate to arts practice-based methods designed to enable this by: (i) creating actions and images that raise curiosity, stir sense perception and imagination; (ii)

[31] As in a dream or image held in mind
[32] This parallels a phenomenological approach. The patient explores their own images and meanings these may bring by direct observation rather adherence to pre-existing concepts from psychotherapy.
[33] Inner response, inner world, inner events of mind

facilitating ways of drawing deep attention to what is experienced in order to describe this; (iii) make space for reflection in and on action and experiential learning. I have used 'Close Noticing' as a collective term to include a variety of processes and methods that achieve the above. Some include innovative methods designed within this research. Others are an innovative adaption or synthesis of existing practices with arts practice-based methods.

Overall methods used in Close Noticing processes

A variety of methods were used such as re-enacting, recording, performing a routine action repetitively and slowly, photography, audio, drawing, painting and sketching, participatory action, gesture and free writing to heighten awareness through focusing, deepening and sustaining attention on sensory experience. These also included the following:

- poetic 'twists' as interventions to de-familiarise, disrupt habitual thinking and draw attention and curiosity.
- immersion in practice to observe sensory experience directly and closely at the time to describe this in detail
- using techniques of contemplation and mindfulness meditation combined with the above to focus and sustain deep attention as well as the following
- paying attention to the arising imaginative dimension as part of the experience, allowing this to expand and noticing what occurs in mind
- make the 'invisible' path of attention 'visible' by drawing, or mapping this out with chalk or pencil as 'attention maps.'
- innovative first person and small group participatory processes that employed both reflexive and reflective methods.
- reflection in and on this action and experiential learning

Why might Close Noticing be important?

During a MA in the Interdisciplinary Arts, I developed a series of methods in which I started to work deeply and in dialogue with images that seized me, sticking closely to the images they made in my mind's eye. Based on this, I created new images for sharing with an audience to see if these could resonate or have meaning for them too.[34] From feedback, I discovered that the images I made from closely sensing a situation were deeply evocative and immersed viewers in experience. Their feedback revealed that hidden, ignored or suppressed meanings came to light. I began to consider that by noticing closely with deep attention, new ways of seeing could emerge and lead to an opportunity for reflection on values and choice of action. During the early PhD experiments here, in relation to the core concept of this work, I noted in my reflective journal that:

> *'....the hallmark of my art and aesthetic work are processes that attempt to get down to the very fine detail of things. To the mental and bodily events that occur in response to everyday small actions in life and then in the clinic. By becoming fully aware of sensing and imagining in these moments and making space for reflection on this, one may have the opportunity to make a deliberate choice for acting in the best humane way rather than a non-reflective or automatic one.'*

[34] Fox, MA work (2011) - '6 Minutes' video piece

This resonates with thinking from other disciplines discussed in the last chapter. For instance, Gablik and Sacks link this awareness and 'response-ability' with moral implications. This may have transformative potential by enabling active choice of best humane action. Saito also argues that the everyday aesthetic is not insignificant and awareness is 'instrumental in steering our actions' (Saito, 2007, p. 244) and linked with values Similarly, in mindfulness-based practice, one learns to become aware of a space between stimulus and reaction in which one can pause and reflect on the freedom one has to choose one's response with care and according to one's values. Furthermore, Brook and Brady's models reveal how closely noticing sensory detail of a situation or object give rise to the imaginative dimension that can lead to insights beyond the immediate issue thus showing that the capacity for human sensing and imagination in aesthetic experience can add valuable knowledge to objective facts.

In relation to healthcare, I propose that this awareness and reflection on it may have potential for considering choice of best caregiving based on this ability to respond. The ultimate aim of this PhD research is to design participatory processes that raise the capacity of awareness to aesthetic experience through direct practice and create a space for reflection on the best choices for humane care.

Practice-based examples of Experiments in Close Noticing.

Initially, many small actions were carried out to explore what sensory perception and the arising imagination could be noticed and the connection this may bring. Examples from a list compiled from reflective journals, notes, jottings, and various reference links can be seen in PoP2:'100 daily connective practices'. From these, several were expanded further for exploration as 'experiments in close noticing.' From the latter, six groups of examples are given in this chapter and use various arts and practice-based small actions and processes. These are akin to 'sketches' made whilst working out ideas that contribute to later work. Examples contain a poetic intervention that draws attention, curiosity, stirs imagination and brings out aspects of the aesthetic experience under investigation and the connectivity this brings. Each experiment explores ways of increasing attention to aesthetic experience and noticing it closely and the connections this brings.

The first example in close noticing is described in full here. This shows the format of recording the whole experiment. The analytic aspects are then given for each of the further experiments in this chapter. These include background and starting points that led to the aim of each; reflections on results and next steps that progress the research and the connectivity that awareness of aesthetic experience each brings. Details of practice-based methods, arising results and a record of documentation can be turned to in PoP2 - 'Experiments in Close Noticing'.

1.Skin Sensing.

Background and starting points: The skin is one of the most responsive sense organs, yet sensory information from the body surface may be taken for granted and fade into unawareness in everyday life. The skin on the soles of the feet and the palms of the hands is particularly sensitive. Also, one is rarely aware of the skin sensing of the surrounding air or of our connection with the world through this skin-world interface.

Aim. This was to closely notice what happened when close attention was paid to the experience of sensing at the surface of the skin. A poetic intervention was used to introduce this in a defamiliarized way, to encourage seeing beyond the habitual.

Practice-based method. Sycamore keys were threaded onto cotton (as in the image below) to allow the breeze to move them lightly against the skin and draw attention to the sensation of the finest movements of the air. These materials were used to draw curiosity, attention and stir imagination and to be more poetic in comparison to the technical clinical neurological examination[35]. A brief time was spent contemplating and reflecting on the arising experience between the researcher and a colleague as participant.

Results: What happened in the experience? Curiosity and attention were drawn by the seeds to the sensations felt on the skin, arising thoughts, feelings and imagination were described. Not only this, there was also awareness of sensing the interface where skin and body met air and earth. This led to a sense of connection with, inner experience and immersion in the surroundings and a sense of being part of it, not separate or disconnected. A rough sketch shows the expansion of the aesthetic dimension. See further images in PoP 2, p 14-15.

Reflections: Close noticing touch in this way triggered aesthetic experience of sensing and arising imagination. Paying attention to what is perceived at the skin surface may not normally happen in healthy everyday life, but this example revealed a way of connecting with awareness of the broader sensorium[36] including the imaginative dimension of the aesthetic domain. This began to demonstrate the type of aesthetic experience I wished to study. This experiment also differentiated the domain of aesthetic experience from objective observations made in the clinical examination. Knowledge from subjective and personal experience was revealed alongside objective findings. I argue it is also important to note at appropriate times as an added resource that may contribute to more connected care. For instance, whilst the clinical neurological examination importantly maps out the loss of sensation due to objective physical neurological damage, the physician may also come to empathically imagine what else of value could be lost for the patient. This may lead to inquiry about how loss of sensation may impact on the values of the patient and what this may mean in terms of wider loss as a more holistic approach. For example, no longer being able to feel the touch of a loved one, pet or variety of objects and other functions. Reflecting on this example, one may begin to see the importance of a

[35]The distribution and functioning of the innervation of the skin, (dermatomes) on parts of the body is methodically tested for different modalities – light and deep touch with pin prick and pinch, heat, vibration, often performed quickly and mechanically in routine clinical neurological examination.
[36] Sensory faculties as a whole.

physician being aware of how aesthetic experience may be entwined with values for the patient and how empathic imagination on the part of the physician may lead to a few questions that connect with the values of the patient alongside objective findings. The latter is at the core of Values-Based Practice (Fulford, Peile and Carroll, 2012).Being aware of this ability to respond to aesthetic experience may be a useful resource in delivering humane healthcare. Interaction with the physicality of the body brings complex and subjective aesthetic experience into play but time pressure may mean that further inquiry and reflection on this can get pushed aside.

In the clinical examination there are instances when gloves are used to examine a patient and other times when we use our bare hands. When appropriate, either may present an opportunity to become aesthetically aware of what happens when we encounter another through skin-to-skin contact, or even with gloved hands, in noticing the absence of direct touch. Furthermore, this had relevance in Covid times where there was extensive loss of direct touch. These latter reflections formed the basis of subsequent group participatory processes 'Bathe: An Encounter with Care' and 'Touch: An Encounter with Care' described in chapters four and six respectively.

Next steps: My research questions and methods developed including how to become increasingly aware of aesthetic experience and how to turn towards it to notice its nature more deeply and closely. As discussed in chapter one, I was familiar with paying attention to experience through attentional training as one of the key practices in Mindfulness. In this way current moment experience can be explored in greater depth. A more poetic example of awareness of this type of experiencing can be seen in the field of eco-philosophy when Abram discusses turning towards sensing of the air (Abram, 1997, p. 225) based on the Merleau-Ponty's writings.

Documentation of this experiment was made in reflective journals using visual thinking in sketches, photographs and written notes[37]. By noticing multisensory detail and rich imaginative components of aesthetic experience, insights could also extended to values that may be associated with touch or loss of it.
The incorporation of an artistic, poetic twist served to raise curiosity, draw attention to sensing and stir the imagination of aesthetic experience as defined in this study, thus opening up awareness of the aesthetic domain.

Connectivity: that awareness of aesthetic experience brought was with personal inner sensing of a broader sensorium and the imaginative dimension.

2.Experimental Writing

Three ways of exploring experimental writing in this research are discussed:

(i)A brief workshop writing Haiku

Background and starting points:

"Haiku happen all the time, wherever there are people who are 'in touch' with the world of their senses, and with their own feeling response to it" (Higginson and Harter, 2009, p. 4)

Aim: Haiku are short poetic forms that convey the writer's experience activating imaginary sensory experience in others. Based on this established method, the aim here was to experiment with generating aesthetic

[37] e.g. detailed notes in Imagination arising through sensing.docx (not included here for space reasons)

experience by creating maximum imagery from minimal words and to explore a way of sharing this process with others.

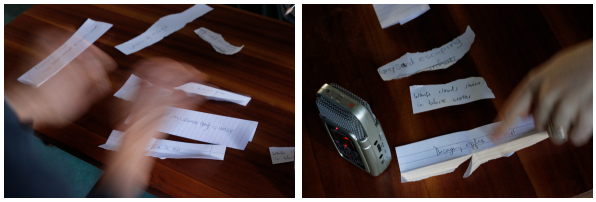
Practice-based methods and results from practice - Sample image shown below. Also see PoP2.

Reflection: Feedback indicated that multisensorial and imaginative details were generated with immediacy when words were arranged in certain ways. Minimal words could evoke an aesthetic impact in others who were able to describe a mixture of sensing, feelings, imagination & images. Here, the experience arising from a small element of daily life could be noticed closely and conveyed to others to trigger sensibility and stir imagination using minimal means.

Next steps: Further research questions emerging from this were: could this strategy be used in a visual way to stir aesthetic experience? For example, the juxtaposition of photographic images in the 'Hospital Corridor' piece in the scoping study described in chapter four. As medicine is full of emotive images and acts even in everyday moments, could this be applied in relation to clinic work to generate this type of experience here using a poetic image? Could I design processes that achieve this? As in the Skin Sensing experiment above, the poetic twist appears to generate aesthetic experience by shifting one out of a habit mode of thinking alone and into the experience. Furthermore, the small group format was a way of sharing and discussing this type of experience.

This took the overall research forward by developing experiential participatory formats such as a series of pared down and juxtaposed photographs or adding an unusual twist to a familiar clinical action during a practice-based process.

Experimental writing: Haiku workshop – minimal words, big aesthetic impact



Connectivity: was made with sensing and imagination of aesthetic experience in each participant and this could also be. conveyed to others through this poetic method.

(ii) Microscripts.

The **aim** was to experiment with short pieces of free writing to discover if aesthetic experience could be activated and noticed closely by removing constraints of pre-existing rules of poetry or prose.

Starting points: following the haiku method above, I wished to know whether short phrases or sentences of prose could be used to convey imagery for others with immediacy.

Practice-based methods and results see PoP2 including lower image on p16.

Reflection: I found that free writing allowed me to capture spontaneous thoughts about my own experience and was a useful way of recording this, by flowing 'straight form the heart....onto the page' (Goldberg, 2005). For others the written word here was a re-presentation of my thoughts rather than a conveyed experience they could participate in and have their own direct experience. However, as a first-person method, these 'microscripts' were a way for me to explore and record aesthetic experience in certain instances. Like brief sketches of ideas, they served as a resource for my further reflection on my own sensory awareness and arising imagination. In processes developed later, I used some of these writings to re-enter and notice more closely as an introspective process. Being connected with my own lived experience also served to project more genuine experience when woven into subsequent design. Whilst skilled writers can evoke aesthetic experience, not everyone is practiced in verse or prose.

Next steps: These brief forms of free writing remained one method of recording personal lived experience, including from the clinic, and were kept in journals as resource material. Some were used and discussed later in this research as a starting points and components in subsequent design processes[38]. For example, in Covid times, sharing short pieces of free writing of my lived experience were evocative and useful in online zoom processes where it was not possible to meet face to face to generate an immersive experience.

Connectivity: was made with my own lived experience. Components of this became woven into subsequent processes that did ultimately convey aesthetic experience to others. The 'microscripts' were akin to brief sketches to be worked up, or ingredients that could be designed into final pieces.

(iii) 'I'm Noticing' I'm Noticing' - Mindful exploration and recording experiencing

Background: Experience in Mindfulness-Based practice was discussed in the last chapter.

The **aim** here was to explore a way of recording experience at the time of meditation or directly after and so be able to reflect on the nature of experience.

Practice-based methods, results and examples of documentation: see PoP2 and image on p17.

Reflections and next steps: From the results, I found that a mindfully informed process of turning towards experience could be a useful direct method of noticing the sensory and imaginal components of aesthetic experience in this research. Both methods of direct transcription and drawn visual maps were useful for recording and reflecting on the nature of aesthetic experience. This progressed the research in that I later developed these methods in the analysis of the finally designed processes. In chapters five and six I show participants' words and phrases were recorded in a similar format of a found poem along with drawn attention maps.

Connectivity: with detailed experience arising in the mind-body complex at the time was made. The drawn attention maps make invisible pathways visible in the form of a visual representation. This is further described below.

[38] A detailed example of this is given in 'Stethoscope Meditation' in chapter six.

3.'A Life World in a Day'

Background and aim: In mindfulness practice one cultivates becoming aware of and noticing details of what is experienced moment by moment. Here, the **aim** was to notice closely the richness of aesthetic experience in routine daily moments as they were lived.

Practice-based methods, results and examples of documentation: see PoP2 including the image on p.19. These were methods of 'close noticing ' akin to Proustian style (Proust, Davis and Prendergast, 2004)

Reflection and next steps: Whilst noticing this amount of detail is not practicable most of the time, this experiment offered an example of how much can be noticed by attending in this way, even in short periods of time. By becoming aware of aesthetic experience, a wide range of multisensory detail, thoughts and imagination were found to be present even in routine daily events and much can be missed by disconnection from this awareness. I also experimented with making mind maps to record this in moments of the clinical day (personal notes). However, when I invited colleagues to participate by re-calling and re-entering a recent day of their own, the experiment became too much of a listing exercise being constrained by words 'about' what had happened rather than being made directly from within their own direct lived experience as briefly mentioned in chapter six.

Use in further research: Again, as in the microscripts, this was a useful first-person way of noticing and recording the expansive detail it was possible to notice even in routine daily events. This led me to read Saito's 'Everyday Aesthetics' (Saito, 2007) and 'Aesthetics of the Familiar: Everyday Life and World Making '(Saito, 2017) as discussed in the last chapter.

Both the 'Microscripts' and 'Life-world in a day' increased my attention to current experiencing during participation in action. As in mindfulness practice, by shifting my mode of mind to being aware during the experience itself, I was able to explore and describe the nature of aesthetic experience more closely. These methods proved to be a useful way of exploring personal experience thus further progressing the research methods.

Connectivity: with personal aesthetic experience enabled close noticing of greater detail.

4.Interpersonal connection

Background: As above, I had started to use a method of drawing out the path of attention to represent this in a visible format. The **aim** in this experiment was to closely notice aesthetic experience in interpersonal connection i.e., what could be subjectively sensed and imagined between two people.

Practice-base methods, results and documentation: see PoP2, including images on p20.

Reflection: These small actions stirred sensing and imagination in both the researcher and the accompanying participant. Here, aesthetic experience was connective and interrelated. The action of drawing this out in a novel and non-habitual way raised curiosity, deepening attention to sensing and imagination in both of us. In addition, the drawing action made what was sensed and imagined visible and present for discussion. Our subjective feelings made me think of the mirror neurone system (Iacoboni, 2009). This brain system allows one to feel the intent of the other. I was also reminded of the use of blackboard drawing in anatomy where the dynamic processes of the working physicality of the body are made visible when explained in action (Harris, 2015). I also thought of the Beuys and Steiner blackboards that revealed invisible forces (Holland *et al.*, 2007).

Next steps: Drawing out paths of inner sensing and attention was developed further in this research. The inter-relational awareness of aesthetic experience later became woven into later designs described in chapter six.

Connectivity: as sensed and imagined between two people was made visible. Here, an inter-relational aspect of aesthetic experience was shown.

Interconnectedness

Noticing felt sense - drawing it out

5.Mindful attention and drawing attention maps

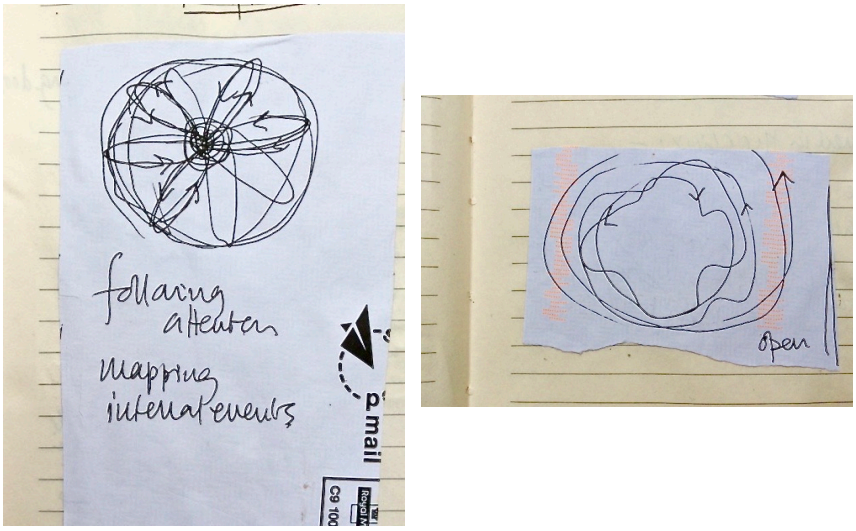
Background and Aim: As above, I continued to discover how a mindfulness-informed practice of paying attention, following and sustaining my attention helped me notice more closely. During mindfulness practice based on (Williams, Penman and Kabat-Zinn, 2011), (Kabat-Zinn, 2011b) (Siegel, 2011), I continued to practice drawing out the path of my attention to make this visible.

Practice-base methods, results and documentation: One example is given below. See PoP 2, p21-22 for additional images

Reflection: what learned and where next? Drawing this out helped me follow the direction the path of my attention took and to stay focussed by noticing this closely. I was able to make visible the invisible path of attention and become aware of an inner experience and the spaciousness of mind by seeing what I had drawn. I called this 'Drawing Attention'(literally).

Next steps: I used this process throughout the research as an aid to becoming aware of experience and and for recording this. I could also use this to see what to choose to turn towards to explore in more detail e.g. an image held in mind. I used both focussed and open meditation from Mindfulness practice. The latter involves turning attention to whatever occurs in mind as it does so. Drawing attention maps show these paths of attention.

Connective: with the path of my attention to different components of inner experience.



Drawing the invisible path of attention, here sketched on the backs of envelopes

6. Work in nature

Background: Here two examples of a series of experiments are given; (i) designing and testing a brief, adapted Goethean practice as a short group participatory process 'Cathedral of Trees'(ii) a first-person participatory process observing an individual living plant. Overall, the aims here were to try out adaptations of Isis Brook's paper on Goethean observation as a method for reading a situation with detailed sensory perception and the arising imaginative dimension. (Brook, 1998).

(i) Cathedral of Trees - a small group participatory experience

Aims. Here, I aimed to explore if close noticing in a natural environment could generate aesthetic experience for participants in a small group process. A brief adaptation of Goethe's method of observation based on Brook's description is outlined in the PoP2 as a way of close noticing. I also wished to consider how I would evaluate this process.

Practice-based method, results and documentation: see PoP2 including images p23-24.

Reflections and next steps: This process proved to be successful in immersing participants in their own aesthetic experience. Recording feedback in written notes demonstrated that this was full of sensing, imaginative detail and there was time to reflect on this. Feedback indicated that participants felt that they had time to closely notice their own experiences and that much was noticed that could ordinarily have been missed. Experiences were complex, layered with sensory and imaginative detail.

Using this brief adaptation of Brook's paper enabled the group to notice and become aware of their capacity for aesthetic awareness in relatively short time. Slowing down and shifting into a 'being'[39] mode of mind was important. Bortoft points out that an important component of Goethe's way of seeing is by 'being' immersed in experience (Bortoft, 1996). This had more meaning for the participants than talking 'about' the nature area.

[39] Being aware of current moment experiencing and the arising imaginative dimension

Practices that immersed participants in their own experience directly allowed more detail to be noticed. Moreover, sharing feedback and reflection enabled others to gain even further insights and different perspectives. This guided small group process was a valuable process for close noticing of multisensorial detail leading to arising imagination and discussion of wider issues, here, for example, the transience of human life and the timelessness of nature and the life cycle. A further research question emerged as to whether such a short, adapted form of Goethean observation, as described by Brook, could be designed and usable for busy healthcare workers for close noticing of aesthetic experience in the clinic. This was developed later in chapter six.

A sense of **connection** was felt, to nature, each other and belonging to the cycle of life.

(ii) Painting Clematis Armandii.

Background and starting points: Using the brief experience of Goethean observation I had gained as discussed in the last chapter and above, I was interested in how a method of close noticing could lead to sensing a gesture and dynamic of the thing observed.

At the start of his Italian journey in 1786, Goethe wrote the following:

> *"…At present I am preoccupied with sense-impressions to which no book or picture can do justice. The truth is that by putting my powers of observation to the test, I have found a new interest in life…Can I learn to look at things with clear fresh eyes? How much can I take in at a single glance? Can the grooves of old mental habits be effaced? This is what I am trying to discover…mentally alert…I find that I am discovering a new elasticity of mind…"* (Goethe, 1970, p. 38)

In this passage I think his way of seeing, sensing and imagining is 'aesthetic' as defined in my PhD research. He also alludes to vitality with a 'new interest in life' that exercising his own sensory capacities and curiosity can bring by setting aside habitual ways of looking and pre-existing concepts and seeing for himself with 'clear fresh eyes.' His 'new elasticity of mind' and relayed mental alertness resonates with a sense of modern-day neuroplasticity. This initial paragraph preludes other writings on his methods of observation in nature.

The **aim** in my experiment was to explore practicing Goethean observation using methods of close noticing to describe, imagine, sense the gesture and behold the dynamics of plants through the imaginative dimension.

