Scientific Contribution

# The Psychotherapeutic Encounter:

## Understanding and Empathy for a Cancer Patient Fearing Death, from the Perspective of the Phenomenology of Intersubjectivity and "Gestaltkreis" (Circle of Form/ Formative Cycle) Described by Viktor von Weizsäcker

Makoto WADA

Osaka International Cancer Institute
E-mail: wada-ma@mc.pref.osaka.jp

Abstract

One of the most challenging and vital issues for a healthcare professional arises when faced with a patient's anxiety about death. During a session, the therapist will try to accept and understand all of the subtleties conveyed by the patient. The cyclic act of "Listen as you speak" is an essential and vital part of the interview. German neurologist Viktor von Weizsäcker named the wholeness of the sensation and act of living "Gestaltkreis" (circle of form, or formative cycle). Gestaltkreis has the exact same structure as a psychotherapy session or playing music; action and perception are simultaneously established. If the clinician succeeds in utilizing "Listen as you speak" (Gestaltkreis in a psychotherapeutic session), sharpening his senses to perceive and accept what unfolds between the patient and himself, then the therapist's preconceptions may diminish, allowing mutual understanding and empathy to develop. An encounter with a patient fearing death is described as an example of this utilization. This case illustrates the phenomenology of intersubjectivity as described by French philosopher Maurice Merleau-Ponty. Being open to intersubjective receptiveness will help to eliminate one's preconceptions. This intersubjective receptiveness appears to be an essential stance for a psychotherapist or healthcare professional who strives to understand a suffering patient and provide support to her/him.

**Keywords: life, death, anxiety, cancer, phenomenology, intersubjectivity, Gestaltkreis, Viktor von Weizsäcker, clinical interview, playing music**

## 1. Introduction[1]

Not many people spend their lives trying to imagine their death. Everyone knows that death eventually comes to all, without exception. However, while the healthy know that death will catch up to them in time, they rarely consider mortality something they must face with any immediacy, and for most, it remains an abstraction in their distant future. When confronted with a life-threatening disease such as cancer, death suddenly changes from an ordinary, distant concept into a very real and immediate source of anxiety and fear.

As a psychiatrist, I work at an institution that specializes in cancer medicine, helping people with cancer embrace their psychological and psychiatric issues.[2] Those with cancer struggle with various forms of psychological anguish. This paper describes how cancer patients experience anxiety about death. Reflecting on my own clinical experience, I discuss how a psychiatrist or a healthcare professional interacts with a patient's fear of death.

## 2. Cancer Medicine and Anxiety about Death

Cancer medicine involves the administration of numerous tests, diagnoses, and therapies such as surgeries, cancer chemotherapy (anti-cancer

drugs), and radiotherapy. More recently, much focus has been directed towards means to ease the agonizing symptoms of cancer, otherwise known as palliative medicine or palliative care. This includes measures to ease pain, dyspnea, nausea and vomiting, malaise, and other forms of both physical distress and psychological suffering.

Not many opportunities present themselves for a Japanese patient to directly address death anxiety and existential distress, while maneuvering through this series of cancer treatments and procedures, laying them out as topics of concern and trying to discuss them with healthcare professionals responsible for their care. Very few people will mention their anxiety about dying, and if they do mention something, then only in very limited settings. In most cases, anxiety regarding death takes a mundane form. For example, the patient will worry about his treatment. 'Will it go well, or will I suffer an adverse reaction?' When a patient learns for the first time that he has cancer or after he has been told that his cancer has recurred or metastasized, it is not uncommon for the patient to develop depression, go into denial, or become confused. The patient may remain in shock for anywhere from a few days to several weeks. In most cases, the patient will gradually come to grips with reality and decide to make the best of the situation. The patient will direct his concerns to individual tests or treatments, on the results or adverse reactions, and it will appear as if the patient has shifted his focus to pragmatic matters, rather than any direct anxiety regarding death. However, even after a successful surgery that has completely removed the cancer, there is no way to wipe away niggling fears. Will it recur? Could it progress someday? And while receiving chemotherapy, how long will the drugs continue to keep the cancer in check? What will happen if it stops working?

Breakthroughs in cancer therapy now cure about half of those diagnosed with cancer. However, in the remaining half, the disease will advance and eventually kill them.[3] Once the cancer progresses, it is not unusual for patients to experience symptoms such as malaise and pain and other forms of physical distress. Eventually, the patients will no longer be able to continue working or meet their social responsibilities. As a father and husband, as a mother and wife, as a son or daughter, or as a grandfather or grandmother, the patient will no longer be able to fulfill his or her roles within a family. The patient will begin to develop difficulties in basic physical functions such as walking, eating, or breathing. Even everyday activities will become more difficult.

Few patients are familiar with the full toll of malignant disease and its medical care. They do not understand the fact that they will eventually lose their physical abilities and experience

diminishing functions. Instead, beset with a vague sense of anxiety, the patient will wonder, 'What will become of me once my disease progresses?' Seeing other patients will make them fear for their futures, or they may become terrified after hearing rumors. They will worry, 'If I can't do my work anymore, will I lose my job? Will my family go bankrupt?'

