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When illness is war: An action-research at the Colosseum

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Quando la malattia è una guerra: Una ricerca-azione al Colosseo

The "war" metaphor is widely used to describe the cancer experience, yet it may generate ambivalent emotional and relational effects. This study presents an action-research project, developed with the educators of the Parco archeologico del Colosseo (PArCo), aimed at exploring how the internal orientation (*tropos*) of war metaphors can be reoriented through embodied and narrative training practices. The project involved 12 professionals (clinicians, educators, and engineers) participating in a laboratory structured into three training modules based on situated experience, reflective writing, and interdisciplinary work. Qualitative analysis of the materials produced (narrative scripts, reflective texts, drawings, and group discussions) led to the identification of 6 categories of pedagogical questions and 3 embodied narrative frameworks used to address waiting, agency, and hope. Results show a change in participants' ability to recognize the *tropos* of metaphors used by patients and to modulate clinical communication in a more empathic and generative meaning-oriented way. The study highlights the educational value of metaphor work as a tool for improving oncological practice.

La metafora della "guerra" è ampiamente utilizzata per descrivere l'esperienza oncologica, ma può generare effetti ambivalenti sul piano emotivo e relazionale. Questo studio presenta una ricerca-azione, sviluppata con gli educatori del Parco archeologico del Colosseo (PArCo), finalizzata a esplorare come l'orientamento interno delle metafore (*tropos*) della metafora bellica possa essere riorientato attraverso pratiche formative incarnate e narrative. Il progetto ha coinvolto 12 professionisti (clinici, educatori e ingegneri) in un laboratorio strutturato in tre moduli formativi, basati su esperienza situata, scrittura riflessiva e lavoro interdisciplinare. L'analisi qualitativa dei materiali emersi (canovacci narrativi, scritti riflessivi, disegni, discussioni di gruppo) ha portato all'identificazione di 6 categorie di domande pedagogiche e di 3 cornici narrative incarnate utilizzate per lavorare sull'attesa, sull'agency e sulla speranza. I risultati mostrano un cambiamento nella capacità dei partecipanti di riconoscere il *tropos* delle metafore utilizzate dai pazienti e di modulare la comunicazione clinica in modo più empatico e orientato al senso generativo. Lo studio evidenzia il valore educativo del lavoro sulle metafore come strumento per migliorare la pratica oncologica.

Keywords: Phenomenology; Medical humanities; Metaphor; Action-research; Oncology.

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1. Introduction

Cancer remains one of the most symbolically dense and emotionally charged experiences within contemporary healthcare. Beyond its biological complexity and clinical implications, cancer reorganizes the existential, relational, and spatial orientations of those who encounter it, whether as patients, caregivers, or professionals (Bury, 1892). Consequently, its meaning is rarely articulated through strict biomedical language. Instead, cancer becomes a terrain of metaphors, narratives, and embodied practices through which individuals attempt to re-establish coherence during uncertainty and vulnerability.

Among the metaphors that populate oncological discourse, the "war" metaphor remains one of the most pervasive. It is deeply embedded in public communication, institutional policies, fundraising campaigns, clinical consultations, and everyday conversations. Patients are encouraged to "fight", "resist", "battle", and "win": expressions that not only reflect cultural expectations but shape personal identities and emotional trajectories throughout the illness (Sontag, 1978).

This metaphorical persistence is not accidental. Decades of cognitive linguistics have shown that metaphor is not a decorative rhetorical device but a fundamental structure of human cognition, grounded in sensorimotor schemas and embodied experience (Lakoff & Johnson, 1980; 1999). The metaphor "illness is war" draws upon primary embodied schemas such as physical confrontation, defense, movement toward or away from threats, and the bodily tension associated with danger. According to neurolinguistics, these schemas are activated not conceptually, but pre-reflectively, orienting individuals toward an uncertain future in ways that may feel intuitive and unavoidable (Feldman & Narayanan 2004; Lakoff, 2014; Casasanto & Gijssels, 2015).

Research on embodied cognition further demonstrates that metaphorical reasoning is linked to neural and sensorimotor processes implicated in locomotion, spatial awareness, interoception, and emotional regulation (Gibbs, 2005; Gallagher, 2005; Shapiro, 2011). In this sense, the war metaphor persists not merely because it is culturally available, but because it resonates with deep embodied structures through which humans respond to threat.

At the same time, scholars have problematized the war metaphor for its potential harm. Semino *et al.* (2017) have shown that while some patients find the metaphor empowering, others experience it as oppressive, guilt-inducing, or misaligned with their reality. Patients who do not "win" the battle may feel that they have "failed", internalizing a narrative of defeat incompatible with the complexity of their condition. War metaphors may reduce the complexity of illness to a binary opposition between victory and defeat, overshadowing experiences of adaptation, acceptance, transformation, and meaning making that are equally central to patients' lives.

Recent evidence shows that metaphors play a central role in patients' coping processes by shaping how illness is perceived, endured, and integrated into everyday life. A large scoping review of metaphor uses in cancer narratives found that patients employ metaphors to express vulnerability, agency, resistance, and meaning, using them as cognitive–emotional tools to navigate uncertainty and regain coherence during illness. Crucially, the same metaphor (including war metaphors) may function as empowering or disempowering depending on how it is internally oriented and contextually lived (Liu *et al*., 2024). Coping, therefore, does not depend on the presence or absence of specific metaphors, but on how metaphorical frameworks support patients' sense-making, emotional regulation, and relational positioning within the illness experience. In this scenario, self-care practices have been extensively reframed as existential and educational processes rather than a set of behavioral strategies; for example, Mortari conceptualizes Care as a practice oriented toward sustaining meaning within lived experience, particularly in conditions of vulnerability, illness, and disruption. In this view, learning and coping converge as processes through which individuals are supported in inhabiting their experience without reducing it to performance, normalization, or emotional optimization (Mortari, 2015; 2022).

Phenomenology offers a crucial interpretative lens for understanding the ambivalent power of metaphors in oncology. Illness does not merely affect an "objectified" body but destabilizes the lived body (*being-in-the-world*) as the primary medium through which the world is perceived, inhabited, and acted upon. As Carel (2008; 2016) notes, illness constitutes an existential disruption: it fragments temporal continuity, alters spatial orientation, and induces a sense of estrangement from one's own body.

Toombs (1992) and Svenaeus (2001) similarly argue that illness induces an experience of "unhomelikeness", where familiar activities become challenging, routines lose coherence, and the world assumes an atmosphere of uncertainty and opacity. Within this existential reconfiguration, metaphors such as "battle" or "fight" become attempts to reorient oneself toward an altered world, providing temporary scaffolding for meaning when habitual structures collapse.

From an educational perspective, metaphors have a pedagogical role: they guide perception, inference, and action, while shaping expectations; meanwhile they influence how individuals relate to their bodies, others, and the environment (Sfard, 1998; Schön, 1987). Transforming metaphors therefore requires the creation of contexts (embodied, relational, and ecological) in which new meanings can emerge, more than linguistic substitution.