Practice and results: see PoP2 including images on p25.

Reflection: Noticing this type of experience appeared to offer an opportunity to connect with my own sensing and through this with something about the plant itself in an imaginative and empathic process. This sensing and arising imagination is an example of what I am calling 'aesthetic experience' in this PhD research. Continuing from the comments above, Bortoft points out that, importantly, to be aware of and to feel this type of experience, one must enter into it 'live'. It is participatory and requires 'being' present to current moment experience, rather than talking 'about' it alone. This requires a shift in consciousness to a mode of mind in which experience is noted as it is happening, in the present moment. Here, one can see a parallel with mindfulness meditation and Bortoft makes this link when he says that Goethe's way of attending to present

sensed experience in ‘being’ mode of mind ‘de-automises’ thinking out of habit mode and that this is transformative (Bortoft, 1996, p. 65) In Goethe’s way of observing one turns towards the contents of imagination as these arise from sense perception as a present experience and content of mind ie. one is mindfully aware.

Connectivity: with my own sensing and arising imagination that in turn drew me closer to the plant and feeling its gesture and imagining its life cycle.

Conclusions and discussion

'Close noticing’ included a series of arts, practice-based methods that enabled a deeper way of ‘seeing’ and noticing. These early examples showed how aesthetic experience could be activated and explored with various methods that: widened awareness to the broader sensorium; brought awareness to aesthetic experience in routine, even seemingly dull or tiny moments of the day; could stir sensing and arising imagination with pared down, minimal means such as a few words or images to notice what was present in even the smallest detail of a lived day; brought awareness to aesthetic experience present in interpersonal connection and could have the potential to bring awareness to connections with wider issues beyond the immediate object of observation.

Key features of these methods for exploring aesthetic experience were to enable shifting into a 'being' mode of mind to becoming aware of experience during participatory action; paying deep attention to all one’s powers of perception, inner experience and arising imagination and observation and reflection on what occurred. A variety of practice-based methods used to achieve 'close noticing' were given at the start of the chapter. Incorporating a poetic twist appeared to draw curiosity, attention and stir imagination. These early methods were starting points for further developments in this research. These ‘close noticing experiments’ can be thought of as similar to sketches in a sketch book, visual workings out, jottings and reflective notes. Some were just brief small actions and others were more in depth.

From these experiments, an initial description of aesthetic experience was compiled and found to be full of rich multisensorial detail that could give rise to an expansion of imagination including potential to connect with wider issues and values. In addition, it was possible to be aware of this in relation to everyday routine events. By shifting attention to noticing experience whilst immersed in participation, detail could be noticed and bring deeper connection with one’s own inner world, the other and environment.

In this chapter a first-person experimental approach was taken, and initial sharing was with known colleagues including postgraduate artists. Whilst introspective, reflexive and reflective, this is an accepted step

for trying out early design works-in-progress from starting points in the arts. And, at this early stage, I thought that the results from these experiments showed that a more in-depth exploration of aesthetic experience was worthwhile as the rich sensory and imaginative detail that emerged that is not often given attention in clinical practice. Moreover, this aesthetic experience may provide a resource that is related to values. This could be particularly important in healthcare where objectivity has primacy. In further chapters (see paragraph below), I describe relevance to the clinic, then expand the research through pilots and scoping with other participants to an ultimate series of six new processes.

Next Steps

'Close noticing' experiments revealed further research questions for the next research steps. These related to relevance to clinic work in chapter three. Chapters four and six include how to: design processes that activate aesthetic experience for other participants, particularly healthcare workers and postgraduate artists; raise awareness, deepen and sustain attention to what is being experienced so it can be explored; be 'open' to what emerges in mind including associations that occur; enable this type of contemplation for others who may not be familiar with formal mindfulness; explore the arising imaginative component in aesthetic experience; draw out potential links to wider issues and values and design processes for analysis and evaluation.

The research path involved spiralling back into some of these early experiments as index points for trying out how subsequent newly designed processes work.

The next chapter discusses how this is relevant to clinic work. I show how aesthetic experience can be closely noticed in routine, habitual, tiny or even in some seemingly mundane moments in everyday clinical practice. I propose that the capacity for noticing aesthetic awareness is readily available to healthcare workers. This could enable new insights and deeper understandings and be a resource for reflection on humane and values-based care.

Chapter summary

This chapter, along with the accompanying portfolio of practice (PoP2) discussed initial arts, practice-based methods called 'experiments in close noticing' to observe and explore aesthetic experience arising in a series of small actions in non-clinical settings. An early description of aesthetic experience in this study was given. Closely noticing multisensory detail opened up the arising imaginative dimension. This had the potential to link with values, wider issues and areas of life beyond the specific experience. These experiments were starting points and generated a list of more detailed research questions that guided the development of further practice.

The Portfolio of Practice contain these and further images in PoP 2.

Chapter Three

Relevance of Aesthetic Experience in the Clinic: Examples from practice

Introduction

In chapter two, I began to explore aesthetic experience in non-clinical settings. Through various arts practice-based methods called 'experiments in close noticing,' I gave an initial description of aesthetic experience in this study and generated a list of further research questions. In this chapter I discuss how becoming aware of aesthetic experience may be relevant in medicine.

Chapter Outline

Close noticing methods and reflection on action are used to further build the description of aesthetic experience from the last chapter. I begin by drawing on Goethe's way of seeing as previously discussed and relate this to closely noticing sensory detail and the arising imagination in examples of aesthetic experience in first-hand practical experience in medical training and work. I show that opportunities for appreciating aesthetic experience can occur in even small moments of routine everyday healthcare. The significance of the capacity for awareness of aesthetic experience in the clinic is discussed. The research is informed by work that draws on and spans disciplines of medicine, psychiatry, psychological treatment methods and the arts and aspects of philosophy.

Goethe's Way of Seeing

I cited the opening passage of Goethe's Italian journey in the last chapter and suggest that this resonates with the type of aesthetic experience I am exploring in this study. I propose that this could be a new and additional way of seeing with 'clear fresh eyes,' 'putting our powers of observation to the test' and sensing for 'ourselves' in the clinic. By setting aside habitual ways of seeing and pre-existing concepts, Goethe is curious to discover what he can see anew. He finds a 'new interest in life' that stretches his mind, and states that he feels 'mentally alert', conveying a sense of vitality this brings. In Chapter one, I outlined Brook's stages of Goethean observation that include closely noticing sensory detail and the arising imaginative dimension. Could this way of seeing also bring new insights in clinic work?

As in the last chapter, I showed how I adapted Brook's stages of Goethean observation. I used painting as a way of sustaining my attention whilst closely noticing the detail in a Clematis Armandii plant. From this, I gained a sense of connection with the plant by coming to imagine something of its whole life cycle i.e., its gesture, dynamism and mutability. This thinking 'into' the plant appeared to be a form of empathic imagination, I felt the possible experience of 'other,' here the plant, albeit from a humancentric viewpoint. It is this capacity for sensing and imagining that I am calling 'aesthetic experience' in my research, and this was an example of its potential to bring a sense of connection. How might this be relevant in the clinic?

Electrocardiogram (ECG)

Extrapolating this to a clinical example, taking a careful history and examining my patient, enables me to carefully observe, sense and notice closely. I may also observe various test results, for instance, carefully 'reading an ECG' and noting objective details. Furthermore, whilst still holding it in my hands, I might take a moment to attend to a sense of the gesture of the heart, its dynamism, it's rhythmic beating, its persistent vitality and pacing out of life. Whilst carefully observing the few tangential moments I hold before me on the trace, I may be able to imagine the person more holistically, imagine a feeling of something of their life force and life

journey. This may occur in mind simultaneously in a short space of time. It may offer a sense of connection with this whole person and some of their human needs. Whilst I would need to check this out with my patient's reality, feelings and values, when appropriate, what I am getting at here is the way the imagination can reach out empathically to be aware of the possibilities of what another person may be experiencing. As well as offering the objective evidence-based treatment, a small act of connection in the moment could also be offered such as a smile, eye to eye contact, a comment that appreciates the human-to-human contact or a question about what is important to them in those moments.

A further example could be whilst engaged in what may feel like a mechanical task such as writing numerous detailed medical reports, I can pause over a few lines that draw my attention and allow myself to notice what I sense about this person and hold aspects of this in my imagination.

Whilst these examples are of subjective feelings arising in me, and I must be aware of the limitations of my imagination regarding another person, I can hold this in my 'mental margin', check this out in a timely and appropriate manner using reflection and professional skill wisely. Trained psychotherapists do a form of this in the countertransference. The patient may unconsciously convey their feelings into the therapist who may then come to feel this for themselves. The therapist reflects inwardly on whether this is the patient's projection or arising from themself, or a combination. This may be tentatively checked with the patient in the form of an interpretation. As the patient feels more understood by the therapist the connection or 'therapeutic relationship' deepens. However, trained therapists work within a framework of pre-existing concepts, or 'school' of psychotherapy eg, Freudian, Kleinian, Independent School, Cognitive Behavioural therapy. Yet it is possible to sense and imagine without pre-existing concepts for example, through empathic imagination. As Goethe implies, using one's own powers of perception may bring new ways of seeing rather than only adhering to pre-existing frameworks. Aesthetic awareness can bring greater human connection and more holistic appreciation. Brook (2009) points out that Goethe's method moves through a diligent and rigorous series of stages, where there is a shift of consciousness to being aware of what can be carefully and descriptively described through awareness of ones' own experience of sensing, imagination and intuition (feeling the gesture) arising from this. She points out that it is through this progression that one comes to this imagining. Thus, although subjective it need not necessarily be a flight of fantasy and can be reflected on wisely.

In the field of medicine, alongside the primacy of objective evidence and the growth of technology, healthcare workers may be accustomed to putting aside their subjective human experience of 'sense-impressions' and the arising imagination stirred in practice. We are often told 'not to be subjective'. I propose that Brook's stages of Goethe's observational methods and other examples of aesthetic engagement given from the authors mentioned in chapter one can be drawn on and adapted for ways of seeing with 'clear, fresh eyes' relevant to work in the clinic. The practices I develop in this research are designed to activate aesthetic experience and facilitate this in new ways of seeing. Coupled with wise reflection this could be an added resource for connective care. Medicine is full of soulful and emotive images and acts where the human encounter is central. It is this connection that often draws students to healthcare in the first place. Yet fixed concepts, objective thinking alone can be deadening or 'anaesthetising.' Awareness of aesthetic experience could bring additional ways of knowing alongside the objective evidence base.

Whilst doctors need to be absorbed in the objective parameters such as in the ECG, taking a pulse or other clinical procedures, they may suppress paying attention to their own sensing and imagination alongside

this. Of course, the focus on the objective task of the immediate illness must be dealt with, yet at the same time, the doctor may notice more deeply the human connection. For instance, the sensation at their fingertips, the living 'beating-ness', the pulsing, squeezing, contracting heart, pushing forward into life as energy and vitality itself, literally at the heart of the very essence of the person themselves. Not only that but we all have this driving force in common as human beings. One may notice this sensing for a moment, in a flash, then push it to the back of the mind to get on with the medical task. However, at an appropriate time for reflection these more subjective feelings may be considered. As Broyard, who was being treated for and died from cancer of the prostate, said, 'Since technology deprives me of the intimacy that is my illness, makes it not mine but something that belongs to science, I wish my doctor could somehow re-personalise it for me....the connotation of going beyond the science into the person is all I'm asking'(Broyard, 1993, p. 47,49). I think this re-personalisation implies a connection with the patient's self that is aided by the sensing, empathic, imaginative human connection of the doctor alongside the objective facts. This may be done at the same time and as Broyard also said...., 'I wouldn't demand a lot of my doctor's time: I just wish he would brood on my situation for perhaps 5 minutes, that he would give me his whole mind just once, be bonded with me for a brief space, survey my soul as well as my flesh, to get at my illness, for each man is ill in his own way.'(Broyard, 1993, p. 44)

We are often told not to get emotionally involved. Yet this requires suppression. I believe a more humane question is: how to notice our own experience and manage it wisely with professional skill? The latter skill includes knowing when it is appropriate to be attuned to this and when one needs to focus more on the technical skill, or a balance of the two. For instance, Galvin and Todres refer to this in their model of nursing practice ('head hand and heart') for rehumanising healthcare (Galvin and Todres, 2013). Schön's reflective practice encourages the professional to consider objective facts coupled with intuitive knowing borne out of practice. (Schön, 1983). In the arts, Nelson also adds in haptic knowledge gained in performance (Nelson, 2013). The latter is discussed in chapter five.

Examples

Examples are given from my medical training and practice. For each example, the reflective commentary is given here in the chapter text. The practice-based methods, written pieces from my reflective journals, diagrams and photographs can be seen in the accompanying portfolio of practice - chapter three (PoP3). After turning to these for each example in turn, the text of this chapter can be returned to. These examples emerged through close noticing whilst re-experiencing and free writing. This form of writing captured my sensing and imagination with immediacy as 'straight from the heart'(Goldberg, 2005), [40] in some cases even years later. Minimal editing was subsequently applied to the free writing piece for presentation.

1. Human Heart

Looking back to medical student days, nearly 40 years ago, it felt as if the objective 'clinical gaze' was engrained from week one. In the training of doctors, subjective aspects may be suppressed, and empathy can be lost as careers progress. The aim was to explore these to continue to build the description of the type of aesthetic experience I wish to investigate here.

[40] I have adapted my method from the Zen method of Goldberg (Goldberg, 2005)

Practice-based methods and written piece: see PoP3 this includes an image, p26.

On reflection of this piece, I had tried to imagine this person's passage in life, its timespan, maybe 80 years; their generosity of spirit in donating their body to the making of new doctors. I made imaginative connections by thinking of those I love in my own life and question what 'being' human is. What was the weight of our 'response-ability' here, for the rest of our careers and what is the cost of ignoring this? I began to sense the weight of a life and wonder how I would be able to respond. It was hard to talk about this back then. Now I ask, about the significance of this type of aesthetic experience that I am exploring. Beyond the immediate observation of one body part, a whole person can be brought to mind, in the arising imagination. This appears to be similar to the development of the imaginative components in Brook's stages of Goethean observation.

2. Anatomy 'Long' Room.

Continuing with the medical student example, in our first week, we entered the anatomy dissection room, 'The Long Room' for the first time. This experience was deeply imprinted on me and remains vivid to recall each time I re-enter this in my mind's eye.

Practice-based methods and written piece: see PoP3.This includes a drawn 'attention map' on p27.

On reflection, in recall and re-entry of this vivid image, I was able to draw out the path my attention took in my inner mind as in the mindfully informed 'drawing attention' maps described in chapter two (p42). A moving and detailed experience remains in most sensory domains even in recall. This scene has stayed with me for many years. My body and mind remains full of multisensorial detail and expanding imagination as the shift in writing into the present tense conveys.

What can be learned from this? Re-entering this deeply imprinted experience still immerses me in detailed re-experiencing. It is much more than a visualisation. Even now, there is an expansion of multisensory detail, integrated, sometimes synaesthetic and an arising imaginative dimension. Each time I return to 'picture' this, I become aware of more detail. From this, I continued to build the description of the aesthetic experience under study here. And indeed, argue that many important learning issues could arise from this as teaching issues in the training of doctors in awareness of aesthetic experience.

This aesthetic experience was full of sensing and imagination. Rather than repression, this could be a rich resource and opportunity for reflection on values and best actions. For instance, in this example there could have been an opportunity for novice medical students to reflect on and discuss values such as what it is to be human, how we are of the same substance or "flesh", how a human is more than a body alone, the risks the objectifying "clinical gaze", the cost of denial of our own subjective feelings, identification and the roots of empathy, the responsibility and the weight or burden of care, and how to strike a balance between all these. The opportunity to notice and be attuned to these, to reflect on and manage this experience skilfully could be re-humanising.

From this example, words[41] and phrases that describe this aesthetic experience are:

- Immersive, resonant, evocative, maybe of something imprinted
- Expansive multi-sensorial detail that is complex and synaesthetic.
- Expansive imaginative dimension

[41] Words used here are as defined in the Oxford English Dictionary

- Immediacy
- A mental shift to noticing experience as it occurs brings awareness to aesthetic detail
- Linked with wider values relating to human connectivity.
- Re-entering the experience brings it back to life - enlivening.

3. Pulse

A first 'taking of the pulse' also became a deeply imprinted and expansive aesthetic experience. It was also reactivated through recall.

Practice-based methods and written piece: see PoP3

On reflection, in this example, it was as if something was suddenly "set off" in terms of multisensory events and associations reverberating in imagination. As demonstrated in the written piece, this continued throughout a whole career and like a rolling stone gathered more imagination and memories on subsequent occasions. This small daily routine clinical action of pulse taking suddenly brought me to my senses and to being present to my imagination.

This is a further example of the aesthetic experience I aim to describe. It leads me to reflect on the shared human condition and through this, brings connectivity with others through empathy and compassion.

From this example, additional words and phrases that add to the description of aesthetic experience are:

- Reverberant
- Can arrive suddenly. I am brought to my senses in a flash. May build over time.
- Can be reactivated through repeating or recalling
- A leaning to a poetic way of describing
- The trigger can be in any sensory mode – here the feel of the pulse beating through my fingertips. A small daily routine can trigger aesthetic experience
- It is a subjective experience.

4. Electrocardiogram

In this example, my attention was drawn into present moment sensing by a kinaesthetic trigger.

Practice-based writing can be seen in the PoP3

Reflection: A kinaesthetic trigger acted as the portal to shifting a gear into noticing the experience I was having - an expansion of thoughts, feelings, further images. I used this to decide on a small action of making contact.

Here, additional words and phrases that begin to describe aspects of aesthetic experience are:

- Connective – here, the experience deepens my connection with this person imaginatively and steers my action to call them.
- It can happen 'in a flash' i.e. all at once from a kinaesthetic trigger

5. Laundry before work.

This non-clinical example from my reflective journal, again leant towards poeticized writing and demonstrated an expansion of aesthetic multisensorial detail, thoughts and imagination from an everyday experience. I include this here as an example of a seemingly routine ordinary action that brings awareness to full

body engagement of the senses, emotions, memory and imagination colouring thoughts about action and connection.

Practice-based writing: see PoP3

Reflection: This also occurred in a flash as the wind touched my cheek and with the smell, sight and feel of the laundry.

This was an entry point or 'portal' that brought me to awareness of what I was sensing and imagining. As in the previous example, here with the kinaesthetic feel of the movement of wind on my cheek I 'shifted a gear' from 'doing' to 'becoming aware' of experiencing. Although the laundry example is not clinical, it demonstrates the type of everyday aesthetic experience I wish to investigate and below, I give 'everyday' moments in the clinic where aesthetic experience can also be noticed. This 'Laundry' example adds the following to further build the description of aesthetic experience:

- There are various types of entry points or portals e.g. a kinaesthetic or tactile trigger.
- Aesthetic experience can occur in an instant and in -
- Everyday moments

Building the description of aesthetic experience.

From these examples I continued to develop an outline of the nature of aesthetic experience that I was attempting to describe from my own clinical experience. From first person empirical description, I found that this aesthetic experience had the following qualities so far:

- An immersive experience that can be something that has been imprinted and is evocative, reverberant, and resonant.
- There is an expansion of multi-sensorial detail, that is complex, rich and synaesthetic as inner mental events. These can be thoughts, feelings, sensations, memories, imagination and reflections.
- Imagination can be mobilised and expansive as it arises out of sensory perception
- Can occur with immediacy or develop over time
- Can be brought to awareness through a mental shift to being in the moment it occurs i.e. participating and closely noticing detail
- May be linked with wider values relating to human connectivity.
- Re-entering the experience brings it back to life, awareness is enlivening.
- Can arrive suddenly and an entry point can be triggered by an experience that may be part of everyday medical life or everyday processes
- Can be reactivated by repeating, recalling through re-experiencing
- Has a leaning towards a poetic way of describing
- The trigger can be in any sensory mode
- Awareness is connective with inner subjective experience
- Can be moving

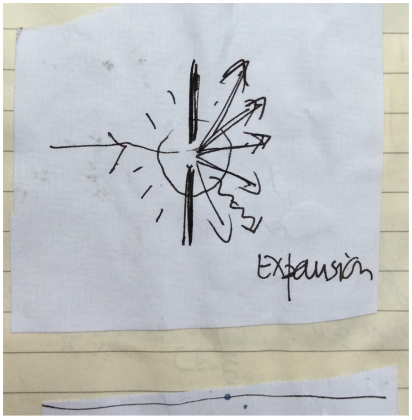
Furthermore, no extra time or resources were needed to become aware of aesthetic experience. It was already with me, present, at hand. It was just a matter of noticing and allowing time and space for reflection.

Everyday Aesthetics in the Clinic

Since working as a doctor, in my clinical practice, I often experience certain instances in everyday actions, such as taking a pulse, walking down a corridor, touch, noticing a gesture, or doing a literature search etc. that can trigger a sudden expansion of thoughts, feelings, sensations, images and imagination in my mind. Some of these may steer my course of action. Visual notes were made of these as photographs in my reflective journal and can be seen in PoP3, figure 3.3, p30-31.

I discussed initial explorations of the nature of such moments using methods of 'Close Noticing' described in chapter two and by reflecting on clinical examples given in this chapter. Additional research questions arose from the examples in this chapter in relation to the clinic: what happens in these moments?; how can I become more aware of all that comes to mind in order to describe this?; what is the nature of this type of experience in relation to working in the clinic?; do others working in healthcare also perceive these types of experience?; if so, can attending to and becoming aware of this experience offer a resource for reflection on values[42] (Fulford, Peile and Carroll, 2012) that may inform the quality of clinical practice alongside the objective evidence base? And can processes be designed to generate this type of experience for healthcare workers for this purpose as an enhanced form of reflective practice?

Further reflections: Struggling to describe this aesthetic experience exactly in words, I woke in the middle of the night as the dynamic form of the experience arrived in mind. Sketched on the back of an envelope, this conveyed the sense of many of the components of aesthetic experience that I have described above. It depicted the expansive contents in this type of aesthetic experience and the directions my attention could take to explore these. There appeared to be a trigger or portal that opens up whatever one was doing in a unimodal path[43] into an oscillating, vibrant sensory experience of expansive imagination as an activated field of energy. This can occur in just a moment. The drawing represented a visual reflection of what was happening. It is this activated field of sensing and expanding imagination that I am calling aesthetic experience in this research. This sketch allowed me to work on my idea further the next day.



The dynamic form of aesthetic experience, sketched out in middle of night on back of an envelope.

[42] Values – as defined by Fulford et al 'are wider than ethics…extend to wishes, preferences…relate to those of the clinician and patient…and are action guiding, negatively or positively…. in clinical decision making'(Fulford, Peile and Carroll, 2012, p. 9)
[43] Carrying out one's day to day life in a routine habitual way

In the blackboard drawing below, I could map out and see more clearly places where further research questions were needed. Viewing different parts of the diagram, I could ask what happens at points (i) the arrow and single line representing going along in one's daily routine, habitual way; (ii) how to enter, or the nature of the 'portal' to the expansive 'oscillating' 'activated field' of energy to the right; how to activate the field of aesthetic experience for others and how might one attend with close noticing and describe the expansive contents.