Taken individually, the concerns that arise during the disease and its treatment can, for the most part, somehow be resolved. Healthcare measures are available to provide patients with both medical and social support. Pain is managed with analgesics, while rehabilitation and wheelchairs are available when ambulation becomes difficult, while caregiver support is another option. Healthcare professionals tend to focus on specific issues such as symptoms. At least on the surface, patients and families tend to direct their attention to everyday problems.

However, it is not that easy for anyone, not the patient, the family, or healthcare professionals, to accept, cope, or resolve the inevitability that the cancer will progress, and that beyond the presence of an unstoppable ailment follows certain death. It is difficult for someone to confront the reality of one's impending death. While understanding that this life-threatening disease will progress and that death is unavoidable, people tend to direct their attention to matters that are more concrete, easier to grasp—matters that they can resolve. By refocusing their attention on actual issues that can be solved, patients can take action to deal with those problems and avoid touching on the more profound issues such as death. This keeps them from becoming overwhelmed by anxiety.

In daily interactions with patients in the medical setting, their anxiety about death—the

fear of annihilation of oneself and the fear of losing one's life, dwells deeply hidden, as an undercurrent to their everyday concerns. In various settings, the concealed "death anxiety" reveals itself, affecting people's emotions and actions. During daily practice as a psychiatrist who treats the psychological issues of patients with cancer, I have often encountered patients as described above. For example, there is a middle-aged man who often exhibits severe rage towards his wife or the nurses in the ward. A cause can usually be identified for the outburst. However, the trigger in each episode of rage may often be a minor matter that would not ordinarily incite such extreme anger. The issue here is that the patient cannot accept his current situation where his cancer continues to progress, and death approaches. The anger is, in fact, uncontrollable raging against his destiny.

The most common symptoms that a psychiatrist sees in the cancer therapy setting are anxiety, depression, and delirium. Properly evaluated, these individual psychiatric symptoms are mostly treatable. Pharmacotherapy and psychotherapy can be used effectively to some degree. In pathological anxiety, where there is a divorce from reality; pharmacotherapy or a specific form of psychotherapy such as cognitive behavioral therapy may have a favorable impact.

However, when a person overcome by death anxiety has an actual life-threatening disease, psychiatric approaches in the narrow sense lose their potency. How should the therapist help a patient who is suffering from real anxiety about impending death? This has been a major theme for of my own career, especially since I began working as a psychiatrist who treats patients with cancer.

## 3. "Listen While You Speak" in the Clinical Interview

Let us take a look at how psychotherapeutic sessions are generally carried out. When a psychiatrist or psychotherapist sees a patient, he must be willing to listen, to accept the patient's feelings, to understand, and to provide empathy. "Listening," "Acceptance" and "Empathy" are the vital foundations of psychotherapy. During a session, the patient's words are important, not only for their content, but also for how they are delivered. The cadence/inflection, power and strength of voice, movements in expression, body position, and other physical aspects should not be missed. The therapist must then decipher the flow of emotion and the flow of thought that underlies these expressions, the psychological function such as how the patient directs his attention or interest, and to comprehend the atmosphere and energy that surrounds the entire person. Through this process, the psychiatrist tries to sense the person's stance on life and how the patient interacts with the world and those around him.

Though, in the psychotherapeutic interview, it is extremely important to listen to what the client is saying; it is no easy task to bend an ear towards another's words and to accept the other person's emotional response. People are diverse, with many ways of thinking and feeling. Clinicians settle into interpretations founded in their own presumptions and frameworks of thought, without even being conscious of that process. One should always remain skeptical of whether one truly understands and accepts the other persons' feelings and intentions. An effective therapist listens to the patient, to note his flow of thoughts and emotions while simultaneously remaining aware of his own consciousness, thoughts, and emotions, and offer some thoughtful, helpful words in response. Most often, a therapist may believe he is listening to the patient, but the therapist's attention may be focused on his own thoughts, not paying enough attention to what the patient is communicating. Not uncommonly, the therapist-listener is not fully cognizant of the patient's words or expressions or movements.

"Listen while you speak." A great deal of training is necessary to fully engage with the patient in this way. As psychiatrists and psychotherapists hone their skills, they need both experience and reflection to realize just how difficult this can be. "Listen while you speak", however, is essential for an effective psychotherapeutic session and fulfills an extremely important part of the interview framework.

## 4. "Listen While You Play" in the Context of Playing Music

The difficulty and importance of "listening

while you speak" in psychotherapy, is the same as 'listening while you play' music. When playing music, be it playing an instrument or singing a song, one produces a note, and ideally, one would simultaneously be listening to the sound one created. This seemingly ordinary act appears very simple, but is very hard to put into practice. When consciously choosing to create a sound or note, one should simultaneously be listening to that sound. Playing the next note after hearing your sound is not a simple task. In most cases, you will hear the sound that you have in your head and not listen to that sound with your ears. A rather unkind comment may be to point out that it is because the player does not hear the actual sound he makes, that he will be able to enjoy his performance, even if he plays atrociously. It is a highly complex accomplishment to produce a sound, while simultaneously listening to that note resound through the environment. In fact, when action and sensation do come together to form a cohesive whole, the effect has an indescribable potency.