Phenomenology of education has long argued that learning is not primarily cognitive but experiential, rooted in the body's situated engagement with the world (van Manen, 1990; Merleau-Ponty, 1945/2012). Spaces, gestures, rhythms, and atmospheres shape understanding as much as propositional content. In healthcare settings, this means that the transformation of illness narratives must involve practices that engage the lived body, emotional attunement, and the specific material and cultural environments in which care unfolds.

Neurophenomenology, as articulated by Varela, Thompson, and Rosch (1991), strengthens this claim by demonstrating that subjective experience and embodied cognition are co-regulated processes. Meaning emerges through the reciprocal interplay of perception, action, neural dynamics, and environmental affordances. Iori (2009) further emphasizes the embodied and relational dimensions of care, highlighting how educational practices in contexts of fragility must attend to corporeality, presence, and listening. Care, and therefore self-care practices, are situated in relationships that sustain dignity and continuity of the self even when familiar coordinates of meaning are compromised. This perspective is particularly relevant in healthcare, where illness disrupts biological functioning and relational orientations in patients, as well as critically challenging the core meaning of therapeutic practices in professionals.

Thus, educational interventions that aim to reshape metaphorical frameworks must attend simultaneously to narrative, embodiment, and context. Approaches limited to linguistic reframing are insufficient if they do not also engage the bodily and spatial dimensions through which metaphors acquire salience.

These insights resonate with emerging evidence in public health and the Medical Humanities. The World Health Organization's 2019 report on arts and health highlights that cultural and aesthetic experiences can significantly contribute to emotional regulation, social connection, cognitive flexibility, and overall wellbeing. Studies in museum-based education and cultural heritage have shown that encounters with historical spaces can foster reflection, identity reconstruction, and new forms of emotional meaning-making (Clift & Camic, 2016; Zaidel, 2010). Simultaneously, narrative medicine has demonstrated that eliciting and engaging with patients' stories contributes to therapeutic alliance, empathy, and improved care outcomes (Charon, 2006; Frank, 1995).

Within Medical Humanities, narrative and reflective practices function as pedagogical devices in healthcare education. Rather than prescribing emotional outcomes, these practices foster interpretative openness, reflexivity, and the capacity to dwell within uncertainty; narrative work thus supports coping by enabling both patients and professionals to recognize, articulate, and inhabit meanings emerging from illness experience (Castiglioni, 2015; Zannini, 2001; 2008).

Narrative practices are therefore conceived not merely as techniques for recounting experience, but as formative devices that enable subjects to interrogate, reorganize, and reorient their lived experience. In contexts marked by uncertainty and disruption, such as illness and care, reflective narration supports coping by fostering awareness, interpretative depth, and the capacity to dwell within experience rather than prematurely resolving it. This perspective further reinforces the pedagogical relevance of narrative and embodied practices in healthcare (Castiglioni, 2020).

More recently, the Istituto Superiore di Sanità (ISS) published the Italian guidelines for Social Prescribing initiatives (ISS, 2023), referring to those cultural and social activities with therapeutic potential that can be enjoyed outside the hospital (e.g., dance therapy, visiting museums, cinematherapy, live concerts, etc.). These converging positions suggest that spaces rich in historical and symbolic resonance

can function as pedagogical and therapeutic agents, providing fertile ground for the transformation of metaphors.

In oncology, this convergence opens new possibilities of care: if metaphors shape how patients navigate illness, and if embodied experiences shape metaphors, then integrating heritage sites and experiential learning into oncological education may enable more generative narrative reframing. Rather than rejecting the war metaphor (an approach that risks invalidating patients lived experience) educators and clinicians can work to reorient its *tropos*, understood as the inner direction of meaning through which the metaphor is lived. By shifting this internal orientation, the same metaphorical frame can preserve motivational energy while reducing emotional burden and constraining effects.

From this perspective, language is inherently polysemic: metaphors do not convey a single, fixed meaning but open a field of possible interpretations that depend on the subject's embodied, symbolic, and imaginary registers (Ricoeur, 1977). A metaphor such as "war" does not operate as a monolithic construct, rather it can be inhabited through different internal orientations (individual vs collective struggle, silence vs noise, endurance vs exhaustion). The notion of *tropos* refers precisely to this directional aspect of meaning: not what metaphor is used, but how it is lived, oriented, and enacted within the patient's experience.

More recently, researchers have demonstrated that patients with aggressive brain cancer can double their chance of survival whether they were resilient or spiritual, meaning that their ability to assign a coherent meaning to their life (*tropos*) could be highly beneficial even in clinically challenging situations (Dinapoli *et al*., 2024).

In this framework, we developed a Medical Humanities laboratory designed to reshape the *tropos* of the "war" metaphor in oncology through embodied, narrative, and situated practices in partnership with the Parco archeologico del Colosseo. Rather than aiming to eliminate the "war" metaphor, the present study is grounded in the assumption that metaphors cannot be removed from lived experience without loss of meaning. The educational task explored here is therefore to work on the *tropos* of the metaphor, that is, on its internal orientation, in order to preserve its motivational potential while reducing its constraining and burdening effects. The laboratory brought together cultural heritage professionals, clinicians, engineers, and educators to co-design narrative frameworks for better communication with cancer patients.

2. Methods

The main project follows the Italian guidelines for designing cultural activities for healthcare.[1] In this project, we designed a pedagogical laboratory as part of the training phase, by employing the traditional action-research methodology (Lewin, 1946; Kemmis & McTaggart, 1988) characterized by 5 elements:

1. Problem Identification. Scientific literature in oncology frequently associates oncological disease with bellicose metaphors (surviving, fighting cancer). This metaphoric frame, while persistent, proves disempowering and often counterproductive for patients, contrary to clinical recommendations. Nevertheless, such language continues to pervade patient dialogue and broader oncological discourse.

2. Action Planning. We designed a laboratory training pathway integrating healthcare personnel, cultural operators, and other stakeholders (engineers, patient advocates) to collaboratively produce symbolic and narrative materials suitable both for guided visits and for physician-patient dialogue.

1. The Social Prescribing guidelines (ISS, 2023) identify seven key steps for developing such initiatives. In our project, these were addressed as follows: a) situational analysis of patient needs; b) the establishment of a multidisciplinary working group to operationalize the project; c) the development of a structured working plan, including training components and a clinical feasibility study; d) the mapping of local community resources, leading to the selection of the Colosseum; e) the engagement of stakeholders, including healthcare providers, volunteers, administrative and research staff, and cultural guides; f) the training of liaison operators, comprising both clinicians and guides; g) the implementation of monitoring and evaluation procedures incorporating action-research cycles, reflective practices, and assessment activities.

3. Implementation. Training sessions and guided visits were conducted. Oncology patients voluntarily visiting the Colosseum are accompanied by expert educators and hospital staff trained to carefully convey engaging narratives for their care journey.

4. Evaluation and Reflection. Each phase was assessed relative to predetermined objectives, enabling continuous refinement and directing future action.

5. Results dissemination. Publication of findings contributes to promoting best practices, professional transformation, and amplification of project impact for replication in other clinical and cultural contexts.

While other frameworks (including health sociology, medical anthropology, positive psychology, and broader humanistic approaches) have highlighted the role of wellbeing and resources in health contexts, the present work does not adopt a model aimed at optimizing outcomes or promoting specific emotional states. Instead, it is grounded in a phenomenological–pedagogical perspective that focuses on changes in practice through the generation of shared and reflective narratives, enabling stories to be inhabited, communicated, and learnt by doing.