Blackboard Drawing attention map showing the activated field aesthetic experience.

Additional questions were how to design processes to activate aesthetic experience for others. What draws attention? How can one be 'in' the experience, in participation to describe it most directly? Does a poetic twist break routine ways of thinking and raise awareness to sensing and stir imagination? In this way, can one, like Goethe, notice closely with 'clear fresh eyes' as in phenomenological bracketing? Or see 'anew with 'beginners' eyes' and curiosity? How can one be immersed in such an aesthetic experience and explore all its complexities of sense perception and arising imagination and deeper connection with self or other? Is this way of seeing transformative in bringing new insights and ideas? Does this type of aesthetic experience have meaning for others? Chapters four and six explore these questions further.

Discussion

Working in an aesthetic mode could be significant and important in clinical settings where the encounter with, and response to other humans is central. Appreciation of aesthetic experience could be transformative in that it could raise and broaden awareness to subjective sensory experience and arising imagination. As I have started to demonstrate, the type of aesthetic experience that arises directly from immersion is complex and can bring connection with self and with the possible experience of others in empathic ways thus 'humanising' healthcare (Galvin and Todres, 2013). Aesthetic experience also extends beyond the prosaic and is 'more than words can say,' embracing tacit and embodied knowing. Paying attention to this aesthetic experience could bring new insights and creative thinking. This could be a resource in which

awareness and reflection could enable conscious choices of action (rather than reactive ones). Furthermore, sharing reflections with others in group discussion could also broaden awareness to the perspectives and values of others. This awareness may also bring a moral 'response-ability' that can steer action. For instance, more connective practice may enhance values-based practice by reflection on best humane care.

Anyone can become aware of aesthetic experience. It does not require years of training or knowledge of existing concepts. It is always at hand, if only one notices, by shifting into a 'being' mode of mind, aware of what one is experiencing, rather than repression. It is possible to be aware of aesthetic experience whilst engaged in daily practice. A trigger to this sensing and expansive imagination can happen with immediacy or build over time. Of course, an appropriate time must be chosen to explore this experience, for instance it may just need to be noticed and reflected on more fully later. Professional skill will aid wise choice of action. I have alluded to Brady's, 'imagining well' and Schön's reflective practitioner. Awareness of aesthetic experience does not need much in the way of resources. In chapter seven, I propose a teaching model for how to become more aware of aesthetic experience in everyday issues arising in the clinic.

The examples discussed here and in PoP3, retrospectively examined instances of aesthetic experience that had drawn my own curiosity. However, relevance and meaning for other healthcare workers still needed to be explored. From my practice in medicine, I believed that many colleagues entered the healthcare professions to be connected with fellow humans by using their own human capacities and that awareness of aesthetic experience is an important dimension through which we read experiences subjectively and for ourselves and have the opportunity to weave these into best clinical care and this this adds meaning and personal sustainability to practice.

Chapter Summary.

In this chapter and the accompanying PoP3, I have presented several first-person examples to demonstrate that close noticing can bring awareness to aesthetic experience in relation to everyday issues from medical school days to clinical work. Through re-entering in mind, re-experiencing, and exploring instances of my own, it was possible for me to connect with, and reflect on, inner experience that was full of multisensorial and expansive imaginative detail. This has progressed the research further in that these examples add to the initial description of aesthetic experience from the previous chapter. Further research questions include how to design processes to activate aesthetic experience prospectively and how to convey and activate this for other participants and see if it has meaning for them. In the next chapter, I will describe scoping studies that expand the research to others by designing two experiential pieces designed for group participation.
Being aware of aesthetic experience could potentially be a resource for new insights and reflection on best choices for everyday clinical care.

Chapter Four

Scoping Studies[44]

Introduction

In the previous two chapters I started to explore and describe a type of aesthetic experience that I proposed was relevant to clinic work. In summary, I described this experience as immersive, resonant, evocative and reverberant leading to expansive multisensorial detail and imagination. This could occur with immediacy in response to a trigger or develop over time. It was possible to become aware of this detail by noticing experience closely as it occurred. I showed how awareness of aesthetic experience could occur in everyday routine moments and noticed when activated by seeing anew, beyond habitual ways or by recalling something imprinted from a past event, for instance, a moving experience may be recalled in a poetic way.

So far, I have mostly used a first-person approach and in chapter two I also included a couple of preliminary small group participatory pieces. In this chapter the aim was to investigate if this type of aesthetic experience also had meaning and resonance for other healthcare practitioners and test out if this could be activated by designing participatory pieces for sharing with them. The aim was to activate and raise awareness to aesthetic experience i.e. to sensing and arising imagination in relation to day-to-day clinical encounters and make space for reflection on values and humane healthcare. I sought to show that awareness of aesthetic experience had the potential to bring one into deeper connection with the inner self, others and the environment in relation to healthcare. This was practice-based work in an aesthetic (sensory and imaginal) mode.

Chapter Outline

Two practice-based experiential participatory pieces were used to scope the work with postgraduate artists and healthcare workers, The first piece, 'Hospital Corridors,' used a form of photographic elicitation as a participatory piece made for the final work of a Masters in the Interdisciplinary Arts.[45] In this PhD, this work was extended by newly testing it out with healthcare practitioners. The second piece, 'Bathe: An Encounter with Care,' tested out the design of a day's workshop amongst postgraduate arts students. Here participants were invited to be immersed directly in experience for themselves in order to notice closely what occurred from their own perspectives at the time. This chapter presents the reflective commentary. Practice-based methods of design, delivery and findings from participant feedback can be seen in the Portfolio of Practice - Chapter 4. (Hereafter abbreviated to PoP4).

Aims of the Scoping Studies

The aims were to test out two practice-based processes for feasibility and acceptability amongst health care practitioners as participants and to discover if aesthetic experience could be activated for them and had resonance and meaning. Participants' feedback, reflection and discussion were recorded through careful documentation and early methods of analysis by thematic review were tried out. Through practice-based scoping, the design was refined further and subsequent developments are discussed in later chapters. The new methods constitute an emergent methodology called 'connective aesthetics in medicine.'

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[44] A version of this chapter was submitted at the Transfer part of this PhD
[45] Oxford Brookes University

Two practice-based scoping studies

These are:

(1) Hospital Corridors

(2) Bathe: An Encounter with Care

For both of these studies, the practice-based components including design, delivery with session outlines and findings from participant feedback are presented in PoP4. Aims, overall analysis and reflections on each, and links with healthcare are given below.

(1) Hospital Corridor Piece

A 6-minute series of photographic images of 'Hospital Corridors' was made from my experience and mind's eye[46]. (Fox, H, 2011) Abstracts outlining the piece were accepted at 12 academic meetings in relevant healthcare disciplines. This work had not been scoped with a healthcare practitioner population before. Scoping also included postgraduate artists who were skilled at thinking about design. At each, a brief background was given to contextualise the work before showing the images. These images were projected life-size at the rate of the breath followed by a further minute's breath meditation. Colleagues and peers in healthcare were invited to offer feedback and comments. One presentation was a poster session.

In this piece, the aims were to: present this work to colleagues in relevant healthcare fields at conferences and academic meetings for feedback and discussion; explore the viability and the feasibility of this type of work and to reflect on how such an artistic aesthetic mode could be useful as a method of inquiry into aspects of healthcare delivery.

I chose to present the work in fields where I considered this type of work would be most relevant and from which I predicted using applied methods to develop my arts, practice-based research. e.g. Psychiatry, philosophy in psychiatry, phenomenology, mindfulness-based practice and artist colleagues. A list of presentations can be seen in the table in PoP4.

Participant feedback was reviewed for sensed experience and arising imagination of aesthetic experience, comments about the process as a whole and comments about links or possible connections in healthcare.

Practice-Based Methods described in PoP4 include making the piece, presentation, gathering participant feedback comments, and details of the thematic review in relation to Ashworth's life-world domains (Ashworth, 2003) and mindful awareness.

Summarising the findings here, participant feedback showed very rich lived experience in all of Ashworth's life-world domains. Viewers were mindfully aware of experience of bodily sensations; feelings, emotions and mood; behaviours; sense of space; atmosphere; time, memory and personal journey; sense of connectedness; sense of narrative (making sense); and sense of self.

Comments about the process overall revealed the embodied quality of experience generated in comparison to traditional papers given at academic meetings. Examples of feedback include feeling a 'shift in gear into the experiential,' 'a deep plunge, a jump, a different energetic level and focus', and of being 'suddenly pushed into an intensity that was fiercely visual.' One participant said that after the conference it would be

[46] 'Beyond the Evidence-Base'. Whilst this piece was initially designed for the major project of an MA in the Interdisciplinary Arts, scoping amongst healthcare peers was new work for this PhD.

‘these images that stay with me’ more strongly than any spoken paper. Another participant from a group of mindfulness practitioners said, ‘There was something very special about experiencing visual poetry with a group of people who could appreciate it mindfully, without judgment, simply being open to the images and the wealth of responses they brought for us in the room.’

Discussion and reflection with participants revealed how awareness of aesthetic experience may be linked with and transformative in healthcare. Examples are given here and the complete list is in PoP4.

'Healthcare workers may habituate to their daily work surroundings and take this for granted. However, even the smallest detail may move people profoundly and in different ways. This type of aesthetic work could make it possible to re-vision daily events, by presenting situations in ways that disrupt automatic habitual thinking'. e.g., ‘A whole lot of tiny details in the world in which we are working can have profound effect. We need reminding sometimes. We need to be very mindful. That’s the business we are in’; ‘it is easy to become ‘anaesthetised’ to everyday issues – here something as simple as walking down a hospital corridor can bring transformed experience by seeing anew’ and ‘I felt a risk of overlooking what we have come to consider as normal. The images were in fact brutal. It’s good to know that someone else can ‘see’ this…this work is an invitation to ‘feeling’, not just discussing, and ‘sensing’ which is then connected to thinking’.

Researcher reflections and discussion: The work was acceptable and generated much interest. Several initial points arose from this exploratory project that demonstrated the advantages of working in an aesthetic mode:

1. Feedback demonstrated that in only 6-10 minutes, rich, complex, and varied experiences arose. These images ‘spoke’ at so many levels and were perceived in different sensory modalities, with immediacy. A poetic image may speak a thousand words.
2. Awareness of sensed, aesthetic subjective experience including the imaginative dimension may offer additional ways of embodied knowing to positivistic research findings and more traditional methods of qualitative research. The importance of phenomenology as a qualitative approach in medicine is extensively covered by Toombs who cites many thinkers on embodiment, eg. Merleau-Ponty explained that one understands the world and others through the body (Toombs, 2001). In this photographic piece, many viewers responded to the work by ‘feeling’ in different modalities including bodily responses.
3. In addition, feedback revealed being able to imagine what it may possibly be like for others in certain situations. Some also said they were able to feel the gaze, gesture and intent of the artist, as if seeing through her eyes. This could be linked with mirror neuron functioning which is involved with empathy (Iacoboni, 2009).
4. Awareness and attention were raised not only in relation to one’s own experience, but also to that of others. Thus, much experience was shared in a short space of time. In this way viewers become aware of a range of each other’s subjective feelings and perspectives.
5. As well as sharing of experience, this participatory piece provided an opportunity for discussion and possible shaping of new ideas with others. This new awareness may contribute to a deeper and more connective way of re-humanizing healthcare[47], enabling greater sensitivity and compassion. Such aesthetic

[47] Work on re-humanizing healthcare in *Caring and Wellbeing: A Lifeworld Approach* (Galvin and Todres, 2013)

work may be a powerful method for promoting greater awareness, reflective capacity and mindful presence in aspects of healthcare by deep entry into experience itself and arising feelings.

6. Viewers' comments indicated that they were able to 'enter' the work and experience it. The artist/maker may deliberately 'sculpt' a piece in such a way to achieve this by presenting something 'in a different gear,' a little strange or with a poetic twist, a surprise factor, something slightly unusual that creates a form of 'suspension'[48] or disruption of habitual fixed ways of thinking. This had the potential to bring new insights and deeper understandings. Artists are well positioned to make aesthetic pieces as poetic and expressive forms that powerfully generate rich experience and trigger imagination. Bachelard discusses, at length and citing other authors, the poetic image as being 'reverberant' and full of vitality. (Bachelard and Jolas, 1994, p. xvi)

Summary

The 'Hospital Corridor' piece, invited audiences of healthcare practitioners, related academics and artists to view life-size images of an everyday situation in the clinic and closely notice their experience. They gave feedback on this that suggested how working in such an aesthetic mode was a powerful embodied mode of inquiry. In this piece, it was possible to see how these projected images of an everyday healthcare issue, here, walking down a hospital corridor had the potential to activate a range of profound and moving feelings.
This type of work suggests that one could become more aware of and sensitive to what happens in a range of routine situations e.g. taking of the pulse, examining the hand or heart, bathing of another etc. Raising awareness to issues of humanity within these moments for patients and ourselves could be achieved through close noticing and deeper in-sighting.

Reflections arising in this piece resonated with the words of Barone and Eisner, ***"Arts based research is not a literal description of a state of affairs; it is an evocative and emotionally drenched expression that makes it possible to know how others feel."*** (Barone and Eisner, 2012, p. 9)

These new ways of seeing and attending to capacities that we already have as humans would incur little in the way of financial resources and more in the way of utilizing existing 'inner technologies' of creativity and imagination.

The aims of scoping were met by testing this piece out for the first time with healthcare practitioners, allied professions, related academics and artists. Aesthetic experience was activated that was rich in multisensorial and imaginal detail. Feedback indicated that aesthetic experience had meaning and that this way of working was acceptable and feasible in the formats used here including lectures to larger groups, small groups and even a poster presentation. Ways in which this type of work may contribute to healthcare were raised in the discussion and comments were made about values and humane care.

A simple method of analysis was devised by the researcher. Transcripts were examined thematically for comments of awareness of lived experience and relevance to healthcare delivery.

In this piece, the photographic material came from my own experience in healthcare settings. This was then shared with others. In photographic form it was easily deliverable as outlined above. A research question that emerged about refining the design was what audience experience would be like if their participation involved being directly immersed themselves? Would this bring participants into more immediate contact with

[48] from a 'natural attitude' - a phenomenological method of 'bracketing' to see anew

relevant issues? In the next scoping study, I refined and tested out the design of a piece that immersed participants directly in their own experience.

(2) Bathe: An Encounter with Care

The human encounter is central to the clinical situation. Meeting and touching one another is a daily occurrence. Yet routine actions may be done in automatic pilot, without further reflection, such as a gesture, touch, clinical examination etc. In relation to this everyday interaction in the clinic, the aims of this piece were to: explore if a process could be successfully designed to activate aesthetic experience so participants could observe this experience for themselves whilst immersed in action; incorporate a brief guided mindfulness meditation as a method of raising awareness to aesthetic experience at the time including introducing how attention could be focussed on different components of experience and could move from one focus to another; explore if a method of adding a 'poetic twist' to such an everyday interaction would create an atmosphere to disrupt habitual ways of thinking, draw attention and stir imagination; test out the feasibility of a workshop format for small groups and seek feedback and discussion amongst postgraduate artist peers on design and other insights.

An experimental day's workshop was shared with postgraduate artist peers in the Interdisciplinary Arts[49]. An invitation to participate or observe was circulated and this was presented as PhD work in progress. This practice-based piece was divided into two main sessions. After a brief background to the work, participants were introduced to a meditation practice to raise awareness to the ways in which they pay attention. This practice was then used to bring awareness to attention during a bathing action followed by feedback and comments about the experience and viability of this work in progress.

First session - Introductory mindfulness-based practice to raise awareness to attention: A brief guided introductory mindfulness meditation was given as the first part in the workshop to raise awareness to the path of attention between the outside world and the inner world of mental events such as thoughts, feelings, memories, images, imagination. (Siegel, 2011, p. 78). In addition, this shows the possibility of observing these events by noting them from a reflective distance. This offers a sense of being able to move around in an inner spaciousness and of being able to watch oneself. The passage of the breath in and out of the body was used as an anchor for the focus of attention. From this, attention may move to other mental events which can be explored, or one can deliberately choose to return attention back to the anchor of the breath[50]. Participants were invited to apply this process of following their attention and exploring what arose in the second session. I also showed an example of one of my drawn attention maps as a method I had used for making the path of attention visible.

Second session - the participatory bathing action: see PoP4. Feedback comments were noted at the time and immediately after and reviewed for themes as in the piece above.

Practice-Based Methods are described in PoP4 including design of the piece, delivery to participants, gathering participant feedback, feedback comments, and review.

[49] MA and PhD students at feedback forum day. Oxford Brookes University
[50] Examples of the researcher's (HF) attention maps as one way of making this visible were shown (discussed in chapter two).

Summary of findings: Participants reported becoming aware of experiencing heightened sensations in all modalities (except taste) whilst touching the hands of others. Examples included the sensed, felt atmosphere as, "a poetic quality in the room…a sweetness and gentleness in the quality of the interaction, of comfort… a ballet of hands, eyes and movements in dialogue, of feeling 'into' each other with empathy, around each other, between and with each other, apart and together, noticing closely and with sensitivity" and that that the 'scene' had been set for the 'possibility of care' and the role of the objects, 'waiting' as people arrived. Other examples of feedback included comments on the sensed interrelationship in connection with one another in different roles of bather, bathed and observer; a sense of vulnerability and helplessness at being in another's hands; the giving and receiving of care; 'gifting' of attention of care; feelings of closeness and intimacy and the varying levels of comfort this brings including the wish to retreat to a more 'mechanical' mode. Thoughts and images of personal past situations were also made. The full feedback of comments can be seen in PoP4.
This workshop concentrated on the design for facilitating an immersive experience rather than its applicability to healthcare. The artists who took part found it relevant to their own work with connective practices. Evaluation forms completed at the end of the day revealed positive comments although one found it too personal, but there was an invitation to just observe. Examples of comments were, 'I could enter the work very easily,' 'I felt free to explore my senses. I valued this experience as much as the actions', 'I could relate all the experiences you offered to everyday to life… empathy… responsibility, our roles in society,' and 'I will hold the image and experience of the hand washing.'

Researcher reflections and discussion: The aims were met. This piece was tested with postgraduate artists to trial the design and running of an immersive experiential participatory process. Feedback and evaluation forms demonstrated that participants were deeply engaged and immersed in the experience directly. Participants found the process acceptable, absorbing, evocative and an involving piece that elicited a range of subjective experiences. Feedback demonstrated that aesthetic experience was activated that was rich and multisensorial. This format proved to be very atmospheric. The set-up of the room and how participants engaged in the process generated much in the way of rich aesthetic experience. The mindfulness practice was felt to be useful and could be applied in the bathing process.

The above piece took up a day as a workshop and required transportation of bulky materials. The process generated deep aesthetic experience, however, this format would not be easily deliverable at healthcare conferences or presentations as in the first scoping piece. Also, taking time to partake in this type of workshop would be more difficult for healthcare colleagues. Thus, for future design, I wished to combine the immersion in direct aesthetic experiential component of this piece with easy portability and delivery for busy healthcare colleagues in meetings they may attend. Next, I needed to design processes that would be in realistic and workable formats that could be easily offered to healthcare colleagues. Similarly, methods of analysis and evaluation would need to be simplified for realistic, practicable use.

Following these scoping experiments, further processes were designed and developed. Each was designed to fit into a one-hour session. A series of processes were planned to cover different areas of connectivity as described in chapter six. This format could have the potential to be delivered as a teaching module discussed in chapter seven.

Summary for both scoping studies

Overall, feedback and discussion demonstrated that both pieces were deeply involving and highly evocative generating expansive multisensorial and imaginal detail of aesthetic experience as defined in this research. Thoughts, feelings, bodily sensations, sensing in all modalities, memories, images, imagination and other components of lived experience were brought to the present moments of the work. Thus, the scoping studies did succeed in activating aesthetic experience. Feedback demonstrated the acceptability of the piece. Lively discussion indicated participants' interest and relevance to healthcare settings. In the second process, in a smaller group setting, it was possible to go further into the detail of aesthetic experience that arose and for discussion about these. Also, I was able to participate and pay deeper attention to participants comments. Thus, the latter format was taken forward for research development of series of experiential participatory processes for small groups. Additionally, the first session proved to be a useful format that could be adapted for presentations at conferences or other such meetings.

Scoping the ‘Hospital Corridor’ photographic piece with healthcare colleagues was carried out for the first time and ‘Bathe’ was scoped for detail in its design with postgraduate artists, in particular those using connective practices in their work in the field of Social Sculpture.

Chapter Five - Overall methodological approach. Format of reporting. Recruitment.

Introduction and Chapter outline.

The aim of this research was to explore and describe the nature of everyday aesthetic experience and relate this to clinical work; to develop and design new experiential participatory processes to activate this aesthetic experience for healthcare workers and to design methods to analyse and evaluate the success of the design.

In chapter one, I stated how this research was grounded in my background of experience in clinical practice in medicine and the arts. Additionally, I described relevant aspects of existing practice and theory that were adapted and synthesised in this research to design new practice-based processes to activate aesthetic experience for others for reflection. In chapters two and three, I described early methods of 'close noticing' that started to explore the nature of aesthetic experience and relate this to examples in medicine. In chapter four, scoping studies demonstrated that aesthetic experience was relevant to other healthcare workers and allied professionals and that by becoming aware and closely noticing, they could describe it.

This chapter discusses the rationale for development of an emergent methodology that employed an arts, practice-based approach. Summary tables are given to show the overall structure for describing and reporting methods used in the development of an innovative series of six experiential participatory processes that were ultimately for use with healthcare practitioners and allied professions. Postgraduate artists were also involved in the development. Details of each of these processes will be reported in detail in the next chapter from first-person explorations through to final design. For the final series of experiential participatory processes, methods used in common are also given in this chapter as a further table.

This chapter also discusses overall methods of analysis that developed as the processes were delivered, particularly to reveal greater detail contents of the imaginative dimension.

Recruitment methods for the final series of participatory processes are given. An 'Artist's Introductory Talk' that was presented to recruited participants before they took part in these processes is described.

Rationale for a practice and arts-based approach to explore aesthetic experience.

Aesthetic experience, as defined in this research, is complex and goes beyond words. A qualitative approach is suitable for describing subjective lived experience. Experiential participation can make it possible to notice greater detail and describe it directly as it occurs. This may bring new insights and understandings as in participatory action research, a 'family of approaches' from the social sciences (Bradbury H, 2013). I discussed some advantages of working in an aesthetic mode in the last chapter (p57) after the 'Hospital Corridor' scoping piece. In my research, added poetic interventions served to release participants from habitual thinking, to draw and deepen attention to sensory awareness and in particular to stir imagination arising from this. In addition, aesthetic experience is difficult to articulate and communicate in words alone, so an experiential arts, practice-based approach was used to embrace exploration of components such as the tacit[51] (Polanyi and Sen, 2009) and ineffable (Thornton, 2013); a bodily 'felt sense' (Gendlin, 2003) of knowing what 'fits'; working with the perceptual and imaginal (Hillman, 1992) (Hillman, 2000) and a willingness to experiment into the unknown.

[51] Thornton says of Polanyi's Tacit Dimension of knowing more than words can tell, 'It cannot be made explicit and it is connected to action...the practical knowledge of a skilled agent'(Thornton, 2013, p. 1049). Whilst this is discussed here in relation to psychiatric diagnoses, the tacit dimension is also relevant to other areas of practice.

Leavy (Leavy, Patricia, 2018, p. 3) takes the view that arts-based research is a separate paradigm to qualitative research and offers more flexibility than other paradigms. Rather than being constrained by existing methodological categories and methods, the research path can be developed, shaped and refined as research questions emerge through exploratory practice and reflection. This path can include adaptation of relevant existing processes synthesised in new ways, entirely new creative methods or a combination of both as the need arises. In addition, the researcher's work may draw on various fields and different paradigms in a creative way to best achieve the outcomes. This is the case in my research. It is accepted that research approaches in arts and design can be a hybrid mix or 'bricolage' of relevant multiple methods that become a 'set' that is developed into a whole emergent methodology. (Gray and Malins, 2004, p. 74). The advantage of this approach is the flexibility to follow the findings including further questions as they emerge from practice. Thus, the findings retain primacy and shape the next steps of the research. To embrace rigour and transparency, the researcher must make this path clear including how findings have been analysed and interpreted. This is my intent in this research.

Leavy lists main features of arts-based research compared with quantitative and qualitative approaches (Leavy, 2009, p. 265). In 'Practice as Research in the Arts: Modes of knowing in Arts Research' Nelson says that practice, 'is at the heart of the methodology of the project and is presented as substantial evidence of new insights,' and that 'it is ideal if the practice can be experienced directly in any assessment process' (Nelson, 2013, p. 26) so the tacit, felt component of the work can be experienced. He calls this knowing arising from experiential, performative practice, "*knowing doing".* Nelson (p37) gives a triangular diagram of 'Arts Praxis.' He indicates that artists generate knowledge that combines three interconnected elements with practice at the core. He calls these 'know-how' or 'insider' close-up knowing that refers to experiential, haptic, tacit and embodied knowledge arising in performative practice; 'know-what' means coming to know what works in practice through critical reflection, for instance on methods, composition, impact and 'know-that' relating to 'outsider or distant knowledge' such as 'spectatorship studies, conceptual frameworks, cognitive propositional knowledge' that position the work. All three aspects in this model are relevant for gaining a deeper understanding of the complexity of aesthetic experience in this PhD by becoming aware of and noticing aesthetic experience itself during practice, reflection on findings and contextualising the work with existing theory and practice[52]. Nelson's model appears to be similar to Schön's reflection in and on action using knowing in action, or intuition. However, Nelson's model explicitly adds the third component of evidence deriving from arts practice itself as at the core. Thus, in my research, sections of the portfolio of practice are embedded within the written thesis in respect to each chapter. These constitute a central part of the argument and are intertwined with the words. One cannot be wholly understood without the other.

Gray and Malins give characteristics of arts-based research as being 'naturalistic' or taking place in more real situations than in controlled trials (Gray and Malins, 2004, pp. 72–73). In a similar way to Nelson, they include 'the researcher as primary generator or gatherer of data, the use of tacit knowledge' i.e. knowing arising from practice and an 'emergent research design and qualitative methods' (Gray and Malins, 2004, p. 200). Whilst they include a 'natural' setting as the artist's studio space, in my case the setting is in the inner mind-body space of sensory experience and the imagination. This 'studio space' is thus a space held in the mind-

[52] In this thesis the examiners were invited to experience sections of the research processes as the participants have done.

body complex and can relate to any external situation. In a written piece called, 'The Artist in Residence,' I described how this studio space has been held in mind during my practice of medicine all along yet was ultimately realised as such through engaging in the arts. (Fox, H, 2017). Excerpts are given in the appendix to the Portfolio of Practice for this chapter (hereafter abbreviated to PoP5.)

Gray and Malins also point out that practice-based methodologies emerge and unfold as the research progresses as in grounded research. They highlight that for trustworthiness, it is important to relate the findings to the specific research setting and that generalisation should only be made with care and that outcomes, meaning and values should also be related to critical review by peers. Of note, the practices in this PhD do not take place in clinical environments, but in a space away from immediate clinical tasks where there is time for reflective practice on aspects of everyday work. As practitioner-researcher, my role included the relevant background experience from my medical career, thus providing relevant theoretical sensitivity and 'insider' knowledge, that aim to offer credibility and trustworthiness. In addition, to seek the views of others beyond my own subjective views alone, I have shared the work with postgraduate artist colleagues, healthcare peers and workers from different disciplines that are both practical and academic. This has allowed the opportunity for feedback of others, advice and support and expands the research from the personal outwards to show it has relevance and meaning for others.

A further example of practice-based design research processes comes from architecture. Zeisel's comments about the complexity of the design process supports my research approach, 'Design is difficult to describe because it includes so many intangible elements such as intuition, imagination and creativity – which are essential to research as well.' He cites various authors and combines these into a prototype of the design process that moves the from inner ideas of the architect to initial sketches, working through and trying out possible ideas, planning, refining, checking, setting within the wider context and regulations to full realisation of the work. (Zeisel, 1993, p. 3). Five characteristics of this design process are given (Zeisel, 1993, p. 6). "Imaging" or mental picturing of design solutions is based on various aspects such as subjective experience, sense perception – often visual, tacit knowledge and specifics of the particular environment in relation political and economic considerations (Zeisel, 1993, pp. 7–8) "presenting" – making ideas visible through methods such as drawings, photographs etc to present to others and for further development. "Testing" out and critiquing alone or with others, reviewing, evaluating and refining, reshaping and taking the next steps forward, shifting ideas creatively in an iterative and spiral model that adds from all these as it progresses towards a final chosen design.

Overall development of this research

In keeping with the above, my research proceeded in a spiral, iterative way developing through practice-based exploration of aesthetic experience and reflection in and on action. The first diagram is shown in the Portfolio of Practice - chapter five (PoP5) shows the complexity of this. It was a form of grounded research in that the approach developed as the "data" (findings) emerged from practice throughout in order to describe aesthetic experience. Starting from a first-person approach and initial description of aesthetic experience in clinical practice, the research expanded outwards to convey this experience to others as represented in the second diagram in PoP5. Processes were newly designed to activate aesthetic experience for them so that they could also explore and describe it to further build the description. In addition, feedback enabled further shaping of the design. As feedback of experience emerged, methods of analysis were designed and developed to

demonstrate the nature of aesthetic experience in this research. Methods also included evaluation, presentation and dissemination of the work. Reflective practice in and on action (Schön, 1983) coupled with learning through experience (Kolb, 2015) to plan subsequent research steps were used throughout. Creative strategies from arts and design practice as taught in a module in the Master of Interdisciplinary Arts[53] program at Oxford Brookes University were used to achieve the research aims.

In summary, there is an established body of arts-based research work in which approaches are broad and span a range of art forms such as performance, dance, poetry, the visual arts and connective aesthetics discussed in chapter one. Multiple methods are often combined in a hybrid approach that permits flexibility to address the research questions and this should be made transparent. In my research, the emergent methodology was called 'Connective Aesthetics in Medicine'.

Overall structure of presentation of the development of an emergent methodology.

In this chapter the overall structure of the presentation of the development of a final new series of six group experiential participatory processes for healthcare groups is outlined from starting points to final design. Three main stages in the development were (i) researcher first-person explorations, (ii) pilot studies with postgraduate artists and ultimately (iii) sharing the processes with healthcare workers and allied professionals as shown in the first column of table 5.1 below. Details of methods developed at each of these stages are described in chapter six and its accompanying portfolio of practice that cover the headings (a-f) in the first row of table 5.1. This table was used as a template to methodically work through and report on the respective stages of the research development.

Table 5.1 Methods at each stage of development of final experiential participatory processes

Stages of development of each process	(a)Aims of each process & contribution to overall research aims	(b)Methods of design & delivery	(c)Methods of documentation of results	(d)Methods of analysis	(e)Reflections & (f) next steps.
(i)First person exploration					
(ii)Pilot studies					
(iii)Final designs of participatory experiences for healthcare groups.					

Overall structure for final series of processes for healthcare groups

The final series of six group experiential participatory processes was designed for small group sessions and adapted for online delivery in Covid lockdown for the healthcare groups.

In each process, a poetic 'twist' was incorporated as a defamiliarisation process to shift participants out of habitual thinking, draw attention to close noticing of experience and stir imagination. A guided contemplation was followed by space for feedback of experience and reflection including new insights that may emerge and possible links with clinical practice. Feedback words and phrases given by participants were noted at the time then transcribed into a format that resembled a found poem. As the processes were delivered, methods of

[53] Creative Strategies Module 2009-2010 led by Shelley Sacks.

analysis were designed, developed and refined to best reveal the detail and nature of aesthetic experience as it emerged. In addition, the researcher's reflections were documented and reviewed from reflective journals kept throughout including steps for subsequent research progress.

The processes were initially developed for face-to-face participation, these were adapted for online participation in Covid times that commenced during this PhD. Adapting the methodology for online delivery will be discussed in the next chapter.

Table 5.2 (b-f) summarise the overall format for methods in common for the final series of processes. The letters correspond and add detail to columns in table 5.1. This format will be referred in chapter six to reduce repetition of reporting. Variations from this are described in individual processes in the next chapter.

Table 5.2 (b-f) Methods in common for final processes for healthcare groups

(b)Method of Delivery. Each process involved:

1.	An individual invitation emailed to each participant.
2.	A Zoom number and password for each online session to those wishing to take part.
3.	A poetic twist was incorporated in point 4
4.	As researcher-participant, I guided each process. Sessions included: a welcome and brief introduction, a short, guided contemplation to draw attention to sensory experience and stages of arising imagination i.e. aesthetic experience. Participants contemplated in silence.
5.	This was followed by time for sharing experiences, if wished
6.	Participants were invited to share any links they made with their healthcare practice
7.	Shared reflection after the process and discussion.

(c)Methods of Documentation and Results

1.	Numbers of participants in each group, number of groups held, disciplines of healthcare workers.
2.	Words and phrases were jotted down from participant's feedback by the researcher during the process. After the process, each participant was emailed their words to review and check they had been correctly represented.
3.	A list of links from 6 above was made
4.	Researcher reflective notes were kept.
5.	Sample questionnaires, if trialled

(d)Methods of Analysis

1.	Words and phrases written in the order they were spoken became transcripts that resembled a found poem. Pauses and grammar were added by the researcher as the sense was understood. Thus, the analysis was revealed through the perspective of the researcher. However, participants reviewed their own words to make sure these were accurately conveyed.
2.	Transcripts were reviewed with a 'brief initial checklist' for qualities of aesthetic experience. Devised by the researcher, this quickly assessed if the process had generated aesthetic experience that was: immersive, evocative, triggered multisensorial detail and expansive imagination, gave sufficient time to explore this, was connective (with self, other, community, environment), linked with values and wider issues in practice and was an engaging process.
3.	Tables: words and phrases were assigned to headed columns to reveal imagination arising from sensing. The table was refined and developed as research progressed to incorporate emerging details of the imaginative component. Column headings were adapted and simplified from Abraham's framework of the imagination and linked with Brady's modes of expanding imagination (see below).

4.	Diagrammatic forms representing the activated field of inner experience were also developed based on previous attention maps as discussed in chapters 3 and 4. Variations of a diagram to map the path of attention were explored to best show the expansive form of the imaginative dimension arising from sensory exploration and to develop a quick, practicable template for analysing participant feedback. These are shown below in figures (a-f) These were refined in practice as the series of processes progressed.
5.	Links with practice were reviewed
6.	Questionnaires were reviewed - see below on Feedback questionnaires

(e)Researcher reflections and (f) next steps included:

1.	Reflection on practices above
2.	Reflection in relation to the aims of each process and the study overall
3.	Summary and next steps
4.	Connectivity.

Development of tables and diagrams for analysis.

For analysing feedback words and phrases, an initial table used the column headings as shown in table 5.3 below. However, a second table 5.4 was developed as I wanted to show further details of the imaginative dimension as different components became apparent. This was devised by adapting and simplifying Abraham's framework of the functions of the imagination as described in chapter one. In the second row, I included Brady's stages where I thought these corresponded. Table 5.4 was therefore used in further analyses.

Table 5.3 Initial table

Situation/trigger generating an Experience: Process name	Awareness of direct sensing, thoughts, feelings, emotions, images: what noticed?	Arising imagination	Reflection: How did arising imagination link with wider issues/values	Comments and Next Steps

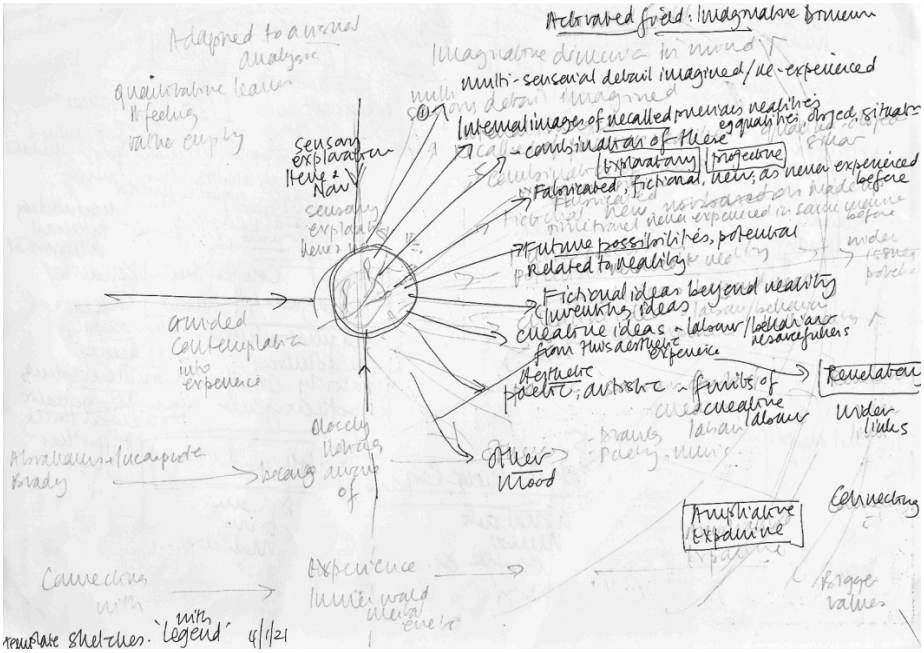
Table 5.4 Table adapted and simplified based on Abraham's framework to show different aspects of the imagination in first row. I have also broadly assigned Brady's 'modes' of imagination in the second row

1.Sensory experience in present situation– mindful awareness.	2. Senses arising in imagination - mental imagery	3.Recollective imagination, intentionality-based imagination. Episodes or combined imagination & those made up/fictional	4.Imagine future possibilities Novel combinator-ial imagination. 'Possibility Space'	5.Creative imagination As in 4.	6.Fictional possibilities created in imagination as in 4	7.Links/revelations. As in 4	8.Connection with…
Sensory perception leading to possible parallels with Brady's model:	Exploratory imagination	Projective & amplified imagination	Projective imagination feeling into	Amplified imagination, Revelatory imagination		Revelatory imagination	Revelatory imagination

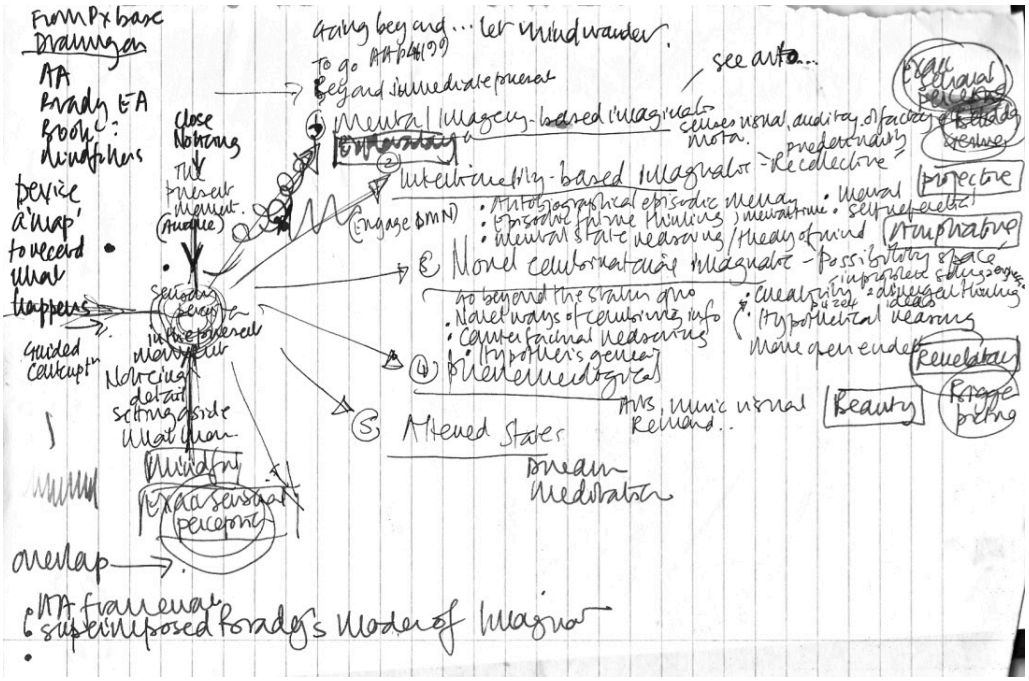
Development of diagrams for analysis

Next, I developed this into a diagrammatic form. From the table above, headings were adapted and simplified from Abraham's framework to show different aspects of the imagination. Reflective journal sketches below show the development of a template for analysis. The diagrammatic form represents the activated field of aesthetic experience arising from close noticing of sensory detail and the arising imaginative dimension.
I have also attempted to add corresponding stages for Brady's modes of imagination.

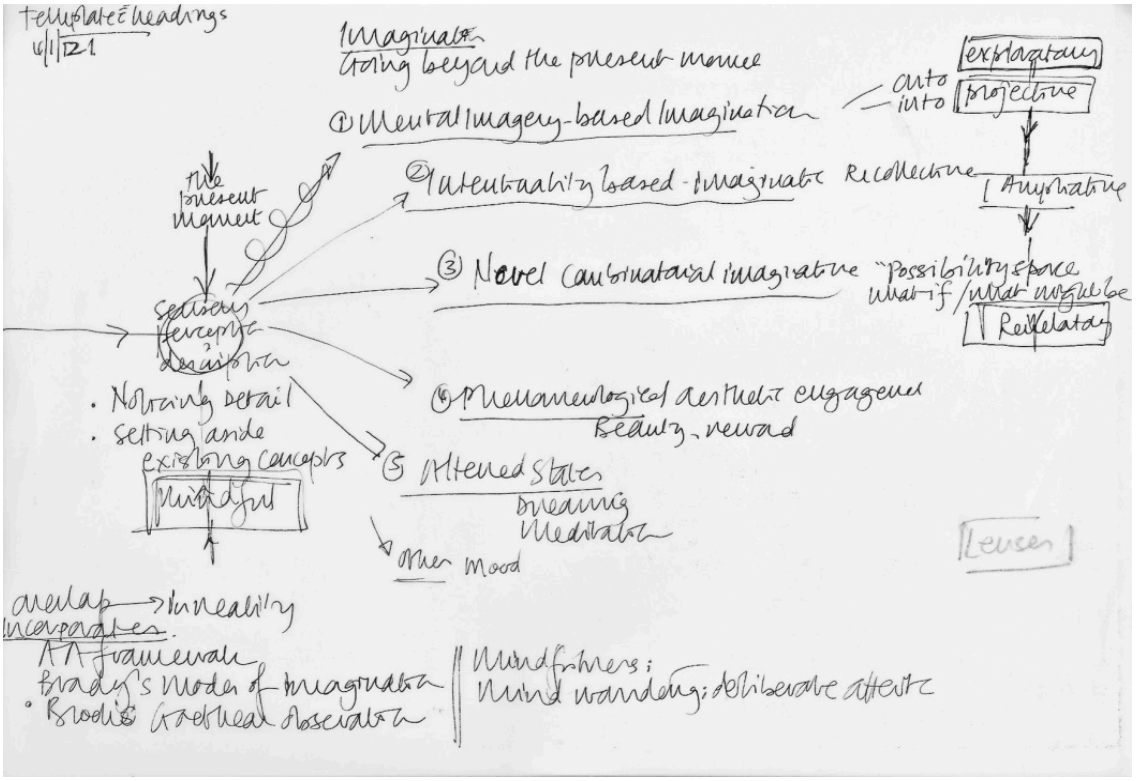
Figures 5 (a-f)
5(a)Working it out.



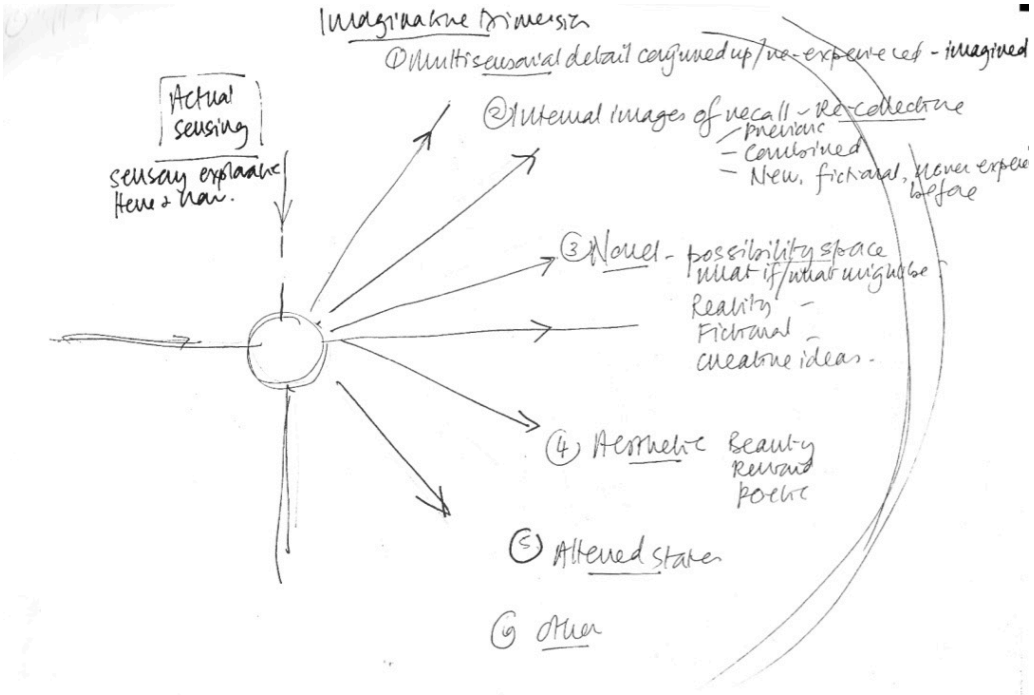
5(b)Sketching out possible alignment of components adapted from Abraham's framework with Brook and Brady's models and mindful awareness (Top right hand corner circled should read 'Exact sensory imagination').