The group included 12 participants: five expert educators[2] of the Education Service of the Parco archeologico del Colosseo (PArCo), three senior clinicians, three engineers, and the pedagogical facilitator; one of the participants was a former cancer patient. The composition of the group reflects the pedagogical and action-research nature of the study. Participants were not selected to represent a clinical population, but to contribute professional perspectives involved in the co-design, narration, mediation, and technological translation of cultural and healthcare experiences.

Educators contributed expertise in narrative construction, symbolic mediation, and guided experience; clinicians contributed knowledge of oncological pathways and patient communication; engineers contributed competencies related to digital interfaces and the translation of narrative principles into design solutions. As pedagogical research shows the importance of multiple perspectives to understand educational phenomena (Mortari & Ghirotto, 2019), this interdisciplinary configuration was intentional and functional to the study aims, rather than aimed at clinical representativeness.

One participant had previously experienced cancer. This experience was not considered as a source of clinical data, nor as a basis for representativeness, but as an experiential contribution within the co-design process. In line with phenomenological and pedagogical research ethics, no information regarding cancer type, stage, or treatment history was collected or discussed, as the study did not aim to analyze patient experience but professional learning and narrative construction processes. All participated voluntarily in co-design and training processes.

The laboratory was designed to generate narrative tools for Colosseum educators for conducting specialized visits for oncology patients, while simultaneously equipping healthcare personnel and engineers with effective communication strategies for patient education (Table 1).

2. Silvia D'Offizi, Elena Ferrari, Francesca Ioppi, Federica Lamonaca, and Andrea Schiappelli; Francesca Bennardo and Ilaria Capolupo also participated in the training seminars.

Table 1. Structure and educational objectives of the training modules.

MODULE 1 | PROBLEM IDENTIFICATION, ACTION PLANNING
Objective. Co-design of the training sessions
Training activities. Brainstorming and reflective work

a. Identification of training needs by the PArCo educators and the clinical team

b. Planning of the laboratory pathway and the museum itinerary

Expected outcome. Identification of three stages of the Colosseum visit aligned with key phases of the oncological pathway (waiting, battle, outcome)
Ex-post action. Delivery of three guided tours at the Colosseum following the identified stages

MODULE 2 | IMPLEMENTATION
Objective. Reflect on the oncology patient experience by identifying analogies with the Colosseum
Training activities. Lecture, reflective writing, multidisciplinary group work

a. Two educational activities on patient waiting (from clinical and patient perspectives)

b. One educational activity on Medical Humanities

Expected outcomes.

a. Identification of metaphors of waiting (from the perspective of the patient, the tourist, or the gladiator)

b. Development of short narratives capable of engaging oncology patients during their visit to the Colosseum, drawing on salient architectural or historical details in analogy with oncological experience

c. Drafting of narrative-performative frameworks to be used in subsequent guided tours

Ex-post action. Delivery of three guided tours at the Colosseum using the drafted narrative frameworks

MODULE 3 | EVALUATION AND REFLECTION, RESULTS AND DISSEMINATION
Objective. Reflection on professional practice
Training activities. Group debriefing, lecture, group reflection

a. Oral sharing of the narrative frameworks used during the guided tours and collective feedback

b. One educational activity on linguistic metaphors (neurophenomenological approach)

c. Group reflection on transformative elements

d. Final evaluation and feedback provided by the facilitator

Expected outcome. Changes in professional practice among participants
Ex-post action. Final assessment and results publication.

This pedagogical orientation conceives education as an interpretative, critical, and situated practice; in fact, pedagogical research cannot be reduced to technical application but involves theoretical reflexivity and attention to meaning, context, and subjectivity (Cambi, 2003). Such framework encourages the use of qualitative, experiential, and action-oriented methodologies in healthcare education

No ethics committee approval was required as the laboratory focused exclusively on professional training and practice improvement; no patient data were collected and oncology patients were only indirect beneficiaries of the training, since it involved practice reflexivity and adaptation among participants.

Data was collected through multidisciplinary group discussions, written reflections from participating professionals, and facilitator field observations during training sessions.

Data analysis followed phenomenological-hermeneutic epistemology and was conducted using In-

terpretative Phenomenological Analysis (IPA) (Smith *et al*., 2009). Texts, drawings, and field notes were analyzed through a manual, paper-based process, combining iterative reading, phenomenological reduction, and thematic clustering. Interpretative Phenomenological Analysis (IPA) was selected as it is specifically designed to explore how individuals make sense of lived experience, making it suitable for examining meaning-oriented transformations within small, purposive samples. The analysis aimed to identify recurring experiential meanings rather than frequency-based categories, resulting in thematic groupings grounded in lived experience and professional reflection rather than in content quantification.

From a methodological standpoint, this study aligns with the tradition of action-research in education, conceived not merely as a problem-solving technique but as a reflective and transformative process embedded in practice (Baldacci & Frabboni, 2013). This approach is particularly suitable for complex care contexts, where learning, meaning-making, and professional change are deeply intertwined.

3. Results

The laboratory comprised n = 3 hospital-based training sessions (duration: 180 minutes each) and n = 6 Colosseum visits (duration: 90 minutes each, mean participation per visit: 21.5 people). All participants received training in Medical Humanities foundations, Social Prescribing, Patient Experience, metaphorical language from neurophenomenological perspective, and the transformative function of storytelling.

Results from the laboratory were co-created materials, including:

- Spatial and experiential correspondences. Identification of N = 3 spaces within the Colosseum, symbolically corresponding to the relevant spaces of the oncological spaces.
- Linguistic metaphors. Analysis of N = 5 metaphorical clusters addressing the experience of "waiting", and identification of semantic polarities to understand (thus, exercising empathy) the first experience a cancer patient may encounter.
- Embodied narratives. Co-creation of N = 3 narratives to engage patients visiting Colosseum toward symbolic stories of transformation, in order change the *tropos* of battle metaphors and illness ad a war.
- Pedagogical questions. Field-derived questions to change the *tropos* of the war metaphor, when going to the Colosseum would be impossible for patients, grouped in N =6 items.

3.1. Spatial and experiential correspondences

In the first training module, participants identified metaphorical correspondences between clinical spaces and Colosseum architecture to emotionally recalibrate the oncology patient's experience through mirroring with the visitor's journey (Figure 1).

The aim of this practice was to find a process to ground patients to an embodied metaphor comprehension, wherein abstract understanding of one domain (clinical experience) becomes meaningful through structural and sensorimotor mapping onto another, concrete domain (architectural spaces). The body's actual navigation through space activates cognitive processing that transcends purely conceptual knowledge, thus activating bodily engagement into cultural narratives.

Three monument spaces were selected as symbolic analogues to hospital environments:

1. The *ambulacrum* (circular corridors and transit spaces) corresponds to the hospital waiting room. A space of temporal suspension, uncertainty, and preparation. Here, hopes, fears, and expectations emerge; refined listening becomes essential.
2. The *hypogeum* (underground chambers) corresponds to the outpatient clinic. An intimate, protected space for diagnostic encounter and vulnerable dialogue where patients "engage" themselves by becoming agents of their care pathway.