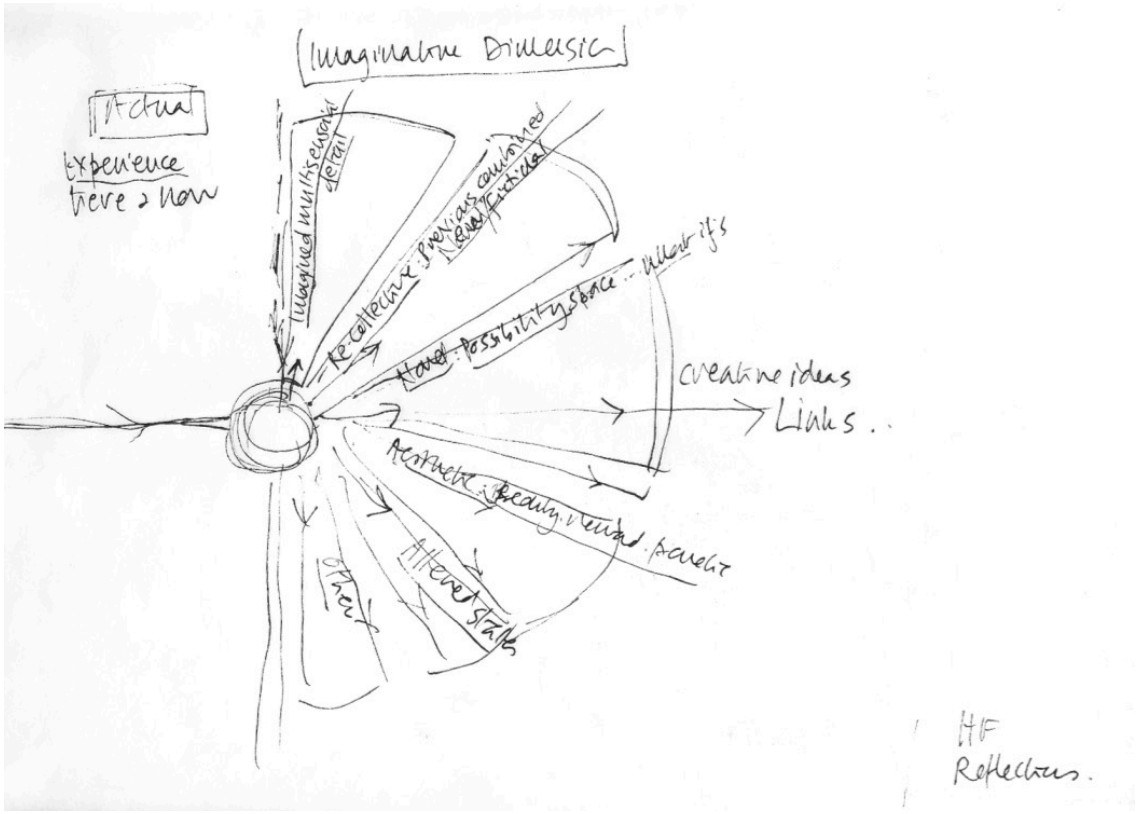
5(c)Clarifying and attempting to simplify into a template.



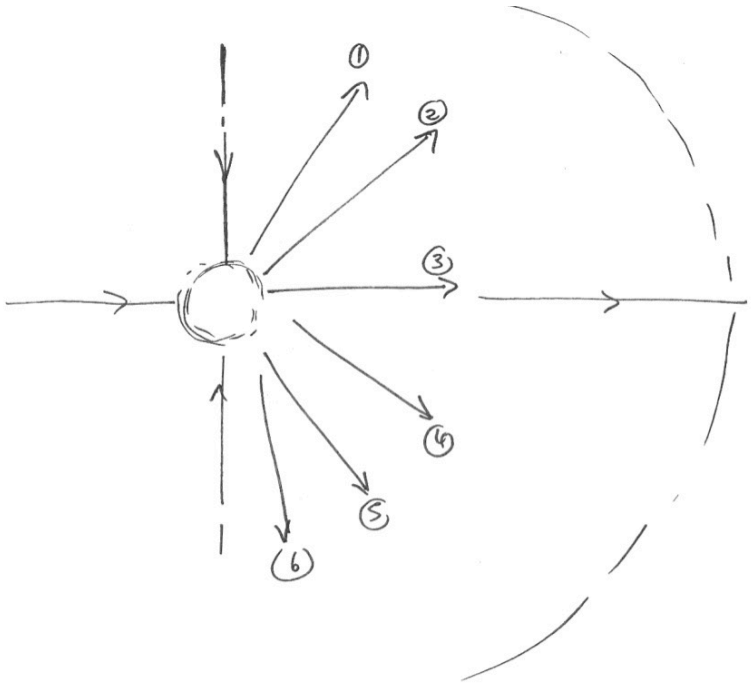
5(d)Simplifying the templates for analysis using categories from Abraham's framework.



5(e)The sections on the right correspond to the arising expanding imaginative dimension divided into Abraham's categories.



5(f)Most simplified format, this does not show legend but represents the activated field of imagination as shown in (a)



In summary, the templates in figures 5(e) and (f) were used with knowledge of the categories shown in figures 5(b)-(d). The use of these diagrams as templates is shown in the analysis of processes described in chapter six and PoP6.

Feedback questionnaires.

I searched for an existing questionnaire to 'benchmark' my findings. The Aesthemos Questionnaire is based on aesthetic emotions and has been tested out in numerous areas of design (Schindler *et al.*, 2017). Whilst my study definition of the term 'aesthetic experience' is broader than emotions alone, several of the items in the Aesthemos were adapted here to my analyses. Therefore, this questionnaire was given to a sample of participants to see if it was a useful addition. Other feedback forms were also trialled with several participants throughout. However, I felt that by the end of each participatory process, the online commitment therein was sufficient.

Thus, overall, methods of analysis for final series of participatory group processes consisted of a combination of:

1. words and phrases written as a form of found poem that evoked something of the sensibility of what was said,
2. assigning words and phrases into a table with column themes based on Abraham's framework to show details of different functions of the imagination,
3. diagrams to show the dynamic expansive form of the activated field of sensing and imagination of aesthetic experience
4. possible links and associations with healthcare practice,
5. a sample of feedback questionnaires
6. researcher reflections.

These different forms of analysis revealed different aspects of aesthetic experience, and all worked to further build the description.

Method of recruitment of healthcare practitioners and related workers to the final series of participatory processes.

The recruitment method for healthcare workers and allied professionals into the study for the final series of processes was by online circulation in Covid lockdown. Stages of recruitment were as follows:

- Participants from healthcare groups were recruited using a poster circulated online - see PoP5
- Examples of groups circulated - PoP5
- Those interested were sent a more detailed information leaflet[54] explaining what was involved.
- Information was also given to recruited participants in an online Artist's Introductory Talk, as the leaflet was lengthy. The talk also introduced the concept of aesthetic experience and offered time for questions. All participants were required to have attended this session prior to

[54] Submitted to and approved by Oxford Brookes Ethics Committee. Accepted 2016. Adaptations approved for online delivery during Covid lockdown 2020.

attending any of the processes so they would understand the way they would be working[55]. This talk was run on three occasions to accommodate all who wished to be recruited.

- Following this, participants were sent a consent form[56]
- Participants were individually invited by email to each process. Invites are shown in PoP6

Delivery of final series of participatory processes.

The final processes were adapted for online Zoom groups due to Covid lockdown. Ethics approval was given for the adaptations. A pool of 26 participants was recruited from healthcare and related fields of work. Processes were scheduled over a 6-month period (2020-2021). Participants could attend all the processes (ideally), or one to several as wished. The processes were offered in small groups of 4-10 as zoom online meetings so that all could be seen comfortably on the same screen. Each process was run on two or three occasions to accommodate all participants who wished to attend. Each lasted approximately one hour. The researcher guided the process and was also participant-observer. In each group session, participants were all present with the researcher at the same time. In the zoom processes, there was a choice for participants to switch off their video cameras if wished (no one did) and choose their on-screen name.

Profile of participants.

The disciplines of recruited participants from various healthcare groups and allied professions is given in the PoP5. Thus, a good-sized pool of 26 participants took part in the study and were invited to attend as many of the six processes as wished. It was not felt realistic that all of them would attend all the processes.[57]

Artist's Introductory talk.

The recruited pool attended the 'Artist's Introductory Talk' that was given on four occasions to accommodate all who were interested in being recruited. An invitation to and details of the talk can be seen in PoP5.

All but two who attended gave feedback comments. 19 gave positive comments that indicated they were interested and engaged; 11 commented on the relevance and links that aesthetic experience could have with clinic work; six comments related to the use of online Zoom processes and two raised questions about the arts-based research paradigm and one asked how outcomes could be measured. Examples of comments are given in PoP5 During the discussion time, I explained how the adaptation of the processes to online zoom would bring a further experimental element to the study – particularly in relation to the connectivity element. This is discussed in chapter six.

Poetic transcription as a way of documentation

Finally in this chapter, I will mention documentation. Participants' phrases and words were written as heard and thus resembled a 'found poem.' A new phrase was written on each line, spacing and breaks were placed at natural pauses or different comments. These were written through the lens of the researcher yet

[55]Aesthetic experience and participatory action were felt to be a new concept to most healthcare workers.
[56] As at note 54 above
[57] For instance, work commitments, interest in particular sessions as wished

checked with participants for correct representation. I thought these were more interesting to read than a transcript of every utterance and that these may stir imagination, further sensing and open up awareness to the perspectives of others in this form, for instance as an evocative representation of results[58] or for sharing as part of a teaching method. There is no one outcome or set answer to any of the processes. They were designed to be open to the various perspectives of participants. These in turn may stimulate further views through group conversation.

Poetic writing compiled from participants' words and phrases as recalled by the researcher is one way of creating a form for re-presentation. I felt that reading short excerpts out as examples of lived experience could be a method that contributed to changing the gear of a presentation by drawing attention and shifting the audience into experiencing. I tried these poetic transcripts out, both used from my own free-writing and participants (with consent) in several of the online processes in the next chapter.

Chapter summary

In this chapter, I have discussed the rationale for an arts, practice-based approach to explore aesthetic experience. Summary tables have been given to show the overall structure for reporting stages of development of methods from first-person explorations to a final series of six experiential participatory processes for health carer groups. An overall format for reporting the details of methods at each stage was laid out that will be adhered to in chapter six. Recruitment methods were also given including an 'Artist's Introductory Talk' for recruited participants entering the study, prior to starting the experiential participatory processes.
I have also discussed a form of poetic transcript for documenting participant feedback and methods of analysis that developed as the processes were delivered, particularly to reveal contents of the imaginative dimension in greater detail.

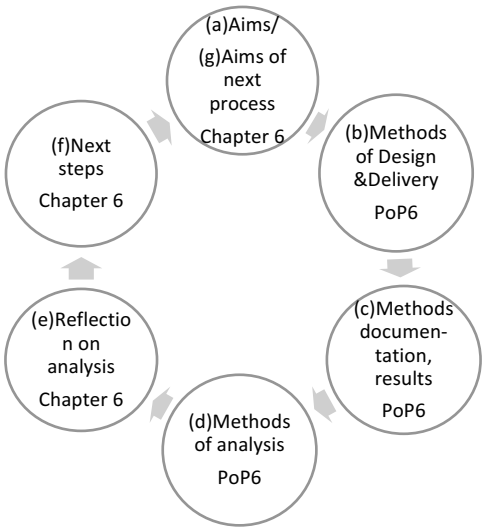
[58] With consents

Chapter Six - Development and design of six ultimate experiential participatory processes.

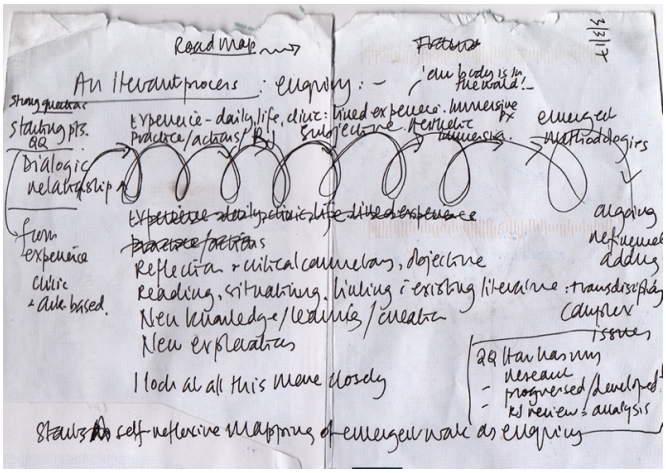
Chapter introduction and outline

This chapter and the accompanying section in the portfolio of practice (PoP6) describe the methods of design leading up to and including a series of six ultimate experiential participatory processes (hereafter, the 'processes'). The layout for reporting the methods for each process was described in the three main stages as indicated in table 5.1 in the last chapter. The diagram 6.1 below represents these in a cyclical mode similar to Kolb's experiential learning cycle (Kolb, 2015), showing all the components in one cycle. The written reflective commentary in this chapter includes (a) the aims, (e) reflections on analysis and (f) the resulting next steps in the research with further aims (g). The respective practice-base that evidences the work is described in the accompanying PoP6 and includes (b) methods of design and delivery, (c) methods of documentation and examples of results (d) methods of analysis.

Diagram 6.1



However, in this research, one cycle leads to the next and in some cases also refers back to previous cycles. In reality, reflection and practice were entwined throughout as shown in the spiral iterative path sketched below and in the more complex drawn diagram shown on the first page of PoP5. To obtain a sense of this path of development, the reader is therefore invited to read the written text in this chapter six, whilst referring to the PoP6 where indicated in the following text.



Each process is described below in a section headed with its final title as follows:

(1) Roots of Imagination.

(2) Close noticing: Beyond the Clinical Gaze,

(3) Touch: An Encounter with Care,

(4) Stethoscope Meditation

(5) Hospital Corridors – Corridors of the Mind

(6) Tea for Ward Rounds.

Earlier titles used in the development of each are stated in the text. Each process was designed to highlight a different connective component of aesthetic experience. In reality there was overlap of this in the processes. Additionally, in the description of each final experiential participatory process, further practice-based details in common are given in the format shown in tables 5.2(b-d). Methods of analysis are also detailed further in tables 5.3 and 5.4 and diagrammatic templates, figures 5(a-f) in chapter five. These will be referred to in this chapter. Individual variations are added along with examples for each process from practice.

In the development phase, two further process not included in the final series were trialled and are outlined in PoP6.

Process 1 - 'Roots of Imagination: Aesthetic experience - sensing and imagination'.

The aim was to design an experiential participatory process, to activate aesthetic experience for participants; raise awareness of this during practice in order to explore it; design a spoken guidance to lead participants through deepening stages of attention; contribute to the overall study aims by introducing participants to the core concept of aesthetic experience through immersive participation and develop methods of analysis.

(i) First Person explorations.

The initial process was called 'Contemplation with an item of nature' and later renamed 'Roots of imagination' for the healthcare groups.

The **aim** was to design a process to activate aesthetic experience that could be used to demonstrate this to others. I felt that starting with a non-clinical item would offer a more familiar issue than a clinical one.

Methods of design, documentation of findings and analysis: please turn to PoP6.

Reflections and next steps: The practice-based methods demonstrated that aesthetic experience was activated with rich and complex sensory and imaginal detail. Immersed not only in vivid visualisation, I also re-experienced other sensory modalities in imagination. Using my recorded audio guidance, I was able to sustain attention and stay connected with inner experience to explore closely and mindfully. In imagination, I was also able to re-connect, with the environment where the items had been found as well as wider imaginings. The pacing of my audio allowed sufficient time and space to do this and move through stages from describing sensory detail to the arising and expanding imagination. This shorter simplified adaptation of the stages described by Brook and Brady was designed for practicable use by clinicians, for example as an hour's teaching session, or meeting. By activating aesthetic experience using a familiar issue, I felt that this process would be of

value to demonstrate and introduce the core concept of aesthetic experience to other participants with a view to later applying this to a clinical issue.

Whilst the analysis in table 5.3 revealed rich multisensorial and imaginative detail, I felt the imaginative dimension was more complex than these column themes revealed. Therefore, I tested out table 5.4 to allow deeper analysis of the imaginative components based on Abraham's framework. These can be seen in PoP 6 - Process 1, Acorn analysis using table 5.3 and 5.4 Contents of imagination could be ascribed to different columns, with some overlap. Table 5.4 revealed further details but as a record it was verbose. In comparison, I felt that the more diagrammatic addition shown in the analysis using 5.3 showed the expansive nature of the imaginative dimension as it arose from sensory exploration at a glance. In combination, both table and diagram gave additive details. Thus, these methods of analysis were both included as the research progressed.

This process served as an example of the type of experience I wanted to convey and activate for others. It also served as an index process for me to return to in the development of further processes and their analysis as I explored aesthetic experience more deeply. The finished spoken guidance could thus be reproduced and used as a prompt for the researcher (me) in guiding the pilot and healthcare groups below. The next step was to test out the above process with other participants.

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(ii) Pilot studies

The **aims** were to discover if aesthetic experience could be conveyed and activated for participants and if the guidance could lead them through stages to explore sensory and imaginative detail. Pilots were offered in 1:1 dialogue and with groups of postgraduate artists.

Methods of design, documentation of findings, a questionnaire and analysis: please see PoP6 for details of practice examples of 'Pilot: one-to-one' (Box 2) 'Pilot groups,' 'Pilot Zoom group' and diagrams. (Box 3-4). In the last pilot group, participants were also given the Aesthemos[59] questionnaire (Schindler *et al.*, 2017) to complete online after the process to discover if this existing rating scale was useful here.

Reflections and next steps: Aesthetic experience was successfully activated in one-to-one dialogue and in small pilot groups both face-to-face and online. Participants were able to become aware of and explore their experience at the time. They described multisensorial experience in reality and in imagery that rapidly led to a rich and expansive imaginative dimension. This short practice with spoken guidance given 'live' allowed them time to observe experience as it arose in detail. Participants appeared engaged and interested throughout and all gave feedback of their experiences. The Aesthemos questionnaires also demonstrated engagement and enjoyment but its use in this research had shortcomings as shown in the reflective note in PoP6.

The items of nature themselves drew curiosity and stirred imagination, both those I presented in the box and those that the zoom participants brought online. In the latter, each gave a few sentences about their item that drew the interest of others on zoom. Along with the items, these acted as poetic elements that also appeared to deepen group engagement and cohesion to the online group despite physical distance in Covid lockdown.

The process was reproducible so it could be shared with a number of groups. Learning points were: whilst giving the spoken guidance, it was important to allow enough space and time for experience to be explored and not be too over directive as to inhibit participants' own imaginations and mind wandering. A

[59] Measures aesthetic emotions and engagement

balance was needed including simplicity and pauses in the guidance to allow space for this. In addition, awareness of aesthetic experience had the potential to lead to insights beyond the action itself, thus potentially offering a creative resource. More time was needed during feedback for these insights to emerge. Of note, this method generated rich experience with few resources other than shifting attention to becoming connected with and aware of aesthetic experience, noticing this and reflection on it. This was possible in the duration of an hour. Therefore, I felt that this process would be suitable as a first process to introduce participants to the concept of connecting with and exploring aesthetic experience. This method could later be used in subsequent processes in relation to clinical settings. This process was ultimately named, 'Roots of Imagination.'

Use of diagrams as methods of documentation and analysis

A series of diagrams including and similar to Acorn 5.3 (PoP6) and those made during works in progress throughout this thesis were shared with postgraduate artist colleagues in a PhD seminar to discuss these as a method for documentation and analysis. These included drawn attention maps using blackboard and chalk, pen and pencil on paper, sketches on backs of envelopes, reflective journals etc.

Examples of comments showing advantages of this as a method included, 'a space to show the workings out of possibilities, externalise thinking,' 'the ephemerality, stirred imagination and was more exciting than words alone', these 'showed the interrelationship of inner events - the form of thought, the dynamics and malleability...' and 'imagination is hard to quantify – yet using the same visual process for each shows rigor...one gets a sense of the processes building through these,' and similarly in 'The Blackboard Anatomist' a drawing of the functioning dynamic brings to life more of the whole. (Harris, 2015).' A full list of advantages and functions given by the group is shown in the table in PoP6 Table 6.1. As a result, I felt that the diagrammatic forms were of value and these were developed as a method of analysis of words and phrases from feedback throughout. I have previously discussed the templates developed in the last chapter as Figures 5(a-f).

(iii) Final online group participatory experience for healthcare groups: 'Roots of Imagination'

In its final form this process was entitled 'Roots of Imagination.' It became the first of six processes shared with healthcare workers and was used to introduce healthcare participants to the type of aesthetic experience in this study. It was intended that awareness of this kind could be related to clinical issues in subsequent processes.

Methods of delivery, documentation and analysis: see PoP6 for invitation, script, participant examples 6.1-6.3 and the analyses of these are shown in PoP6. A superimposed map that represents the collective group imagination is also shown at Box 5.

Reflections: Aesthetic experience was successfully activated and found to be rich in sensory detail that expanded into an imaginative dimension that contained complex and different components. The three methods of analysis revealed complimentary detail about the nature of aesthetic experience: words and phrases revealed sensibility; entered into table 5.4 these showed verbal details of sensory and imaginative content and the diagrammatic format using the template, figure 5(d) revealed the expansive nature of aesthetic experience at a glance. Thus, different aspects of the nature of aesthetic experience were revealed by each method. Further points of reflection were:

- The transcript of words and phrases in found poem[60] format conveyed something of the sensibility of the experience. The words and phrases were in the order they were said by the participant and, as researcher, I added lines, spaces, pauses, punctuation as I felt they had been intended. Thus, these were analysed from my perspective. However, participants reviewed these to check they had been represented accurately.
- In the table, I was aware that analysing complex aesthetic experience could risk reducing it by using words alone or assigning fixed column headings as themed. Some comments overlapped or were difficult to place. The tables were verbose. However detailed and different components of the imaginative dimension were revealed.
- Diagrammatic representation gave a sense of the form and dynamic of expanding imagination from sensing and showed this at a glance. This tallied with points previously given by postgraduate artists in the pilot studies. However, the diagram also needed accompanying explanation.
- A strength of this process was hearing different perspectives amongst a group. To analyse aspects of the imagination into set codes could be deadening and disconnected from what emerged in experience on each occasion.

Further possibilities for analysis, and not tried here, could include for instance, drawing out the attention maps during feedback with the group. This could stimulate further imagination, discussion and group collaboration in the analysis. Discussion with the postgraduate artists in the pilot groups above showed advantages of this. Gray and Malins refer to this as 'creative construction' for 'making sense' (Gray and Malins, 2004, p. 154).

There are also other possible ways to present results. For example, reading out the words could convey experience. I tried reading them out and recording on audio. Here they were spoken through my voice, tone, pauses etc. as an analysis or filter. These become a secondary form. Furthermore, listening to the spoken words and phrases in a poetic format may evoke something of this experience in others. Participants reading their own words would be a further experimental possibility.

Overall, the three methods of analysis I used revealed different aspects of aesthetic experience. Thus, these methods, used in combination, revealed more of the quality of the type of aesthetic experience generated than using just one of them alone.

Other relevant factors that also play a part in this would be how naturally imaginative the participant was and how the delivery of the spoken guidance is such that these elements are drawn out.

Connections and links with aesthetic experience in healthcare practice: Participants were invited to reflect on whether they thought that being aware of this type of aesthetic experience could be linked with their healthcare practice. These were embedded in participant 'Words and Phrases' in examples 6.1-6.3 PoP6. A separate list collating connections and links made from all feedback comments is given in Table 6.2, PoP6.The feedback here shows how the arising imaginative dimension could reach beyond the item itself to a space of potential and possible links with practice. In this way, awareness of the capacity for aesthetic experience may offer a resource in practice through new insights or ideas. This 'revelatory'[61] aspect occurred here in the short

[60] 'A pure found poem consists exclusively of outside texts: the words of the poem remain as they were found, with few additions or omissions. Decisions of form, such as where to break a line, are left to the poet.' (Poet.org).

[61] Brady – final stage of modes of imagination in the Integrated Aesthetic.

space of time of the hour given to the whole process. That such connective potential can be drawn out in this time space is of benefit as it would be feasible to fit such a process into the usual time for a meeting, teaching session, lecture, short workshop etc and thus be usable by a busy healthcare population. A further example 6.3, 'Horse Chestnut Shell' also beautifully demonstrates this in PoP 6.

In **summary** in all the healthcare groups, participants were engaged and immersed in the experience throughout. Feedback demonstrated that the process activated aesthetic experience for them. They were able to connect with this and closely notice and describe multisensorial detail that led to expanding imagination. This occurred in a relatively short time. The guided contemplation was around 7 minutes in a whole group process that lasted an hour. The process was immersive, evocative and stirred their imagination. The latter included a variety of components such as memories from the past, thoughts about the future, travelling far in geographic imagination and making possible links with wider thoughts and broader issues beyond the nature item itself. Participants were invited to reflect on how this type of aesthetic experience could be relevant in their healthcare practice. Participants were experienced and knowledgeable in their areas of healthcare and they all, except one[62], gave possible links.

Aesthemos questionnaires were emailed to a sample of 9 after the process. 8 were returned complete. Relevant items were tabulated, shown in Table 6.3, PoP6. Overall, results showed that the process was an engaging, positive experience that generated feelings of wellbeing.

Further discussion points: In Social Sculpture, exchange and discussion processes last much longer to deepen the exploration. However, the process here showed that it is possible to show the expansive nature of aesthetic experience in an hour and that even in this time much could. The benefit of this is that it could potentially be useable as a reflective teaching method for busy healthcare practitioners.

A further point here was the multidisciplinary aspect of the participants. Hearing participants' feedback from other disciplines offered different perspectives thus offering new insights to others about the way they worked, felt, thought, and imagined. For example, an osteopath explained how they were highly attuned to sensing flows of energy through the body whereas doctors attend to more objective findings. A radiologist thought it was possible that she could hone her skills of close noticing away from work and transfer this to reading X-rays and scan images. I thought that listening to comments brought by participants kept other group members engaged, stirred imagination and possibilities for new ideas.

The zoom process took people far in imagination in a short space of time. They were engaged throughout and voiced that 'it worked well on zoom.' This adaptation had thus been an opportunity to test out the connectivity of this mode of delivery. Working in a digital mode is gaining importance and methods that retain connectivity would be important[63].

This imaginative space is a space of possibilities. It arose from close noticing sensory detail. I have aimed to show something of the emergence of the expanding imagination from stages through sensing and the possibilities that arise. This suggests that making space to consider these may be a creative resource.

There may be benefits of this type of process over usual reflective practice. Traditional reflective practice in medicine is a verbal, fill the box type of exercise for appraisal[64].

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[62] One left the study.
[63] An expanding field is NHS Entrepreneurs. A future development of this work could be to make a link.
[64] The General Medical Council give existing examples.

Here, participants became aware of aesthetic experience whilst contemplating an item from nature. The spoken guidance led them through stages from close noticing sensory details to their expanding imaginations. This process advanced the study in developing a method of introducing the concept of aesthetic experience through immersion in practice. This was therefore used as the first process in the series of 6 final processes. The next steps were to demonstrate with the participants how this type of aesthetic experience could be relevant in clinical practice as a reflective tool.

Process 2 - 'Close noticing: Beyond the Clinical Gaze.'

The initial process was called **'ECG contemplation,'** then renamed as above for the healthcare groups.

The **aim** was to design a process using a similar method for raising awareness to aesthetic experience in relation to a clinical issue, here using a medical investigation, the electrocardiogram (ECG). In chapter three, I discussed an example in relation to an ECG in my clinic. In moments aside from objective tasks, I had suddenly become aware of my aesthetic experience which gave me a 'feel' of my patient. The human trace literally moved me and this led to a decision to connect with my non-attending client in a simple email asking how they were. In developing this second research process, I wanted to see what happened if one became aware of aesthetic experience in such a way rather than reading it only objectively.[65] I wanted to review what could happen whilst paying mindful attention to experiential details whilst holding an ECG trace in my hands as an example of reading beyond objective data. Could closely noticing the paper trace of a persons' heartbeat whilst passing it from one hand to another activate aesthetic experience? Could this bring a feel for a more holistic connection with the person, for instance as in the close sensory observation that brings a sense of a dynamic whole in Brook's stages of Goethean observation?

(i)First-person explorations.

Methods of design, documenting, analysis and results are discussed in PoP6

Reflections and next steps: First-person practice showed that it was possible to explore rich aesthetic experience by closely noticing an ECG trace. I became aware of the complexity of the imaginative dimension as it arose from sensing. This included mental imagery that was visual, tactile, kinaesthetic; contained past memories and imagery from the clinic; and furthermore, I was able to think of possibilities for creative design of a process for others to share. The ECG makes a visible trace of the dynamics of the invisible electric forces in the heart picked up at different places on the skin surface. I drew out these physical forces. See images PoP6 - process 2. I also wished to explore the invisible imaginative dynamics that could be at play. I imagined how I would set up a process to try as a pilot study.

(ii)Pilot studies

Next, I wanted to see if this could also activate aesthetic experience for others. Using the made traces, a process was piloted with others. First, this involved a couple of others on a one-to-one basis, then extended to groups of postgraduate artists. I also wanted to discover how a group of contemporary artists would experience the ECG trace. They were familiar with aesthetic ways of knowing and broad ways of seeing. I thought that they

[65] Whilst the objective reading is crucial for the immediate physical safety of the patient, noting other experiences that arise could be reflected on at a separate and appropriate time.

may be able to 'see' beyond the objective measurement and have other insights. I wondered if their feedback would offer ideas that could also stretch the imagination of healthcare workers and raise awareness of aesthetic capacity. Could other participants become aware of aesthetic experience in a similar way and with the same type of guided contemplation designed in process one?

Methods of design and delivery: see PoP6 for images

Documentation, results and methods of analysis: see PoP6. Words and phrases were noted and collated as given in the format of a found poem (Box 6). These were reviewed with the brief checklist to see if aesthetic experience was activated. I read the transcript of words and phrases out and recorded it as a soundtrack ECG - PoP6 to see if this was evocative as a secondary form of documentation.

Reflections and next steps: Both groups were absorbed in the process and curious about the traces. All put on the gloves and held the traces. All gave feedback. Several became caught up in not being able to read an ECG which made me realise that I had not given them as much guidance in process one. This needed re-shaping to allow participants to be aware of what occurs to *them subjectively* and their imaginations whether they can read an ECG trace or not.

The process was evocative and triggered the imagination as can be seen in the words above. Wearing the gloves made the action feel 'precious' and 'honourable', the gloves gave a sense of care for the traces, 'a real sense of these being people – this representation of a person', 'these people but we can't code them, a sense of vulnerability', depersonalizing yet personal, noticing the time the traces were made. The sonic artists in the group saw it as a form of musical score and one improvised to several of them on electric guitar, the sound seemed to me to represent something of the 'tone' of the person from whom the trace was made. Some commented on the papery feel of the trace even with the gloves on. The themes of the second group were more around the body, heart and breath. When read out and back to them as a found poem, these words were moving and evocative in their own right, as a secondary form. This audio can be heard in the portfolio PoP6 process 2.

In **summary**, this simple process triggered aesthetic experience within these artists' groups. This was shown by their feedback of what was in their imagination and experiences of sense perception. This was a predominantly imaginative process for them. This may have been because the ECG traces were unfamiliar to them and unreadable in a medical way. Although they knew what they were, the artists contributed seeing anew, with clear fresh eyes or beginner's mind[66].

This process was successful in activating aesthetic experience in the artists' groups. Their imagination was very rich. In these groups, the white gloves along with the unfamiliarity of the ECG traces served as the poetic intervention. The artists were not hampered by trying to read the objective measurements of the ECG and their imaginations took off with minimal guidance after a brief introduction. I wondered if their way of seeing could facilitate healthcare practitioners to become aware of an aesthetic dimension as well as their usual way of reading the trace objectively. I predicted that the healthcare workers would be habitualised to reading the objective parameters and may find it harder to be aware of the aesthetic component.

The process was reproducible and I thought that it could be tested with the healthcare groups to discover what would happen if they extrapolated the method of becoming aware of aesthetic experience aesthetic from Process 1 to this aspect in clinical work.

[66] A concept from Zen Buddhism of seeing anew, as if never seen before

(iii) Final group participatory process for healthcare workers: ultimately named **'Close Noticing Beyond the Clinical Gaze'**

I wondered how other healthcare workers might find such a process of closely noticing these heartbeat tracings in this way, beyond objective parameters. The next steps were to test out the process with the recruited healthcare groups. The **aims** were for them to be able to extend the awareness of aesthetic experience developed in process one and relate this to an everyday clinical issue, here the ECG trace. An additional challenge was adapting this process for online delivery in Covid lockdown. I predicted that this would not work as successfully without the real traces and the white gloves. I wondered how a poetic element could be incorporated. In an adapted version for online, I explained to participants the more experimental aspect of this process and invited their feedback.

Methods of design and delivery (email invite and guidance script)**, documentation, analysis of results and examples 6.4 - 6.6:** in PoP6.

A key for Abraham's framework of functions of the imagination is also shown in Box 7, PoP6.

Reflections: In example 6.5, the analysis reveals the many aspects of the imagination, the complexity of the expansive component of aesthetic experience (sensory perception and the arising imagination) and its potential for discussion of wider issues including even wider counterfactual imaginings. What of the latter? In 'imagining wisely,' Brady discusses how one may draw on the contents of imagination and actively discern what is relevant and appropriate to the issue at hand. For instance, the imaginative component about the bat may be deemed fanciful, however, it was not unrelated to other group members who made comments about how traumatic and anxiety provoking reading an ECG as a junior doctor was and having to 'blindly' make life and death decisions in the absence of a more senior colleague thus fostering an urge to flee or 'fly out.' Another participant, as shown in the reflective analysis below the table in example 6.6, PoP6 indicated that that her traumatic memories of being unable to read an ECG as a junior doctor were voiced and eased by the discussion in this process. This imagery could have been explored further as metaphorical imagination.

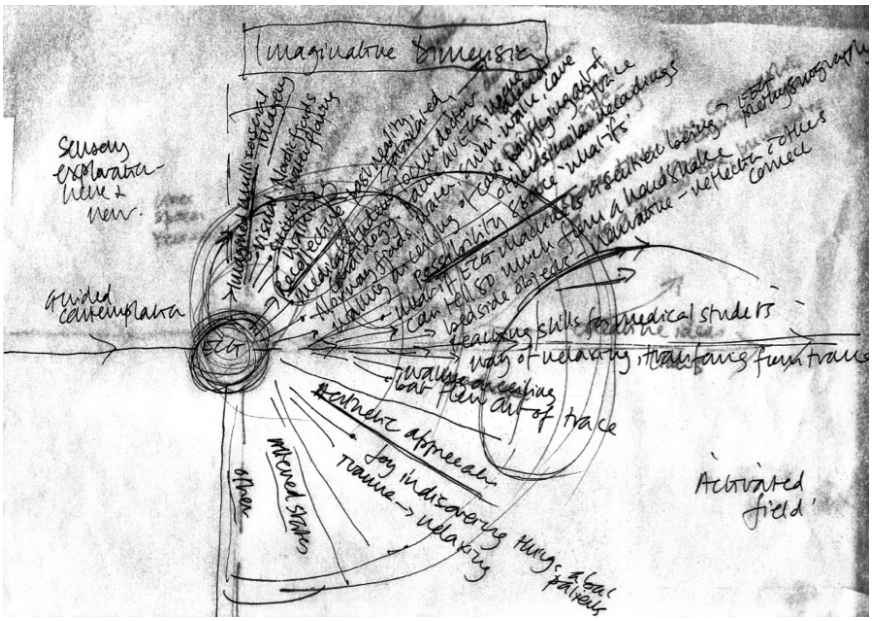
The skill here is in knowing which aspects of aesthetic experience bring insights that are useful and appropriate in a given situation or may be the seed of a creative possibility. In this same example 6.5, the potential of narratives entwined with personal objects by the bedside could also invite a brief discussion with the patient that is connective with them as a person, with insights into their lifestyles and values as Charon points out (Charon, 2006). Furthermore, this participant's fabricated imagination opened up to the possibility of the ECG machine as a sentient being. This could have led to discussions centring round, for instance, artificial intelligence, but was not further drawn out here.

A criticism is that personal experience and the imagination are too subjective. I have previously discussed Brady's point about 'imagining well' in chapter one. In line with this and in relation to my research processes, it is a professional reflective skill to work out what is and isn't relevant. The imagination is how one reaches beyond one's immediate reality to generate new ideas. This needs space to emerge. My research processes offer an enhanced reflective process in experiential participatory action away from the clinic where all imaginings can be critically reflected on for relevance (or not). An aim of these processes overall was to create a space for awareness of aesthetic experience and reflection beyond positivistic paradigms and discover new

insights that may extend ways of knowing alongside hard facts alone. Thus, reflection in this study adds a space for possibilities. A quote from this participant in example 6.5 was, 'We must have time to think'.

These and other participants' feedback demonstrated that aesthetic experience was activated. The guided process worked well on zoom evoking rich detail in the imaginative dimensions and wider connections linked with practice including more creative possibilities. The process offered a space for stirring the imagination that expanded from closely noticing sensing. This was shown at a glance in the diagrams for individual participants and for the group as a collective in the combined diagram below where the density of comments predominantly lie in the first 3 of Abraham's functions of the imagination i.e. mental imagery, recollective and novel combinatorial imagination (legend can be seen in templates in figure 5(c-e). These appear to correspond with divergent thinking of the DMN of brain as in Abraham's framework in which novel combinatorial imagination is a 'possibility space' and importantly gives rise to new insights and creative thought. Additional questionnaires were not used in this process.

Combining diagrams shows that a collective expansion of the imagination



The process also allowed sharing of multiple perspectives for reflection. In this process not everyone was as imaginative as the participant in example 6.5, however, in a group situation, such a person's creative thinking may serve to trigger wider thoughts and imaginings in others and lead to discussion.

All participants made possible links and connections with practice and several reported difficult feelings e.g. three re-called traumatic negative emotions as a junior doctor when they had felt unable to read an ECG yet had to face medical decisions alone, without the help of a senior doctor. One non-medic working 'virtually' on a Covid ward also felt this on seeing the ECG and it rekindled her feelings on interacting with these patients remotely. Another healthcare related worker recalled his anxiety in relation to uncertainty about his own result in a past ECG test; two others felt anxious at the 'feel' of the shape of the trace in relation to the heights and drop. These participants also commented that the guidance allowed them to creatively imagine other things that brought a feeling of well-being.

Difficult feelings and associations are also part of aesthetic experience, and these processes may trigger these as in everyday life in healthcare, even more so in Covid times. The ECG process made me reflect on the order of processes offered. I did not wish to offer a series of processes that all trigger difficult feelings without offering some that are more enjoyable or nourishing. Thus, I deliberately choose to order the delivery of processes by interspersing those that may have this effect e.g. Hospital Corridors (later called 'Corridors of the Mind') with processes that that participants could find more relaxing. My aim was to remain sensitive to the needs of participants, especially as all are navigating through the anxiety of Covid times and this healthcare group were more likely to be immersed in this work. In mindfulness-based programmes, one is actively encouraged to schedule in more nourishing activities, even if small, to help build resilience amidst difficulties.

Findings showed that the type of aesthetic experience activated in the first process could be translated to this example of a medical issue, here the ECG trace, in the way this process was delivered. Furthermore, the description of aesthetic experience was added to in that the imaginative component could contain fabricated creative ideas that could potentially lead to discussion if seen, for instance, as a metaphor. As in the pilot, examples of imagination going beyond the item itself included a musical score, rhythm, birdsong, landscape, waves and troughs.

Process 3 – 'Touch an Encounter with Care'

In Covid lockdown, physical contact between participants was not possible. 'Bathe: An Encounter with Care,' was described in chapter two as a scoping study. The aim now was to adapt a design for online delivery without the physical encounter at one's fingertips, yet still raise awareness to aesthetic experience that may arise in the between self and another. Touch may easily be taken for granted in the clinical setting yet is a central part of the human encounter in healthcare. Awareness of aesthetic experience, even for a few moments, may offer an opportunity for reflection on the connection with another. Could aesthetic experience be noticed whilst caring for one's own hands whilst applying hand cream and could this be linked imaginatively with caring for others? This action was also a nourishing form of self-care at a time when hands were often dry and sore from frequent washing in Covid times.

(i) First person exploration.

Methods of design, documentation and analysis: see PoP6 including Box 8 for process 3.

The next step was to pilot this process with the postgraduate artist group.

(ii) Pilot study.

This took place in an online seminar[67]. The **aims** were to seek feedback on design and delivery of this process to activate and explore aesthetic experience; explore how successfully connection could be made online; discover if this would work as a third process in the series for healthcare workers; continue development of a simple diagrammatic form of analysis.

Methods of design and delivery, documentation and analysis: PoP6 including the invitation, 'drawing attention map' and sketches and images of group participation.

[67] Interdisciplinary, contemporary artists in PhD seminars, as before.

Reflections and next steps: Participants focussed on sensory experiences at the time rather than imaginary content. They offered useful reflections on how the method of delivery could be refined. It was pointed out that choices should be offered with the guidelines at all times as there were mixed feelings about being able to see others during the process when screens were turned off. This gave a disconnected feel for some, yet others thought it too intimate. Also, it was felt that a slower grounding process was needed at the end §to return to the present moment in the group. Seven completed the Aesthemos questionnaires. This showed that most had a relaxing, enjoyable and nourishing experience. This was important as the process was designed to be engaging and inviting. Embodying a caring and attentive attitude so that participants felt connected, engaged, interested and enlivened were important aspects of being the researcher. Feedback comments about connection online included an overall preference for delivery of the spoken guidance 'live' rather than as the audio that was also trialled. 'Live' was felt to be more genuine, spontaneous, responsive to participants and 'from the heart' rather than an audio. Additionally, being able to see each other for some of the time was felt to be more connective than screens off for the whole contemplation. A summary of comments about issues of connectivity online is given in with those of the healthcare group in the PoP6, Box 9.

This process worked well and the aims at this stage were fulfilled. The next step ensured that attention was drawn to the imaginative component in the spoken guidance. To mobilise imagination for the healthcare groups below, I added some images of the original 'Bathe' process as a poetic intervention.

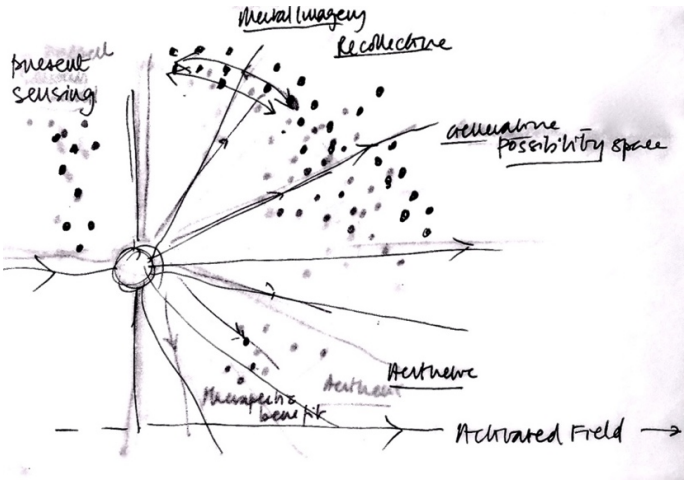
(iii) Final group participatory process for healthcare participants in online sessions.

Bearing in mind feedback above, the next step was to share this process with healthcare participants and to discover if aesthetic experience was activated for them.

Methods of design and delivery, documentation and analysis: see PoP6 for invitation, script, images and examples 6.7-6.10

Reflections and next steps: To what extent are aims achieved? The guidance allowed time for the imaginative component to expand and develop. This was important in this piece where the imagination had to reach out to experiences connecting with one's work. Words and phrases given in feedback demonstrated that this process successfully generated rich aesthetic experience of both multisensorial detail and the imaginative dimension. Here, the areas in the imaginative dimension that predominated were mental imagery, recollective imagination and novel combinatorial, generative imagination i.e.. the 'possibility space'. This process successfully led to thoughts of connecting with self and through this action, they could consider touch with others in their healthcare practices. This suggests that imagination has an important role in connection with others when actual touch was restricted in lockdown. In addition, it proved to be a nourishing experience for participants which was welcomed in lockdown. Therefore, this process worked well as the third process in the newly designed series.

By using diagrammatic templates figure 5(e-f) headings adapted from Abraham's framework were added to each section. It was possible to assign words and phrases more quickly to each of these. Each participant's response was analysed on a sheet of transparent paper laid on top of the template. A simpler version was trialled of applying only a dot that represented a word of phrase from the transcript.



In the diagram above, by laying the transparent sheets together, the collective results for participants as a group could also be seen at a glance. The predominant functions of the imagination were mental imagery, recollective and the 'possibility space' of the novel combinatorial imagination groups in Abraham's framework.

Thus, the aims of this process were achieved, participants were able to reflect both on their own experience and through their imaginations, consider aspects of their healthcare practice where touch is important. The online zoom process was felt to be connective and a list of how this worked was collated. Genuine attention given by the researcher, overall sensitivity and reactivity to group members individuals, attentive listening and responsiveness in the researcher and to each other was favourable compared to an audio delivery or screens entirely switched off as, for instance, in a webinar. A summary of comments can be seen in PoP6, Box 9. The found poem format of noting words and phrases was used as it was spoken and the simplified template with clusters of dots showed at a glance the main aspects of the imagination at play. Here, the imagination could reach out to make links with practice by connecting with mental imagery, recollective imagination and the 'possibility space' of generative, novel combinatorial thinking.

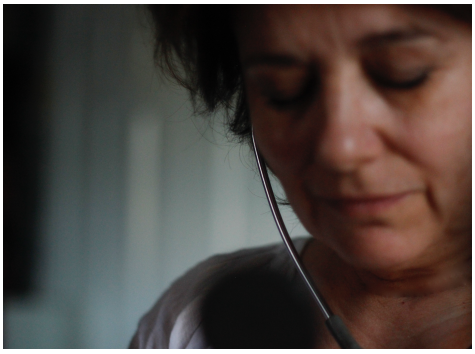
Process 4 – Stethoscope Contemplation: 'The Heart of the Matter'

(i)First-person explorations

Testing out different methods in a series of rather laboured, mechanical experiments to deliberately create a further process did not always work. Designing 'to task' could be unproductive. However, design ideas that worked well seemed to occur when I was not expecting it and often whilst my attention was directed elsewhere. More spontaneous ideas could emerge as if in peripheral vision, at the edge of attention. My mind needed to adopt an open mode of awareness to notice these. Task focussed activities can inhibit the DMN[68] of the brain which is active in divergent thinking, as discussed in the section on Imagination, chapter one. A detailed example of my design process is given in an excerpt of free-writing[69] from my reflective journal - the full piece can be seen in the PoP6 -'Free-writing excerpt' with image, and reveals and conveys the spontaneity of this method:

[68] Default mode network
[69] I used a form of free-writing adapted from the Zen practice of Goldberg (Goldberg, 2005).