3. The *arena* (central exposed space) corresponds to the therapy room. Time is dedicated to healing and improvement despite potential adverse effects.

This architectural correspondence (Figure 1) enables patients to inhabit the Colosseum not as external spectators but as subjects in care pathway, recognizing in monument spaces dimensions parallel to their clinical experience and finding in that resonance possibility for meaning making and reorientation.

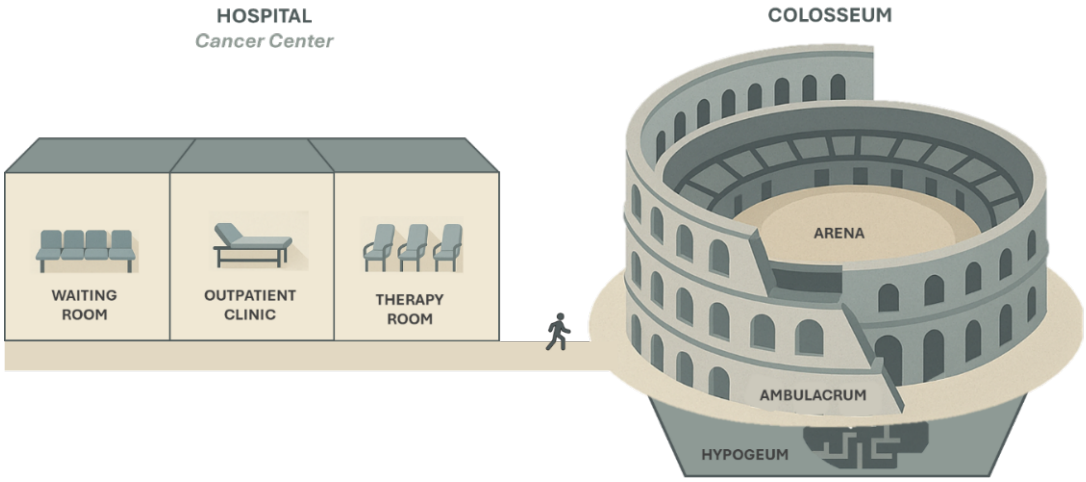

Figure 1 – Spatial and experiential correspondences between Colosseum spaces and the oncology pathway.

Massa's conception of education as a symbolic and institutional device offers a useful lens for interpreting the role of space in this project. Educational environments are not neutral containers but meaning-laden *dispositifs* that orient experience and practice. In this sense, the Colosseum functions as an educational setting capable of reorganizing perception, emotion, and narrative through its spatial and symbolic affordances (Massa, 2003).

3.2. Metaphors of "waiting"

Following lectures on clinical and existential expectations about "waiting" in the oncological journey, all participants generated metaphors on this topic. Through individual reflective writing, five recurring semantic categories emerged, ordered by frequency:

1. "Uncertainty" (1st category) emerged as the distinctive feature of oncological waiting, as an experience devoid of certainty regarding progression and outcome (n = 4), "suspended time" (n = 3) where temporality loses its linearity.

2. "Transformation" (2nd category) was represented through "oscillating rhythm" (n = 3) capturing emotional oscillation between hope and fear, "flowing movement like a river" (n = 2) as a sub-metaphor of temporality continuing despite uncertainty, and Colosseum transformation/mutation (n = 1).

3. "Anticipation" (5th category) was captured through forward-oriented metaphors: "a spectacular event, celebration" (n = 2), "the rising sun" (n = 1), the "pregnancy" metaphor (n = 2), and Leopardi's masterpiece *Saturday in the Village*. These reflect generative waiting despite clinical uncertainty.

4. "Agonism" (3rd category) was represented by the gladiator image in the Colosseum (n = 3) and stadium events (n = 1), evoking simultaneously competitive anxiety and personal challenge.

5. "Relational place" (4th category) was highlighted through n = 3 metaphorical declarations: a place of "familiarity and welcome", an "experiential home", a location "for encountering others".

Although participants were not oncology patients themselves, their engagement with metaphors of waiting constituted an exercise in empathic imagination. By attempting to inhabit the experiential horizon of a patient awaiting diagnosis or treatment, participants performed what phenomenology describes as *Einfühlung*, an embodied and imaginative attunement to another's lifeworld (Stein, 1989).

Rather than projecting their own expectations onto the scenario, they sought to access the affective atmosphere of waiting: its temporal suspension, its ambiguity, its anticipatory tension. Interestingly, participants expressed this empathic effort through heterogeneous narrative forms. Some chose simple written metaphors, privileging clarity and immediacy. Others produced complex metaphors, such as Giacomo Leopardi's *The Saturday of the Village*, pregnancy, or the rising sun. These responses attempt to situate waiting within broader symbolic frameworks capable of conveying temporal dilation, uncertainty, or emerging hope. Finally, a few participants opted for drawings rather than verbal descriptions, translating the affective quality of waiting into spatial and visual relations: shadows, horizons, thresholds, or concentric forms.

The semantic polarities examination suggests that waiting (as apex experience in oncology) is perceived as a complex space of symbolic tensions (*tropos*): between stasis and movement, loss and generativity, uncertainty, and anticipation (Figure 2).

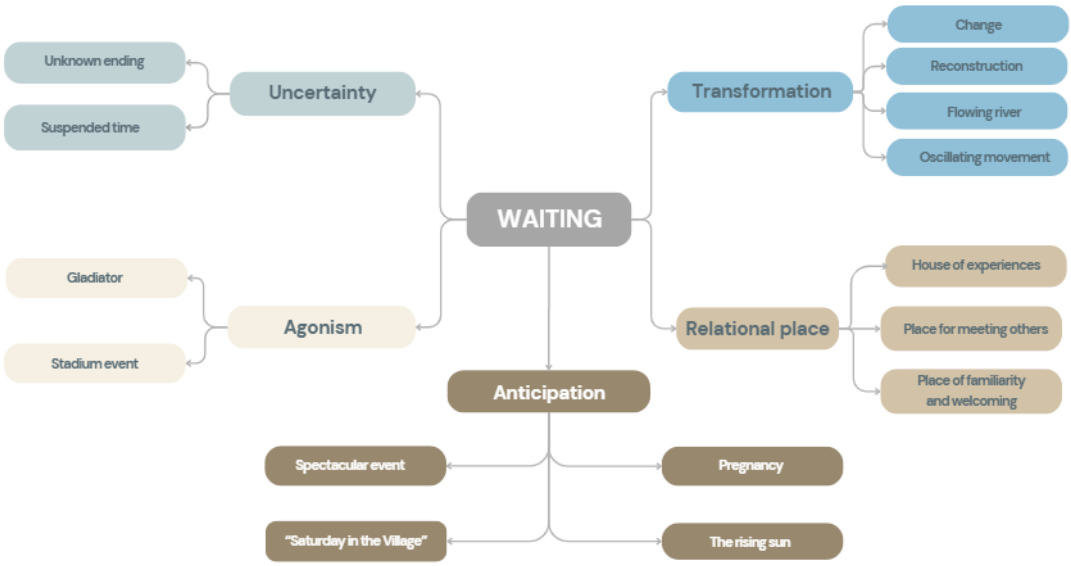

Figure 2 – Semantic polarities shaping the lived experience of waiting.