"Watching a colleague listening with a stethoscope I notice, 'It is his eye movement change, his change of gaze from outer to inner that seems to be a key point. What happens whilst he attends to his listening, in these moments? What happens when one listens to a heart - deeply? Aesthetically? To explore this further, I set up a mirror and camera to capture images whilst I listen to my own heart. Do I do this when I am using a stethoscope in the clinic? Does my attention similarly shift inwardly? What does it look like from the outside? And, at that point, what is happening in my inner world?
In the photos I have managed to capture that same downward gaze indicating my awareness and attention moving to the inside – whilst listening to my own heart. It brings me to a vast interior space in which imagination can be amplified...".



Inner look whilst listening with a stethoscope

Furthermore, my thinking was not only verbal, it was also visual including diagrams, sketches and photos shown in PoP6 - 'Examples of record of visual thinking'.

(ii)Pilot studies.

The next steps were to pilot this with other participants to discover if aesthetic experience could be activated for them whilst listening to the heart. Pilot studies were two face-to-face meetings involving two postgraduate art groups and one further group of healthcare workers and related professions at an academic study day of the 'Aesthetics in Mental Health' (AiMH) network. This latter group is described here.[70] 22 participants attended the latter meeting.

Methods of design, delivery including an abstract for the AiMH group delegates and the script of the researcher's guidance can be seen in the PoP6 Pilot studies.

Reflection, next steps and design refinements: Results[71] revealed that participants were successfully engaged in activated aesthetic experience. They gave feedback of experiences demonstrating that the process successfully produced an immersive, evocative, lived experience in which there was awareness of multi-sensorial detail and arising imagination. The size of the group and the time restraint (an hour) limited the extent to which these could be explored in more detail including wider thoughts and connective associations with clinical practice, although some were given. Therefore, I felt it would be important to keep further groups to a smaller size where there would be more time for this deeper exploration.

For me, observing the photographs of people listening, reminded me of the tenderness involved in caring for others.

This pilot stage progressed the study aims overall by designing a further participatory process for a final series.

[70] www.valuesbasedpractice.org. Aesthetics in Mental Health Network
[71] In personal notes

Example 6.11 Feedback of words and phrases

"I will take a stethoscope
Into my existential practice,
Needing one of these…
How can I listen without being able to hear?"

Psychotherapist

(iii) Final group participatory process for healthcare groups.

This process was adapted for online delivery. The **aims** were to see if this worked in a similar way to the pilot and to give more time to explore expansion of imaginative detail and links with clinical practice. This process became the fourth in the finally designed series.

Methods of design and delivery, documentation and analysis including invitation, guidance script and examples 6.12-6.15 of participant feedback are given in PoP6.

A **list of links** connecting aesthetic experience to existing practice was compiled from the transcripts. Examples 6.16 and 6.17 from practice are given in PoP6, Box 10.

Reflections and next steps: Participants contributed rich aesthetic experience and different disciplines gave different perspectives. Comments were moving. Examples of the content included: connection with self, others, of wonder, awe, life force, being heard, attending to another, vulnerability, brevity of life, mortality and gratitude. Examples of themes from feedback are given in PoP6, Box 12.

Diagrams revealed that feedback of experiences lay mostly within the sections of Abraham's framework that corresponded with recollective imagination, novel combinatorial imagination i.e. the 'possibility space.' Some reported aesthetic emotions. This form of diagram proved a quicker way to analyse feedback and again, suggested that the functioning of the imagination from feedback corresponded with the DMN of the brain.

The process worked well on zoom. It was more conversational when I offered my own lived experience and some free writing with images at the start.

Superimposing maps drawn from each participant on template (e) showed at a glance where the majority of components of the imagination given in feedback clustered PoP6, box 11. These were in the recollective imagination and the 'possibility space' of the novel combinatorial generative imagination in relation to Abraham's categories.

Process 5 – Hospital Corridors

This process was discussed in chapter three as a scoping study.

(i) The **first-person** design stage was described as MA work.

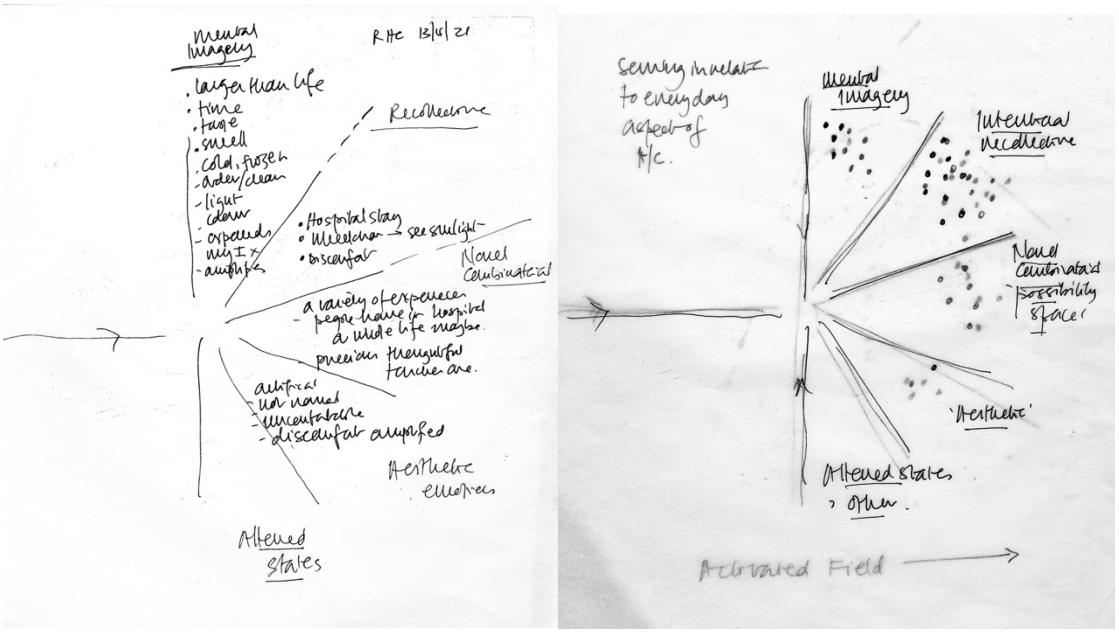
(ii) A pilot was carried out with the postgraduate artists and adapted to see how the series of photographs would run online. The Zoom rendering appeared less smooth indicating a minor technology problem. However, it was usable for the healthcare workers group as below.

(iii)Final group participatory process for healthcare groups. This online process was the fifth in a series.

The **intent** was to explore aesthetic experience in relation to the work environment.

Methods of delivery, documentation and analysis: see PoP6 including invitation to the process and the guidance script.

Reflection: Feedback of experience revealed that for all participants, imagination was most active in the areas of mental imagery, recollective and novel combinatorial imagination as shown below with additional emotions. 5 participants gave reflective links with their wider current practice.



Analysis using templates from figure 5(e) and 5(f). Abbreviated words added on left diagram. In the right diagram, dots represent words and phrases. Here, one participant's diagram is superimposed on another's

An aim was for awareness of aesthetic experience to connect with the healthcare environment others are placed in. In this piece, arising mental imagery triggered by viewing the photographs was prominent and evoked memories of both personal and work experience in such a setting.

Links with practice made were compiled into a list. Below is an example. Examples from two participants include are given in PoP6 Examples 6.18 and 6.19, box 13.

This worked well as a process on zoom although the quality of flow of the photographs needs amending. The process successfully activated aesthetic experience in participants, and they readily related it to their own healthcare practices and inner experience of this environment. This process conjured up sensory details and the imaginative dimension in relation to the environment health carers work and meet patients in and connection with being moved.

Examples of themes were similar to the scoping study using this process and included participant awareness of memories such as relatives in hospital sharing sad and frightening experiences, waiting with uncertainty for prognostic news of recovery or illness progression. Different times of life were imagined of when one may be hospitalised from birth to death. Patient disempowerment came to mind on seeing images of stark hospital barriers as a 'superstructure' and imagined difficulties of the patient cast in a passive role, isolated and lonely juxtaposed with warmth and human connection that a human touch or personal item, shown in some photographs, could bring.

Process 6 – Tea Ceremony for Ward Rounds

The **aims** were to: create a process to activate aesthetic experience whilst giving and receiving care; incorporate a poetic twist to draw attention and stir imagination; relate to connectivity with others such as one's team and contribute a further process to the new series.

Reflecting on work in the clinic, sharing tea in ward rounds appears to be a lost practice. Rushing in with disposable cups, sucking through holes in the lid whilst some of the team have nothing appears insular and disconnected. Lengthy ward rounds require focused intention for severe problems and can be depleting. Examples from conversing with colleagues are given here:

"We might have stopped halfway round for tea and biscuits…so old fashioned. It may have been good for team building but may not have been an efficient use of time, I can't prove it or see patient outcomes eg. greater satisfaction, shorter hospital stays. Yes, the staff might be happier and kinder. It may improve staff retention…if the tea was nice…."

"How brainwashed we are into only looking for efficiency in terms of numbers rather than quality of care which may be linked to how cared the staff feel?"

Recollecting and free writing in my journal about junior doctor days:

"I remember three-hour ward rounds, in old asylums, with corridors nearly a mile long. Sitting amidst piles of thick case notes and clouds of smoke (many psychiatrists smoked throughout then), the team reported to the Professor. The patient's relative may be invited into this 'cloud.' The matron would bring the tea trolley. Pale green and white thick institutional cups and biscuits. I can see her[72] now, kindly handing the cup and saucer out to all of us, through the smoke - a gesture of connection, giving, a sharing of refreshment and humanity, sustenance amongst bleak histories to keep us going."

[72] Now tea can be served by any team member in a more democratic way.

My idea in designing this sixth process embraced Saito's discussion of the Japanese tea ceremony as 'communicating a caring attitude through aesthetic means' in which 'the minute details, the care taken to consider what would most pleasure the guests and make them feel comfortable…… the host's heart and intention get translated into some kind of sensuous manifestation in the form of body movement, manner of tea making and the objects' appearance.' (Saito, 2007, p. 236). 'There is thoughtfulness, consideration and respect towards the guest who reciprocates with gratitude'. The Japanese Tea Ceremony is also described in detail in 'Zen and the Art of the Tea Ceremony'(Hammitzsch, 1979)

(i)First person explorations.

Methods of design and documentation included conversations with colleagues, free writing, reading, imagery and reflections woven through with experimental practice. With the above in mind, in practice I made tea and using my video camera closely noticed whilst pouring and offering tea as if for others shown in PoP 6 - first person design images.

Reflection from close noticing: Watching my own actions on video revealed there was more than meets the eye. Immediately, I noticed gestures of taking care, or lack of it. A careful manner of placing the cup on the saucer, offering and taking care not to spill tea, contrasted with hurried careless gestures such as clanking the lid on the teapot or avoiding eye contact. Given Saito's comments about care taken reflecting values, and thinking about shared tea in ward rounds, could something of value be retained by sharing tea through this relational and connective action? For example, sustaining attentiveness and presence with others whilst busy thinking 'about' problem solving.

(ii)Pilot studies.

Methods of design, delivery documentation of a face-to-face pilot group with postgraduate artists and images can be seen in PoP6.

Results from feedback - Participants' feedback indicated immersion in the experience and brought awareness to aspects of care for each other in the group. PoP6, Box 14

Researcher reflections: Sharing tea in this way proved to be an opportunity to notice experiential and relational aspects of care as they happened, and to reflect on action. Participating in the experience was immersive and quickly generated a rich array of comments about what was experienced. Components of care were perceived from both verbal and non-verbal gestures: offering, considering the other, receiving, thanking, appreciation, respect, a sense of community and connection. It was also felt that care was taken in the preparation for the benefit of the participants.

By shifting perspective to being in the experience directly, participants became aware of noticing what occurred at the time.

In **summary,** the micro-environment created in this process offered an opportunity to become aware of the capacity for aesthetic awareness and sensibility. The process here contains many of the competencies needed to be an empathic doctor. It's also refreshing, revitalising and can be bonding and connective for teams. And not only relevant in healthcare as in PoP6 - summary slide.

This initial feedback was from a small pilot of postgraduate art students. Artists may be more aesthetically aware than most and the next step was to try this out on the healthcare groups.

(iii) Final group participatory process for healthcare workers.

The **aims** were to adapt this for online zoom for the healthcare workers in Covid lockdown and discover if aesthetic experience could be activated in this way and so contribute a sixth process in the final series in the overall study. Here, a main theme would be connection with others.

Methods of delivery, documentation and analysis: The invitation to participate, the guidance script and examples can be seen in PoP6.

Researcher reflection and next steps: Aesthetic experience was activated. Again, this was very rich and much emerged in feedback. In this process, close noticing of aesthetic experience raised awareness to themes of respect, sensitivity, care, connection with others, including connection and links with practice were made as in examples 6.20 and 6.21 in PoP6. Sensory aspects of making the tea stirred up the imaginative dimension, including recollective imagination for past tea breaks, the richness in sharing a cup of tea together whether individually like this, yet on zoom, or in a team. I felt an urge to keep the discussion on track but on reflection, comments that appeared as asides may be the very things that bring connection alongside focussing on the process. A tea break is also an opportunity for these tiny moments of connection with the humanity of others.

Evolving methods of analysis throughout the above processes.

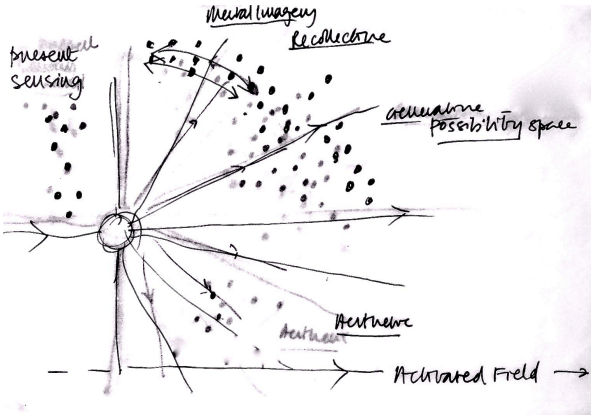
As the above series of experiential participatory processes developed, the methods for analysis evolved and showed different aspects of aesthetic experience. In summary, the four final components designed for analysis are shown in the diagram below as bullets. These were: (1) participant feedback of words and phrases transcribed into the format of a found poem that revealed sensibility; (2) assigning words and phrases to columns in the table adapted from Abraham's framework showed verbal details of the different components of the imagination; (3)this became the basis for a diagrammatic form that showed the expansive nature of the imaginative dimension including the potential for thinking about links with healthcare practice and related possibilities and (4) a list of links related to practice was also compiled. This final summary was developed and emerged through the process practices.

Ultimately, the diagrammatic form could be used on its own as a 'pen and paper' method for faster analysis and could show the expansive nature at a glance. This could stand alone with the words and phrases as a found poem. Knowledge of Abraham's categories would be needed to draw the diagram. A key for these is given in PoP6. Box 7.

In reality, many of the feedback comments had some overlap and didn't always neatly fit the models. It is therefore useful to have the transcription of words and phrases that collate the feedback as it is said to reveal immersion in sensory detail and the arising and expanding imaginative dimension. So far, I have applied these methods myself. It is possible that constructing the diagram with participants collaboratively as part of the group discussion would the reflective process open.

Methods of Analysis

- Words and phrases - found poem format: sensibility
- Tables - verbal: imaginative detail
- Diagrams/Attention maps - visual representation: expansive nature
- Wider links with practice listed - possibilities, ideas open up: divergent thinking



Summary of final methods of analysis. Bullet points show four components

Chapter Summary

This chapter reports methods used in the development of six experiential participatory processes from researcher first-person explorations to pilot studies with postgraduate artists to ultimately testing these out with healthcare groups as outlined in the chapter introduction and outline. Methods of design, delivery, documentation, analysis, reflection and progressive refinement to create the final series were reported. An emergent methodology called 'connective aesthetics in the clinic' was developed. The accompanying portfolio of practices 1-6 also evidences this work. Methods used in the final series of group processes for health carers included practice-based participation with guided contemplation and space for 'close noticing' aesthetic experience in issues relevant in everyday healthcare, feedback of experience as reflective inquiry, and group discussion. Poetic interventions were incorporated to activate, stir imagination, raise curiosity and awareness and closely notice personal aesthetic experience of multisensorial detail and imagination. Methods of analysis were refined throughout and are summarised.

All categories of Abraham's framework were relevant in my research processes. Imagination arising in the processes arising from close noticing predominantly included mental imagery that could be in more than one domain; recollective imagination i.e. associations from the past and predictions about the future that could be factual or counterfactual, or a combination and the expanding imagination of the novel combinatorial category that could bring new, creative ideas, insights, shifts in perspectives, alternatives and possibilities. Participant feedback of sensory and imaginative details of aesthetic experience were given and these further built the description of aesthetic experience in this study. This was a desired aim of the newly designed research processes. The structure of the processes needed to be designed with a balance that was not overly directive to be so 'task orientated' that the imagination was inhibited, nor too open that there was no space for reflection as a more cognitive and meaning making process. In relation to Abraham's fourth category, it is important to note that the definition of 'aesthetic' experience in my research incorporates all five categories of Abraham's

framework and is broader than that defined in in her fourth section entitled 'aesthetic' imagination. In relation to Abraham's fifth category of altered states, dreaming was reported once in my research.

Two final feedback comments made about the experience of participating:

General Practitioner

"…. I wonder if I could have survived without becoming anaesthetised, not just at medical school -where it starts, but also during the stressful first days of being on the wards…and even dealing with so many people in distress as a GP. And yet I feel the most powerful bit of being a doctor is being able to develop an aesthetic rapport with patients, and colleagues".

Consultant Psychiatrist

"..... It's so important in healthcare to stand back and consider.... and yours is a unique and different perspective that considers one of the key characteristics of what makes us human and humane".

Chapter Seven - Evaluation, discussion, key findings, implications, beneficiaries and further research

Chapter introduction

This chapter restates the research aims and evaluates the extent to which each of these was achieved. This is followed by an overall evaluation of how the study was conducted including restating links with existing practices and theories. A summary of key findings is given followed by the contributions these make to knowledge. Implications of the research and beneficiaries are discussed including areas for future research development. Paying attention to everyday aesthetic experience in this research aids articulation of complex experience in only a few minutes without participants requiring extensive training. This has the potential to be developed as an enhanced reflective teaching tool for healthcare workers and a teaching model is proposed.

Aims

The aims were to explore and describe the nature of aesthetic experience in relation to everyday clinical work of healthcare practitioners; develop and design new participatory experiences that activated aesthetic experience for them to observe, explore and offer feedback that further built the description; evaluate the emergent arts, practice-based methodology that was newly designed to achieve these objectives including the methods of practice, documentation and analysis leading to the final conclusions.

Evaluation

The starting point was a recurrent type of experience that I have had throughout 40 years of medical practice and wished to investigate. I have defined this phenomenon as 'aesthetic experience.' In this study, this term was used throughout to refer to complex inner experience of sensory perception and the arising imaginative dimension. Articulation of this required an approach that went beyond words alone. Therefore, an arts, practice-based approach was used to achieve the aims. The extent to which the first two study aims were achieved is next discussed. The third aim was to evaluate these.

Taking each aim in turn, **the first was to explore and describe aesthetic experience.** Evidence this was achieved came from practice-based work that generated an initial description from early methods called experiments in close noticing. These explorations started in non-clinical settings in chapter two and in chapter three, I began to explore the nature of aesthetic experience in examples related to the clinic and add to the description. By making this type of aesthetic experience tangible in a diagrammatic form I was able to begin to communicate my findings and design further participatory processes that conveyed and activated aesthetic experience for others to describe. Scoping studies in chapter four showed that this was successful so others could also explore this experience and add to the description. The research then expanded to design a final series of six experiential participatory processes. Postgraduate artists were involved in pilot studies. Ultimately the processes were shared with healthcare workers and allied professions. From these, participant feedback further built the description of aesthetic experience. More details in the complexity of the contents of the imaginative dimension were also revealed. Chapter six gave the more detailed findings of aesthetic experience from each of these six processes.

Descriptions came from individual participants' words and phrases that were written down by the researcher during each process. Each participant reviewed their own transcripts to confirm they had been

represented accurately by the researcher. Feedback descriptions were documented clearly by the researcher and checked by participants.

The first aim was thus achieved. Within the parameters of this research and amongst the recruited participants, a type of aesthetic experience related to everyday clinical practice was explored and described. This arose from starting points of a recurrent phenomenon experienced by the researcher. The research was successfully expanded by designing methods to convey and activate this for other participants to explore. Their feedback further built the description of aesthetic experience. Thus, the final description was empirical, arising directly from practice-based research.

A pool of 26 healthcare workers took part in the finally designed experiential processes. They gave rich descriptions that contained details of multisensorial perception and the arising imaginative dimension. The latter was shown to be complex involving different functions of the imagination.

Points that added credibility are next discussed. Although methods of exploration and design started with first-person introspection of a personal recurrent phenomenon I have called aesthetic experience, my experience did not start in a vacuum. It was informed by years of experience in psychiatry within medicine, listening to lived experience in the psychotherapies and reflective practice. Additionally, I had an arts-based practice, particularly inspired by connective aesthetics in Social Sculpture. These gave me appropriate skills and theoretical sensitivity to undertake this research. An arts, practice-based approach allowed flexibility to combine skills from clinical and arts-based disciplines and draw on aspects of other practices and theories that were felt to be relevant. Thus, my initial first-person views had credibility. This was borne out as the research extended to involve other participants who were postgraduate artists, health carers and allied professions. Their feedback confirmed that they also had this type of experience and that it had meaning for them. Methods designed for closely noticing sensing and attending with open awareness to arising contents of the imaginative dimension enabled detailed exploration and description for both researcher and participants. The description of aesthetic experience was further built through scoping studies, pilots and the final series of processes that were conducted methodically and rigorously to represent a description of aesthetic experience in this study with these participants. Participants chose to be part of this study and it was their experiences that contributed to the overall description of the nature of aesthetic experience. Adding to credibility, participants were experienced healthcare workers from different disciplines and postgraduate artists were also involved in piloting the designs.

Whilst meanings of ‘aesthetic’ and ‘aesthetic experience’ are broad, here the description arose from empirical findings, in the research processes, during participation.

The **second aim of this study was to develop and design** experiential participatory processes to convey and activate aesthetic experience for others. Evidence this was achieved is next given. Chapter five explained how the overall emergent methodology employed arts, practice-based methods that allowed a flexible way of researching in a spiral iterative path throughout the course. In this way, it was possible to follow more divergent ways of thinking and imagining that are normally suppressed or excluded from clinical work or by set methods in quantitative or more traditional qualitative paradigms. Maps demonstrated this research path (PoP5). This research thus developed in a creative way in order to design methods suitable and tailored to achieve the aims, rather than adhere to fixed pre-existing ones. Reflection in and on practice was used throughout and experiential learning guided progressive steps in the research development.

As in the first aim above, early methods of exploration were designed to start to describe aesthetic experience then expanded to develop and design methods that successfully and prospectively activated aesthetic experience for others. In these, poetic interventions were incorporated to slightly defamiliarize everyday clinical actions that achieved a break from habitual thinking, drew attention and stirred imagination.

Scoping studies, described in chapter four, showed the success of design methods in activating aesthetic experience for others in group experiential participatory processes. The first study ('Hospital Corridors') worked well with large groups of workers in health care fields in academic presentations, however, it was not possible to notice how all participants responded and there was limited time to share feedback. The second study ('Bathe: an encounter with care') invited postgraduate artists to participate directly in the bathing action. This was to test out a process in a smaller group setting where participants were immersed in their own aesthetic experience as it arose. Additionally, the small group setting and the longer duration of the whole process allowed more time for everyone to share detailed feedback and discussion, including comments on design. Here, the researcher was also participant so could attend more closely to group members' experiences.

Overall, processes in both studies worked well. Feedback from both contained rich detail that was multisensorial and gave rise to the imaginative dimension. In both studies, feedback also suggested that methods of design were viable and acceptable ways of working. The design of the smaller group format was taken forward as this gave more time for exploration and description of aesthetic experience. From this, methods were developed to successfully design a series of six experiential participatory processes for delivery in small group settings in which aesthetic experience was also activated so participants were able to observe and explore it. The first scoping study was a useful model that provided a basis for presentation at meetings, lectures or other larger group settings where a shorter experiential component would work. The 'artist's introductory talk' could also work in this way.

The design of the processes enabled participants to closely notice their sensing and arising imagination during guided contemplations. A method of documenting participant feedback was developed in which words and phrases were jotted down at the time in a way that did not detract the researcher's attention from group members. These words and phrases, written in the order they occurred resembled the format of a found poem and projected sensibility in many of the comments. As further processes were designed and delivered, methods of analysis were also developed to reveal further detail, complexity and different components of the arising and expansive imaginative dimension. This was evidenced by the verbal detail documented in tabular form and the expansive and dynamic nature of aesthetic experience was revealed when represented in diagrammatic form. The methods designed thus enabled the richness and complexity of aesthetic experience from feedback to be revealed. Although participants reported their own subjective experience and perspectives, these methods of analysis revealed a consistent pattern in the nature of aesthetic experience that could be seen to have an expansive form with several components in the imaginative dimension. Superimposing participant 'maps' showed a collective pattern.

Thus, the second aim to develop and design experiential participatory experiences to activate aesthetic experience for others to observe and describe was achieved. Methods of analysis were also successfully designed and developed to draw out the detail of content and form of aesthetic experience. Methods of design were carried out methodically and reported in detail to make the emergent methodology transparent and rigorous. This is an important component of arts-based research allowing new methods designed to be varied

and tailored creatively to the needs of the research rather than applying set pre-existing methods. It was also shown how the research findings linked with the researcher's background experience.

Overall evaluation

The aims and the terms ‘aesthetic’ and ‘aesthetic experience’ were clearly defined for the purposes of this research. Whilst different traditions of thought on aesthetics span the globe, each field with its historical background and theories, this research explores and describes aesthetic experience from empirical findings arising from direct participatory practice. An awareness of the human capacity to closely notice and describe what is sensed and what arises in the imaginative dimension during experience, in participatory action, adds knowledge of a qualitative nature. An arts, practice-based approach can also embrace knowledge that is experienced in imaginal, haptic, tacit and embodied domains. It was possible to design methods to draw out and reveal these findings rather than using than fixed, standardised evaluation methods. Whilst the possibilities of arts, practice-based approaches are broad and varied, the new methodology described here was tailored to the study aims. Detailed reporting gave transparency to methods of new design, processes, adaptation and synthesis of existing practices, application, documentation and analysis. In the experiential participatory processes, time was sufficient for detailed feedback of experience. Feedback from participants was written down as words and phrases during each process by the researcher and checked with by them for accuracy of representation. Recording video or audio felt too intrusive. Methods of analysis evolved and modified to show components of the imaginative dimension. Full descriptions were given that showed how this was done. Online adaptations worked well. The interpretations of overall findings made by the researcher from collective feedback were given and evidence can be seen as to how this view was arrived at. Other interpretations are possible by either participants or readers with different background experience and perspectives. No separate analyst reviewed the findings however continual peer feedback throughout from postgraduate artists, supervisors, academic and clinical peers served this purpose.

With regards to generalisability of findings, postgraduate artists and healthcare workers from different disciplines and allied fields chose to take part. Findings were thus based on the experience of these particular participants. They were all experienced within their respective fields. This research may thus be more biased towards those who were interested, or more familiar in working with, and exploring inner experience for instance as in some fields of healthcare and artists’ reflective practice. The extent of the capacity for awareness of aesthetic experience is not known in those not choosing to take part. This would be an important consideration if, for instance, the final series were offered as a teaching model to a set group. Questions to address would be how to consider those not interested or engaged. This is a possible area for exploration in a further study.

The processes triggered differing perspectives from participants. These details were enriching, giving insights and understandings into the views of others in discussion. Rather than bias, this was a valuable outcome from this type of research as a way of broadening knowledge. Alongside this, the description of the nature of aesthetic experience reached saturation in revealing its expansive form and the types of contents. The six participatory processes appeared sufficient to allow this. The theme of each process, although there was overlap, as in reality, was designed to centre round a different aspect of the human connectivity of aesthetic experience. These included awareness of and connection with inner experience and through this, connection with others individually, with those in teams, community and the environment of these encounters.

Ethical approval and standards were adhered to. The findings within the parameters of this research are clearly stated (p101 below) along with contributions to knowledge this makes (p 102 below).

Design development was also informed by aspects of Social Sculpture, Brook's stages of Goethean observation, Brady's modes of imagination, sensibility in Saito's everyday aesthetics and mindful awareness. Links with these are discussed further in the next section.

With regards to replicability of the study, the methods could be repeated and the processes delivered by a suitably skilled facilitator. Scripts for the spoken guidances are included in the portfolio. The final six processes offer a prototype for a teaching model to be developed in further steps. See appendix for this chapter.

Links with existing practices and theories described in chapter one are next outlined in relation to the design of this study's research methodology. Closely noticing sensory detail in actions related to everyday clinical issues resonated with the 'Everyday Aesthetics' described by Saito (Saito, 2017). The arising imagination from this had an expansive form that appeared to be in line with Brook's stages of developing imagination that arose from closely exploring sensing (Brook, 2009) and the expanding modes of imagination of Brady (Brady, 1998). The detailed content of imagination appeared to correspond with the different functions of the imagination in Abraham's framework (Abraham, 2016). In all these there was overlap which these authors also describe. In contemplation, participants were able to be mindfully aware of their experiences similar to the awareness of present moment experience shown in early taught mindfulness practice (Williams, Penman and Kabat-Zinn, 2011). Furthermore, the imaginative dimension also contained associations and connections with healthcare practice that went beyond the participatory action at hand. Brook and Brady's models show how awareness of the imaginative dimension can ultimately reach to relevant wider issues and values than the specific observation. Abraham's framework includes time travel as a component of the functions of imagination in which reaching forward to the future can combine with past recollections (real, combined or counterfactual in past or future), and new possibilities can be construed in imagination in the 'possibility space.'

Less successful design processes in first-person research methods were more task orientated attempts to produce designs with an end result. However, adopting a more exploratory stance of open awareness to the arising, expanding imaginative dimension during practice was more successful. A personal attitude of discovery, curiosity and close noticing of inner experiences whilst being open to more divergent and imaginal thought allowed more process-led, creative design. This included design of the poetic twists. This suggested that the more successful designs emerged from within practice and the moments when genuine immersion in aesthetic experience occurred for the researcher herself. This also resonates with the importance of awareness of the capacity of the imagination to function in divergent, hypothetical and creative ways to generate possibilities as Abraham discusses (Abraham, 2016). The part of the brain corresponding to this has been shown to be the default mode network which is inhibited in focussed, task orientated activity. This suggests that the first-person design methods employed here were successful in the more generative mode of mind. Rather than suppressing such ideas, these can be embraced and reflected on to consider what may work and what is relevant as in Brady's discussion on 'imagining well' (Brady, 2003b, p. 158) This also parallels a saying in teaching mindfulness of 'lead from the practice.'[73]

[73] OMC teacher training retreat 2014

In the design of the group processes, giving overly directive instructions with verbal explanations 'about' experience was found to be dull and disengaged participants in contrast to processes designed to immerse participants in action so they could become aware of their own experience as it occurred. In addition, each action designed into the experiential participatory processes was carefully chosen to be familiar and generic in everyday clinical actions. Along with the brief guidance, these were offered in a way that was sufficiently open for participants to notice experience from their own perspectives.

Portfolio of practice-based work.

This was divided into sections for each chapter respectively and forms an integral part that accompanies, evidences and is entwined with the written section of this thesis. The portfolio shows practice details from each stage including other public presentations.

Summary of key findings

A type of aesthetic experience related to the everyday practice of healthcare workers was explored and described. 'Aesthetic' and 'aesthetic experience' were defined as used in this research and pertain to multisensorial perception and the arising imaginative dimension. The researcher's background informed in clinical practice and arts-based experience was combined to develop an emergent methodology that was arts, practice-based. This developed from first-person starting points to ultimately design a final series of six new experiential group participatory processes that activated aesthetic experience for health carers to closely observe. Postgraduate artists were also involved in piloting the design.

Aspects from other practices and theories relevant to exploring inner experience were also drawn upon, adapted and incorporated in various combinations, synthesised in new ways for practice-based purposes of this research. These include aspects of the Connective Practice Approach from Social Sculpture, Brook's stages of Goethean observation and Brady's Integrated Aesthetic, the sensibility of Saito's 'Everyday Aesthetic' by being mindful of the experiential details in everyday actions. These all have links with values. This research adapts and synthesises aspects of these along with new methods of arts-based practices in innovative ways applying them to the clinical work of healthcare practitioners.

In the newly designed processes, poetic interventions slightly defamiliarized everyday clinical actions to break habitual thinking and raise awareness to sensory detail and the arising imaginative dimension inherent in aesthetic experience. Guided contemplations enabled participants to directly observe and describe this whilst immersed in such actions. The description of aesthetic experience was developed from collective feedback and its nature was found to be rich in multisensorial detail both as directly perceived and as imagined. The arising imaginative dimension was expansive in form and complex in content revealing different components of the imagination. In analysis, it was possible to align these with themes taken from Abraham's framework for the functions of the imagination, particularly those that corresponded with divergent thinking, possibility and creativity. This also had parallels with Brook and Brady's modes of imagination arising from sensing that expanded to link with wider issues, values and possibilities relevant to humane care giving.

In my research, the description of aesthetic experience arose from empirical findings from participants' experiences during contemplative actions in the new processes. The emergent methodology was successful in activating aesthetic experience and designing methods of analysing findings to draw these details out.

Further findings included hearing different perspectives from other healthcare disciplines in feedback. This had the potential to add new understandings for example, an osteopath working with haptic knowledge in practice revealed a different way of working to the objectivity mostly employed by doctors. This added to the findings in an enriched way suggesting that processes including a mix of disciplines could bring further insights.

Adapting the processes in covid lockdown worked successfully. It offered an example of running a participatory experiential process online. Thus, this would be a suitable model for online delivery. This has implications for dissemination to a more geographically spread audience. A list of helpful methods for online connectivity was compiled from collective reflections. Whilst aspects could be done as a webinar, I think that connectivity was maintained by offering the 'Artists Introductory Talk' live, followed by smaller participatory groups. However, hybrid forms of delivery would also be possible as shown in the overall development.

The emergent methodology described was called 'connective aesthetics in medicine'. Each final experiential process was designed to cover a theme of connectivity that aesthetic experience may bring. These included connection with personal inner experience and through this a sense of connection with others and the environment of these encounters.

A prototype for a teaching model is presented.

Contributions to knowledge.

1. This study describes aesthetic experience in relation to the everyday clinical work of healthcare practitioners from empirical practice-based findings. This description has not been reported before in this way. This contributes a new emergent methodology called 'Connective Aesthetics in Medicine'. In this, new methods of 'close noticing' were designed that pay close attention and bring awareness to sensory detail and the imaginative dimension that rises from it. New methods of delivery, documentation of participants' feedback including in the form of poetic transcript and analysis were also developed that were tailored to draw out findings relevant to the aims in this research. These were applied in first person design methods through to scoping, piloting and ultimately to the design of an innovative series of six experiential participatory processes that contribute a prototype for a new teaching model.

2. This study extended traditional qualitative ways of knowing by designing new methods that led to awakening awareness to aesthetic experience in moments of everyday clinical practice. Because of the complex nature of this experience and the creative, innovative aspects of the methodology, this research adds a model to the broad span of hybrid methodologies accepted in the paradigm of arts-based research. Some argue the latter is a separate paradigm, rather than just an extension of the qualitative approach. In reality, there may be overlap. In this research, through participatory processes, arts-based methods activated awareness of, and enabled articulation of the complexity of aesthetic experience. This included multisensorial and imaginal details of personal experience and went beyond words alone to the tacit, haptic and embodied. This contributed experiential knowing that was broader than words alone as the descriptions arose in direct action. Furthermore, awareness of the perspectives of others could also be gained through listening, reflection and discussion. This allowed deeper insights and understandings to emerge related to working in more holistic, connective ways with fellow humans.

3. The new methodology of ‘Connective `Aesthetics in Medicine’ included both newly designed methods and, where relevant, incorporated aspects of existing practices and theories. Methods were drawn on and adapted from my background of practical experience in clinical medicine, psychiatry and arts-based practice and extended my practice and research in the latter. In addition, aspects from existing practices and theories from different disciplines were adapted and synthesised into the research arts-based practices in various new ways, combinations and designs.

   My artistic practice and research thus extends the scope of connective aesthetic practices in field of Social Sculpture (Sacks, S, 2021) in that each process incorporates an aspect of human connection with self, other, environment in relation to clinic work. In addition, it adds to the field of Contemporary Aesthetics, describing everyday aesthetic experience in the clinic directly from empirical findings in relation to sensory perception and the arising imagination, shows a practical extension in relation to the clinic of Brook and Brady's models; and extends Values-based practice in health care through direct experiential participation that can be reflected on in relation to values in caregiving (Fulford, Peile and Carroll, 2012). I have created a new application of Abraham’s recent framework (Abraham, 2016) of the functions of the imagination. She explained that her framework was a means to discussing concepts across different disciplines. This research adds a new example to this by demonstrating how the research findings of aesthetic experience in healthcare workers correspond with this framework. Furthermore, the researcher’s first-person design process employed an open awareness to divergent, hypothetical and creative thinking. The functions of the imagination found overall suggest correspondence with the default mode network of the brain. This has a role in creative and generative thinking about possibilities, thus offering an important resource rather than suppression of subjectivity. Enhanced reflection would be a skill worth cultivating to use this resource appropriately.

   Arts in Health, has been extensively reviewed (Fancourt and Finn, 2019) and so far there is a gap in relation to practitioners working with aesthetic experience arising in everyday actions related to their practice. However, in a recent paper published between my thesis submission and viva entitled 'Aesthetics for everyday quality; one way to enrich healthcare improvement debates', Cribb and Pullin delineate aesthetics in healthcare as pertaining to everyday actions as in Saito's 'Everyday Aesthetics' and separate from Arts in Health[74] (Cribb and Pullin, 2022). Like Saito, Cribb and Pullin make a strong case for the importance of aesthetic considerations already present in everyday practice.[75] Cribb and Pullin uphold that these are not marginal or inconsequential, yet have the potential to inform quality of care (Cribb and Pullin, 2022, p. 482). The topic of my study is aligned with their paper in that it offers a way of activating aesthetic experience in relation to everyday issues of healthcare workers through participatory processes. Similarly, I have implied that aesthetic experience is not simply to be dismissed as too subjective (p 100 above). My research thus contributes to the conversation about the importance of aesthetic considerations that 'welcomes many voices' from various forms of practice and academia (Cribb and Pullin, 2022, p. 486).

   In addition, this research contributes to building the new field of aesthetics in mental health and wellbeing within contemporary aesthetics. This area is still being carved out. The researcher jointly

[74] Although they explain that there is some overlap
[75] Rather than separate engagement in the Arts

convened and continues to develop the group for Aesthetics in Mental Health[76] to gather a new group of those working across related disciplines and is also co-editing and contributing a chapter and section introduction to a forthcoming textbook[77] that draws together those working in related fields in new ways. This section will cover theories in contemporary aesthetics to practice-based work in the clinic.

Finally, whilst mindfulness-based practice explores current moment experience, mind wandering, or the contents of imagination are not usually a focus. In the research processes here, a poetic twist contributes to actively stir imagination and divergent thinking. Participants are guided into this area of inner experience as it arises out of closely noticing sensory experience.

4. This research extends the scope of traditional reflective practice in health care.[78] Exploring the capacity for, and awareness of, aesthetic experience has the potential to reveal deeper understandings and insights. Task orientated work in day-to-day clinical work does not normally allow space for such detailed reflection on subjective qualitative experience. These processes create a space for an enhanced form of reflection arising from observation whilst immersed in action related to practice, yet away from the task orientated fast pace of clinic work. Each process affords space to closely notice multisensorial and imaginal details of aesthetic experience that may otherwise be missed. The present research explores, for the first time, the effects of slowing down and closely noticing aesthetic experience in everyday actions that are familiar in healthcare work. The new research processes offer an innovative way of enhanced reflection in time and space away from the busy clinic.

   Whilst current reflective practice in clinic work aims to raise learning issues through verbal exercises including thinking, documenting and talking 'about' events, the research processes offer new ways of conveying, showing, sharing and activating aesthetic experience whilst in action. Along with multisensorial perception and the arising imaginative dimension, these processes also embrace tacit, haptic, and embodied experience. Poetic interventions served to break habitual thinking, stir imagination and draw curiosity, attention and awareness to aesthetic experience that may otherwise be ignored. Along with guided contemplation and raised awareness to aesthetic experience, new insights, links and associations with practice emerged.

   In addition, as discussed in the point above, research findings suggest correspondence with Abraham's framework for functions of the imagination as related to activation of the Default Mode Network of the brain. Thus, the enhanced reflective practice in the research processes may contribute to creative, generative thought in a 'possibility space.'

5. Also, these processes had to be adapted to working online in covid lockdown. This was successful and thus contributes an example of online working in experiential connective processes.

[76] Aesthetics in Mental Health Network within the Collaborative Centre for Values-Based Practice in Health and Social Care. www.valuesbasedpractice.org
[77] Oxford Handbook of Contemporary Western Aesthetics in Mental Health (eds Poltrum et al). In preparation
[78] Given by the General Medical Council

Implications, beneficiaries. Further research and next steps.

1. Participants were able to become aware of the complexity of aesthetic experience that arose in direct participatory actions in the research processes and this revealed rich detail. Being immersed in such practice away from clinical tasks would allow space for more holistic awareness of experience that goes beyond words alone. The capacity for awareness of this type of aesthetic experience may bring benefits to quality in practice in relation to deeper connectivity and humane working and link with values-based care. In this way, these processes have the potential to benefit healthcare professionals through enhanced reflective practice. Next steps would be to test out how awareness of this type of aesthetic experience impacts on quality.

   The new processes have the potential for use as one hour teaching sessions either as stand-alone sessions, or a series. This could be used in student or continuing professional development in healthcare practice. For instance, these could be tested out as a teaching module or workshop with groups of healthcare students, professionals, or multidisciplinary teams, in teaching settings away from task orientated clinical work and with space for reflection and discussion together. A practice-based teaching model compiled from the final series of six experiential participatory processes is given in the Appendix to this chapter.

2. This research is not limited by the boundaries of any one particular tradition, theory, concept or discipline. There are different traditions of philosophical thought on aesthetics, each with its historical background and theories. Mindfulness is a practice that requires cultivating, other psychotherapies require training and knowledge of their concepts and arts-based practice requires a range of skills. Becoming aware of aesthetic experience does not require any former lengthy training or knowledge in the participants. The focus in this research is on aesthetic experience that may be noticed as it arises in clinical work, by the practitioner. The latter can benefit by noticing experience that is already at hand in this *'practice first'* approach. However, facilitating and guiding the groups would require some training that is similar to the skills of the researcher. Training needed for others to run these groups would be a next step following the present research.

3. These practical processes that activate aesthetic experience bring together new combinations and adaptations of existing practices and theories. This research has the potential to stimulate new and exciting connections across disciplines from those engaged in practice to academics. The recently developed network in Aesthetics in Mental Health and the forthcoming Handbook (in preparation) in this area mentioned above are examples of this as is the recent paper by Cribb and Pullin alluded to in the section above (p 103, point 3) (Cribb and Pullin, 2022, p. 486).

4. In addition, this emergent methodology may benefit artists, particularly those interested in applying connective practices, and or, those working in arts in health. This could be offered as teaching and, or tutorial sessions.

5. The final experiential participatory processes worked online. A teaching model is therefore workable in this mode or as a hybrid model. I think that the online adaptation made it easier for participants who were geographically distant to attend. Thus, wide dissemination of a teaching model would be possible and could be tested further for teaching healthcare professionals in this way.

Appendix Chapter Seven

A Proposed Teaching Model: Connective Aesthetics in Medicine
Aesthetic engagement, awareness and enhanced reflection in practice.
Eight sessions (One hour each)

Introductory Talk: Connective Aesthetics in the clinic.

Awareness of sensing and the imaginative dimension – What is aesthetic experience & engagement?
Why is this important?
Examples from practice
What will this course/module cover?
Information on participation - leaflets explained, format of sessions
Method of enhanced reflective process. Feedback questionnaires
Questions and discussion

Process 1: Roots of Imagination

Process 2: Beyond the Clinical Gaze

Process 3: Touch: An Encounter with care

Process 4: The Heart of the Matter

Process 5: Corridors of the Mind

Process 6: Tea for Ward Rounds

Final Session

Overall feedback and discussion
(Further session possibilities - Brief collaborative actions)

Learning Points – enhanced reflective practice will cover the following:

- Noticing sensory perception and the imaginative dimension - aesthetic experience - in a reflective space away from clinical tasks, yet in relation to everyday clinical situations.
- Awareness of connectivity with self, other, community and the clinical environment. Across disciplines
- Valuing the capacity for awareness of aesthetic experience as a resource for human connection and central in the clinical encounter.
- Making links with practice. Ability to 'imagine well' and appropriately. Valuing creative thought and possibilities.
- Modes of mind.
- Space for aesthetic engagement away from crisis face of clinic pressures – time to think and reflect
- Learn about the underlying context from five main areas – connective aesthetics, phenomenology, aesthetic engagement, introduction to a neurophilosophical framework for aspects of the imagination, introduction to informal mindful awareness.
- Sharing, discussion and collaboration in a facilitative supportive group setting – as wished.
- Working together in an online platform.

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