The emergence of both stasis-oriented metaphors (suspended time, uncertainty) and movement-oriented metaphors (flowing, transformation) suggests how the body simultaneously experiences temporal freezing and relentless temporal flow. Besides, the abundance of relation-focused metaphors (including the agonistic posture) indicates that during uncertainty, social cognition systems remain highly activated; hence, the patient might experience waiting not in isolation but through implicit reference to relational fields. From a neurophenomenological perspective, participants' narratives reveal how such metaphorical poles correspond to distinct neural dynamics: dorsal system engagement (related to action potential) versus ventral system engagement (related to interoceptive awareness).

These diverse expressive modalities likely reflect differences in participants' cognitive styles, comfort with abstraction, and personal approaches to meaning making. They also reveal how empathic imagination is not limited to verbal articulation: it can unfold visually, symbolically, or narratively, allowing participants to explore the phenomenology of waiting beyond the constraints of clinical language. Such variability underscores the pedagogical value of multimodal narrative practices in training contexts, as they enable professionals to recognize the multiplicity of ways in which patients may inhabit, describe, or silently endure the temporalities of illness.

3.3. Embodied narrative frameworks

Participants were organized into 3 multidisciplinary groups (each comprising clinicians, educators, and engineers) tasked with transforming emergent metaphors into engaging narratives, intended as short, situated stories capable of bridging patient experience with Colosseum visit.

Each group developed narratives to be tested (between the second and third training sessions) during the visits. Each story represents a strategy for transforming the oncological *tropos*, operating on distinct planes: identity, body, and time (Figure 3). Meanwhile, the educators anchored the stories within the specific spaces of the Colosseum during the visits, performing the storytelling as embodied narratives across the hypogeum, ambulacrum, and arena; therefore, also the spatial *tropos* gains another direction.

This step represents a crucial methodological moment, since aims at co-creating narratives that re-engage the patient (in body and mind) through storytelling designed to bridge cure, care and culture.

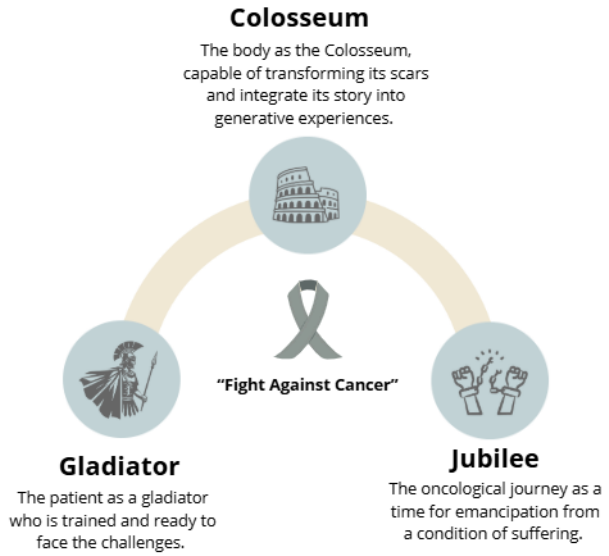

Figure 3 – Embodied narrative frameworks emerging from the training laboratory.

The transition from theoretical reflection to situated intervention, from professional knowledge to incarnated narrative practice, marks the critical passage where embodied cognition principles become operationalized.

3.3.1. From passivity to strategy: the Gladiator[3]

Within the Colosseum, educators embodied the gladiator's voice in first person and omniscient narration in third person. The gladiator emerges as an embodied metaphor for cancer patients but offers a radical alternative to conventional bellicose narration.

Unlike war oncology (which positions the patient as anonymous, obligated, sacrificial soldier) the ancient gladiator embodies three simultaneous dimensions:

1. Professional expertise and corporeal competence. Not a generic soldier but an athlete specifically trained with techniques, preparation, and expertise. Educators' narratives emphasized how the gladiator knows his body (its limits and capacities) enacting a familiarity resonating with patients learning to understand their illness.

3. Narration proposed by Elena Ferrari e Andrea Schiappelli.

2. Strategic agency and dignity. The gladiator is not sacrificed but a moral agent: he makes choices, develops strategy, assigns a higher meaning to his challenge. This dimension transforms oncological experience from passively "suffered" to "actively engaged": the patient is not a victim but protagonist of a defining challenge.

3. Personal commitment. Unlike impersonal war erasing personhood, the gladiator's challenge is radically singular: *my* struggle, *my* body, *my* victory or glorious defeat. This restores the dimension of personal agency and adherence to clinical experience.

Participants reported that this image conveyed strength, offering new meaning and direction to struggle, rendering the meaning of the battle metaphor more tolerable and even empowering. Participants succeeded in transforming the *tropos* of the bellicose metaphors: from disempowering schema to a narrative of self-signification through a major challenge.

3.3.2. From scars to integration: the Colosseum[4]

A second narrative strategy positions the Colosseum as somatic metaphor. Like the patient's body, the monument is traversed by time, exposed to trauma, restoration, and metamorphosis. From a place of sacrifice to a living monument that preserves its history in modern times.

Educators narrate the monument's visible lesions (weathered stones, architectural stratifications, restoration scars) not as degradation but as resistance traces. Wounds are not erased or hidden but integrated into structure itself: each lesion tells stories of survival, reconstruction, and transformation.

When the patient observes the Colosseum (structure that has known destruction, loss, yet persists in its complexity) somatic mirroring can occur: the monument's body becomes a mirror to one's own body, as locus of living memory, transformation, and continuity despite suffering. In this scenario, the monument offers participants an embodied model of resilience. Not total healing (scars disappear) nor resignation (damage irreparable), but transformative persistence: the organism survives, witnessing traces of its history integrated into novel forms.

Here, the Gladiator narrative finds increasingly fertile ground: a gladiator does not fight in abstract arena but in space preserving the marks of human history. His challenge is not isolated but rooted in the monument regeneration.

3.3.3. From struggle to regeneration: the Jubilee[5]

The third narrative introduces temporal and spiritual dimensions. During the Jubilee year, educators integrated the Jubilee metaphor (a cycle of liberation and rebirth from Christian and Roman traditions) as a symbol of temporal transformation in the oncological pathway.

Educators narrated the Colosseum as a "living Jubilee" locus: a monument experiencing centuries of decline-regeneration cycles, transformed in Christian era into martyrdom site and subsequently into a redemption space, today is a shared memorial space. The Colosseum represents the principle that regeneration does not cancel violent past but integrates it in broader narrative. In this context, the Jubilee is an event of recalibration and collective rebirth: a moment when debts were forgiven, enslaved people were freed, time recommenced.

In oncology, this narrative transforms the *tropos* of "healing" from returning to the previous state (before the disease) to the conscious liberation from cancer through therapies, while acquiring a new quality of life. The story suggests that the therapeutic pathway means entering a new temporal cycle: a passage, a radical change, a regeneration within continuity. As Jubilee repeats every 50 years, the oncological body enters cyclical time of rebirths, released ancient burdens, and reintegration into community in novel forms.

This narrative primarily addresses spiritual and societal dimensions: not the individual patient fighting alone in the arena, but a member of a community entitled to rest, forgiveness, and restoration.

4. Narration proposed by Silvia D'Offizi e Federica Lamonaca.

5. Narration proposed by Francesca Ioppi.

3.4. Field-derived pedagogical questions

Metaphors do not describe cancer: they reorganize the world in which cancer is lived. Therefore, understanding the *tropos* that a patient assigns to the bellicose metaphor can be fundamental for healthcare professionals and educators to acknowledge and address one's specific needs.

During the training sessions, participants engaged in guided reflection on the metaphor of "war" as used by oncology patients to describe their illness experience: healthcare professionals reported that patients' war narratives often conceal complex emotional, relational, and existential dynamics that remain unspoken during clinical encounters.

> A cancer diagnosis is a form of devastation. It resembles what we witness in times of war: people lose their sense of home, their future plans, and often parts of their identity. They are suddenly displaced from their ordinary lives and, upon entering the hospital, they are required to learn a new language (the language of medicine), adapt to altered circadian rhythms and interact daily with unfamiliar people. This experience profoundly disrupts the continuity of their existence, forcing them to renegotiate meaning, belonging, and trust in an environment that initially feels foreign (Oncologist)

In this reflection, the oncologist implicitly recognizes that patients often enter the clinical encounter already oriented by discouraging *tropos*. The diagnosis is not experienced as neutral information, but as a rupture that displaces the person from familiar coordinates of meaning, language, and trust. By describing cancer as a form of devastation and displacement, the clinician demonstrates an awareness that patients arrive carrying an initial orientation marked by loss, estrangement, and existential dislocation. This recognition constitutes the first step in working with the metaphorical *tropos*: not imposing a new narrative but acknowledging the direction in which the patient's experience is already unfolding.

> As a patient, I didn't expect miracles. What I needed was not to feel abandoned nor alone. When doctors speak as if everything is already decided, hope collapses... And hope is not denial: it is what allows you to stay present, to keep inhabiting your life while you are being treated. Physicians should not take hope away from patients, because without it, none of this makes sense (Participant)

Here, hope functions as a *tropos*: an orientation of meaning that keeps experience open, rather than closed, in the face of illness.

> In the app we are designing for cultural visits, these insights can be translated into narratives that do not merely describe places but help orient the user's experience toward meaning... By supporting processes of imaginative identification, the app could enable users to assign a transformative value to the experience itself. Similar narrative principles could be applied to other sites beyond the Colosseum, for example in places whose spatial and symbolic features can support transformation (Engineer)
>
> This experience made me realize that the way we narrate places can be improved across many of the sites we work in... It's not only about historical accuracy, but about helping visitors enter a story. When narration allows identification, even familiar monuments can become spaces where people recognize something of themselves and their own journey (Educator)

This exchange highlights that the engineer and the educator were capable of knowledge transfer from the Colosseum context to others, which is a particular feature of metaphorical thinking. While the engineer translated metaphorical orientations into design principles for digital interfaces, the educator reinterpreted the same insights as narrative strategies applicable to multiple cultural contexts. In both cases, metaphor functioned as a shared cognitive and pedagogical tool, enabling interdisciplinary dialogue, change in professional practice, and the circulation of meaning across professional domains.

Through facilitated discussions, 6 items of pedagogical questions emerged at the end of the training, as practical tools to help participants explore how patients inhabit and orient themselves within this metaphor (Table 2). Such tools function as structured ways of listening, enabling especially clinicians

to uncover what lies beneath the metaphor: its tone, its direction (*tropos*), and the forms of agency or burden it conveys.

Table 2. Pedagogical questions to explore and reorient the "war" metaphor.

PHENOMENOLOGICAL QUESTIONS
Objective. To understand how the metaphor is lived, before interpretation.

- When you describe your illness as a war, how does this war appear to you right now?
- In this war, how do you feel yourself present at this moment?
- What aspect of this war feels most immediate to you today?

Description. These questions help clinicians assess how the war metaphor is currently lived by the patient, making visible the initial *tropos* of the illness experience.

EXPLORATIVE QUESTIONS
Objective. To understand the structure and landscape of the metaphor.

- *How does this "war" begin for you, suddenly or as something that built up over time?*
- *If your illness is a war, where would you locate the "front line"?*
  - *In your body, your emotions, your relationships, or elsewhere?*
- *What does "winning" this war mean to you? And what would "losing" represent?*

Description. These questions help patients articulate the implicit coordinates of the metaphor, revealing whether they feel overwhelmed or mobilized.

REFLEXIVE QUESTIONS
Objective. To deepen self-perception and embodied postures.

- *How does the war metaphor make you feel about your body?*
  - *Like an ally, an enemy, or something in between?*
- *Are there moments in your day when the war becomes stronger or weaker?*
- *If your body could speak during this war, what message would it send you?*

Description. These questions allow patients to reconnect with bodily sensations and emotions often overshadowed by biomedical priorities.

CIRCULAR QUESTIONS
Objective. To map perceptions within the care network.

- *If someone close to you described how you "fight", what would they say?*
- *How do you think caregivers or clinicians perceive their role in your war?*
  - *As commanders, allies, strategists?*
- *Whose presence changes the course of the battle the most?*

Description. These questions can be particularly useful for understanding relational dynamics that influence resilience.

SYSTEMIC QUESTIONS
Objective. To identify resources, support networks, and possible blockages.

- *In this war landscape, what alliances (personal, social, spiritual) feel strongest?*
- *Are there negotiations or armistices you wish could happen within yourself or with others?*
- *What parts of your life remain outside the war untouched, sacred, or protective spaces?*
- *If this war had chapters, which one are you living now?*
- *Who or what helps you reorganize your strategies when the battle becomes unpredictable?*

Description. These questions map the opportunities to activate support services, including psycho-oncology and community resources.

TRANSFORMATIVE QUESTIONS
Objective. To gently open alternative orientations beyond the war metaphor.

- *If this war ever became too heavy, what alternative image might better support you?*
- *Is there a moment when the war pauses? What happens in those pauses?*
- *What qualities do you discover in yourself when you are not fighting but simply being?*

Description. These questions are gateways to new forms of agency, to reduce the emotional burden associated with militarized language.

These phenomenological, explorative, reflexive, circular, systemic, and transformative questions were recognized as immediately usable in clinical and cultural settings. Together, these field-derived inquiries reveal how working on metaphors can function as a pedagogical device: not to replace the patient's narratives but to explore their direction, uncovering possibilities from reframing their stories.

Clinicians reported that using these questions can help them access dimensions of meaning that would otherwise remain implicit or inaccessible in routine consultations. Rather than providing definitive answers, the questions can open a shared space of inquiry where the patient's metaphor becomes a relational tool rather than a fixed label.

In this way, metaphor exploration can be a phenomenological and educational practice capable of deepening understanding, strengthening therapeutic alliance, and supporting more humanistic approaches to oncological care.

4. Discussion and conclusions

The findings provide evidence that metaphors in oncology can be resources that shape the existential, relational, temporal, and spatial experience of illness.

4.1. Giving a new direction to illness perception

Educational research highlights that experiences of uncertainty can become sites of learning when individuals are supported in reinterpreting their lived experience rather than merely adapting to it. Such pedagogical processes shape identity through an active reorientation of meaning (Bruzzone, 2012). Experiences of crisis, illness, or loss are not educational per se, but require pedagogical mediation to be transformed into opportunities for reorientation. From this perspective, coping emerges as an embodied learning process through which individuals reorganize their relationship with uncertainty, limitation, and meaning.

War metaphors reveal the tension (*tropos*) between empowerment and burden that characterizes the subjective experience of cancer. Phenomenology has long suggested that illness reorganizes one's lived world: it alters bodily awareness, disrupts temporal continuity, and transforms the spatial meaning of familiar environments (Carel, 2008; Toombs, 1992; Svenaeus, 2001). In this altered lifeworld, metaphors act as orienting devices that help individuals navigate uncertainty and vulnerability. Metaphors as narratives are not ornamental elements but cognitive and affective structures through which experience becomes intelligible. In contexts of disruption, symbolic imaginaries function as mediators that allow subjects to sustain coherence and agency, making narrative reframing a legitimate pedagogical intervention (Dallari, 2005; 2024). Therefore, the metaphor "illness is war" does not simply describe cancer, but structures how individuals perceive threats, organize resources, anticipate outcomes, and assign roles within the care network. These orientations are enacted through posture, gesture, breath, tone, and movement. From this perspective, the persistence of war metaphors reflects not only cultural saturation, but the activation of deeply rooted sensorimotor schemas linked to confrontation, defense, and survival.

Educational phenomenology has emphasized that experience is always situated within relational, institutional, and professional frameworks that silently orient perception and action. In this sense, professional practices do not merely respond to patients' narratives but actively participate in shaping the horizons within which such narratives become intelligible. Studies in pedagogical research have shown

that reflective training (especially through writing and narratives) can modify how professionals perceive situations of vulnerability, enabling a shift from automatic interpretative frames to more open and responsive modes of understanding (Biffi, 2014). Within this perspective, working on metaphors in oncology can be understood as an intervention on professional perception itself, supporting clinicians in recognizing how their own interpretative habits contribute to reinforcing or transforming patients' lived orientations.

While some individuals draw strength from imagery of resistance, battle, and victory, others feel constrained by expectations of heroism, pressured to maintain emotional fortitude, or judged as "failing" when treatments do not lead to remission (Semino *et al*., 2017). The laboratory offers a phenomenologically grounded approach for transforming these metaphors: an approach that values lived experience, embodied learning, and cultural situatedness as central to pedagogical innovation in oncology. This approach acknowledges that cognitive change (particularly with illness and vulnerability) requires not abstract reframing alone but full body, context-based participation in meaningful experiences.

The embodied nature of metaphor is supported by research in cognitive linguistics and embodied cognition, which shows that metaphorical reasoning recruits neural and somatic processes linked to action and perception (Lakoff & Johnson, 1999; Gibbs, 2005; Shapiro, 2011). Accordingly, simply telling a patient to "avoid war imagery" is ineffective if the underlying bodily and affective orientations remain unchanged. Our results suggest that the issue is not eliminating the war metaphor but transforming its *tropos*, its "internal orientation".

Symbolic and narrative imaginaries play a crucial role in how individuals interpret experience, particularly in situations marked by uncertainty and disruption. Metaphorical narratives function as cognitive and affective mediators, enabling subjects to sustain coherence and agency (Dallari, 2003; 2012). The findings confirm that alternative narratives can be generated and inhabited to change perceptions of illness experience.

4.2. Accessing new meanings

The finding aligns with emerging research in museum-based education and cultural heritage studies, which suggests that historical spaces can act as catalysts for emotional regulation, existential reflection, and identity formation (Clift & Camic, 2016). However, the present project expands this literature by demonstrating that cultural spaces can also play a crucial role in accessing dimensions of illness meaning inaccessible within clinical settings.

From a phenomenological perspective, coping cannot be reduced to behavioral strategies, but involves the capacity to orient oneself meaningfully within lived experience. Care, in this sense, is an existential and educational practice that supports subjects in sustaining meaning under conditions of vulnerability (Mortari, 2015).

One of the most significant insights emerging from this research is the role of the Colosseum as a pedagogical and phenomenological agent. For participants, the Colosseum functions as a "witnessing body": a structure that embodies vulnerability, endurance, collapse, and renewal. Its scars, reconstructions, and stratifications resonated with participants' narratives of illness, evoking analogies that were not imposed but discovered through embodied exploration. The Colosseum thus became a lived space (Merleau-Ponty, 2012), capable of eliciting reflections that were spatial, temporal, and corporeal in nature.

From an educational standpoint, access to meaning is not achieved through interpretation alone, but through situations that allow subjects to encounter experience in non-instrumental ways. Pedagogical research on experiential learning has shown that meaning often emerges indirectly, when individuals are exposed to environments that suspend habitual cognitive and clinical frames, allowing alternative forms of attention to arise (Gamelli, 2011). In this sense, the Colosseum did not function as a symbolic representation of illness, but as an experiential threshold through which participants could access layers of meaning otherwise unavailable within clinical discourse.

The process observed in this study suggests that cultural spaces can operate as mediating environments, enabling participants to move from explanatory models of illness toward experiential comprehension. Such environments do not impose narratives, but create conditions in which meaning can

be sensed, inhabited, and progressively articulated. This shift aligns with phenomenological accounts of understanding as a process that unfolds through perception, movement, and affective attunement, rather than through propositional knowledge alone. Accessing new meanings thus emerged as a gradual reorientation of experience, supported by spatial immersion and embodied engagement rather than by interpretative instruction.

4.3. Learning through the body

The project demonstrates that embodied learning is essential for transforming metaphors. Educational phenomenology asserts that learning occurs through lived engagement with the world through movement, perception, gesture, and relational attunement (van Manen, 1990). Neurophenomenology (Varela *et al*., 1991, Gallagher, 2005) further argues that experience arises from the dynamic coupling of organism and environment. When participants moved through the ambulacrum, descended into the hypogeum, or observed the arena from above, these bodily engagements acted as experiential analogies for waiting, vulnerability, repair, and confrontation while changing point of view.

The three narratives developed in the laboratory (the gladiator, the Colosseum, and the Jubilee) did not emerge from abstract reflection but from embodied encounters with place. Participants thought, felt, perceived, and inhabited alternative meanings. This suggests that the reorientation of metaphors is a transformation of the lived body's openness to meaning.

Educational research on embodiment has emphasized that the body is not a vehicle for learning, but the primary site through which experience becomes meaningful. From this perspective, bodily movement, posture, and sensory engagement are not secondary to cognition but constitute the very conditions of understanding. Studies in experiential pedagogy have shown that learning occurs when the subject is placed in situations that engage the body as a sensing, orienting, and meaning-generating presence within the environment (Gamelli, 2011).

Within the present project, bodily engagement with the Colosseum allowed participants to experience metaphor not as a linguistic construct, but as a lived orientation. Walking, stopping, descending, and looking from different vantage points activated shifts in perception that preceded verbalization. This finding supports the idea that metaphorical transformation involves a reconfiguration of bodily intentionality: the way the body positions itself toward uncertainty, threat, endurance, and possibility. Learning through the body thus emerged as a necessary condition for reorienting illness metaphors, particularly in contexts where purely cognitive reframing would remain ineffective.

Importantly, this embodied learning did not aim at producing specific emotional states or therapeutic outcomes. Rather, it supported participants in developing sensitivity to how meanings arise through bodily experience, and how such meanings can be shared, narrated, and negotiated in professional practice. In this sense, embodiment functioned as a pedagogical medium that enabled professionals to remain open to patients' lived worlds, rather than as a technique to induce change (Marone, 2016).

Within phenomenological pedagogy, the body is understood as the primary locus of intentionality, through which the subject encounters the world and orients action, perception, and meaning. Educational experience does not occur "in" the body as a container but unfolds through the body as a relational and meaning-generating structure embedded in a concrete situation (Bertolini, 1999).

From this standpoint, embodied learning involves a reorganization of the subject's way of being-in-the-world, rather than the acquisition of new representations. The transformations observed in this study can therefore be interpreted as shifts in intentional orientation: changes in how professionals position themselves toward uncertainty, vulnerability, and patients' narratives. Such shifts precede verbal articulation and operate at a pre-reflective level, confirming that work on metaphors necessarily involves the lived body as the ground of experience and understanding. The body therefore emerges neither as a therapeutic tool nor as an expressive surface, but as the condition of possibility for meaning-making within clinical encounters (Cappa, 2025). This perspective strengthens the claim that reorienting illness metaphors requires educational practices capable of engaging bodily intentionality within situated contexts of care.

4.4. Professional transformation

One of the most important outcomes was the impact on professional practice. Participants (clinicians, educators, and engineers) reported changes in how they listen to patients, how they identify metaphorical cues, and how they engage with narratives of illness.

Several participants noted that they had previously responded to patients' war metaphors either by reinforcing them or dismissing them, without recognizing the underlying existential orientation these metaphors expressed. Through the laboratory, they learned to recognize metaphors, not as static linguistic forms but as indicators of lived worlds. This pedagogical shift aligns with research in narrative medicine and person-centered care, which demonstrates that attending to patients' metaphors can deepen empathy, improve therapeutic alliance, and enrich clinical decision-making (Charon, 2006).

Moreover, the project suggests that working on metaphors may improve interdisciplinary communication within professional teams. Clinicians, educators, and engineers each brought distinct perspectives to the laboratory, and the collaborative processes generated a shared language for understanding illness and care. This collective meaning-making is itself a form of professional development, enhancing reflexivity and mutual understanding (Zannini, 2001).

Research on professional learning in healthcare contexts highlights that meaningful change in practice rarely derives from prescriptive guidelines alone, but emerges through reflective processes embedded in concrete situations. Pedagogical studies have shown that training experiences grounded in lived practice can foster shifts in professionals' interpretative frameworks, particularly when they involve dialogue, narrative exchange, and collective reflection (Ghirotto, 2012). From this standpoint, the observed changes in clinicians' attention to metaphorical language can be interpreted as indicators of a deeper transformation in professional stance, involving listening, interpretative flexibility, and responsiveness to patients' lived worlds.

4.5. Implications for healthcare education

From a pedagogical perspective, these findings have several implications resonating with adult education. Narrative practices support learning not by producing definitive interpretations, but by sustaining a reflective space in which experience can be revisited, interrogated, and reoriented over time. In this sense, the laboratory did not aim to replace patients' metaphors or prescribe alternative narratives, but to cultivate professionals' capacity to remain with metaphorical complexity and ambiguity (Zannini, 2015). Such an approach reinforces coping as an ongoing interpretative process, grounded in reflexivity and experiential awareness rather than in resolution or control (Castiglioni, 2015).

Phenomenological research has further highlighted the importance of embodied learning as a methodological and ethical posture in professional education. Rather than aiming at the transmission of predefined meanings, embodied education supports practitioners in critically examining how meanings are produced, stabilized, and transformed within practice, starting from the senses (Tarozzi, 2013; Tarozzi & Francesconi, 2013). Applied to healthcare education, this approach underscores that metaphor work is transformative practice that enables professionals to interrogate the assumptions shaping clinical interactions by inquiring the body. In this sense, engaging with metaphors becomes a way of cultivating epistemic responsibility toward patients' experiences.

The project also suggests that metaphor work is most effective when integrated into embodied, situated, and culturally rich experiences. Rather than presenting metaphors in abstract form, educators can guide patients and professionals through environments that naturally evoke alternative meanings.

Thus, the project demonstrates that interdisciplinary collaboration can enrich metaphorical reframing. Educators, clinicians, and engineers, each contributed unique insights to the development of metaphors, resulting in frameworks that are adaptable and resonant across contexts. Third, it shows that cultural heritage sites can act as partners in care: when approached phenomenologically, the Colosseum functioned as a living archive of suffering, endurance, and renewal. An environment capable of supporting reflection and emotional transformation.

4.6. Limitations and future directions

This study has limitations. As a project focused on professional training, it did not include co-creation with or feedback by oncology patients. To address this limitation, one of the participants was a former patient, whose insights were precious in crafting the narratives and the overall projects. Future research may explore how the metaphors developed here impacts patient experience, emotional wellbeing, and clinical communication when implemented in guided tours, ward-based interventions, or social prescribing programs. Additionally, while the Colosseum offered a uniquely powerful space, further work is needed to determine whether similar outcomes can be achieved in other historical settings. Comparative studies could explore whether specific cultural spaces enhance or constrain metaphorical reframing.

As is common in pedagogical action research, this study is grounded in a situated inquiry that took shape within specific professional practices and lived contexts. While the Colosseum offered a unique symbolic and material horizon for this work, the account presented here proposes a model to be reproduced. It offers an indication of possibility, showing how professionals, in other cultural or institutional settings, might come to reflect on metaphors, narratives, and embodied meanings already at work in their own lifeworlds. In this sense, what may be transferred is the orientation toward inquiry: attentiveness to place, lived experience, and the co-emergence of meaning.

In line with phenomenological and pedagogical approaches to care (Mortari, 2015; Zannini, 2008), recent research on cancer metaphors shows that coping is deeply influenced by how patients inhabit and orient metaphorical frameworks. Metaphors function as experiential scaffolding that may support or constrain patients' sense of agency depending on their internal orientation (Semino *et al*., 2017; Liu *et al*., 2024).

This project demonstrates that transforming war metaphors into oncology requires engaging with the lived body, spaces, and narratives. By integrating phenomenology, embodied cognition, neurophenomenology, and cultural heritage education, the Colosseum laboratory enabled professionals to develop alternative metaphorical orientations that honor human vulnerability while supporting dignity and agency.

The implications of this work extend beyond the Colosseum and beyond oncology. They invite healthcare educators, clinicians, and policymakers to consider how environments (as architectural, relational, and symbolic devices) can shape illness experience. When care is grounded not only in biomedical expertise but in embodied, aesthetic, and narrative encounters, the metaphors that guide patients' journeys become richer, more truthful, and more deeply aligned with the complexity of human experience, in which practices of "self-care" (Cambi, 2010) may become educational "best practices" for the benefit of other human beings.

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