To listen as you produce a note, hearing both your own note and the notes produced by others is challenging. To capture all of the sounds that both you and others have created is even more difficult. However, as you produce a note and hear the sounds that you and others create together, you are guided by this composite note to produce the sounds to follow. This structure creates an essential and valuable momentum towards the establishment of an ensemble[4,5].

## 5. Gesltaltkreis by Weizsäcker

The German neurologist, Viktor von Weizsäcker, saw how living beings interacted with their environment (*Umwelt,* in German), and experienced the wholeness of "act" and "sensation."[6] This experience is also the wholeness of the "active" and the "passive", when living beings interact with their environment. Weizsäcker named this *Gestaltkreis* or "circle of form"/"formative cycle." Weizsäcker's representative work "*Gestaltkreis"* [3] has, at least to my knowledge, never been translated into English. Below is a description of *Gestaltkreis* from Bin Kimura, a Japanese psychiatrist and psychopathologist.

*The organism and the environment continue to encounter each other. The "principle" that works at the interface, providing the grounds/basis for establishing the encounter, is the subject. Regardless of the mode of the principle, it is in no way a "thing" or concrete object that can be substantively understood.*

<Excerpted from Kimura's *Aida* (*Between*) pp. 13-14 [2]>

*The organism forms an order in its encounter with the environment in the principle of the subject. This order continuously undergoes a crisis (Krise, in German)-like transformation of disappearing and becoming. For as long as the organism lives, this process will forever maintain a "unity." Weizsäcker referred to this unity as "coherence" (Kohärenz). Although a discontinuity is created by the relentless crisis, as a whole, continuity is maintained between the organism and the environment. If we borrow the words of the Japanese philosopher Kitaro Nishida, this can be described as a "discontinuous continuity". The interaction between the organism's sensation and action ensures this discontinuous continuity. This interaction is what Weizsäcker called "Gestaltkreis" or circle of form, formative cycle.*

*The "Gestalt" of Gestaltkreis should not be confused with that of Gestalt psychology. It is not a form that can be objectified, but rather a type of principle that forms this form. The principle behind the formation works through the circular (Kreis) interaction between sensation and action. This interaction maintains coherence between the organism and the environment. Thus, the entire structure is called a circle of form (Gestalt), formative cycle or Gestaltkreis.*

<Excerpt: Kimura's *Aida* (Between) pp. 18-19 [2]>

In the psychotherapeutic session, the "listen while you speak" structure allows for cohesion in the action and sensation that develops between the therapist and client, and co-establishes the passive and the active. Is this not *Gestaltkreis* itself? A musical performance where one "listens

while playing" is yet another manifestation of *Gestaltkreis*. In the patient interview, since the patient is him- or herself a living subject, this structure can be actualized comprehensively and simultaneously from both sides. The focus can and does change continuously, from a stress on listening to a stronger focus on speaking.[7] Instead of these transformations of form, the establishment of this structure itself will be maintained.

Viktor von Weizsäcker's medical anthropology is one of the original sources that instigated the development of psychosomatic medicine in Germany. It has also had a considerable impact on psychopathology and the field of medical philosophy in European nations, particularly in those where German is spoken[5][6][7][8][9].

Renowned psychiatrist and psychopathologist Bin Kimura introduced Weizsäcker's thoughts to Japan. Kimura was also strongly influenced by the philosophy of Japanese philosopher Kitaro Nishida as he developed an original key concept that he named "Aida" or "between-ness"[2][10][11].

In the realm of medical philosophy and medical ethics, Seishi Ishii has made great strides in introducing Weizsäcker's medical anthropology to Japan[12]. He introduced manas on life and death in medicine and biology[13], the pathic view of life, and the concept of crisis and biography[14]. He has also delved into the coherence of the second-person connection in a caregiver-patient relationship[15]. Yutaka Maruhashi further discussed Weizsäcker's thoughts on medical ethics[16]. [8] [9]

However, to the best of my knowledge, none of the papers published to date that quote from *Gestaltkreis*, discuss how medical professionals such as psychiatrists should deal with their relationship to patients who have diseases such as cancer and other fatal conditions. Moreover, there are no preceding references that describe the interaction between the interviewer and interviewee from the standpoint of *Gestaltkreis.*

To add to the existing substantive contributions mentioned, this paper presents a new perspective by discussing the interaction established between the therapist/physician and patient/client during psychotherapy in terms of *Gestaltkreis*. During a psychotherapeutic encounter, the *Gestaltkreis* that occurs between the psychotherapist/physician and patient/client can be observed not only during psychotherapy sessions, but also as part of general communication. However, during a psychotherapeutic interview, how and how well the therapist understands the patient/client is brought into sharpened focus. Thus, in a psychotherapeutic interview, the simultaneous act of listening as one speaks, the simultaneous establishment of passive and active, the interaction between the two persons who are subject and object and the manner in which they interact, is clearly illuminated as the focus, providing an excellent platform to discuss issues in the context of *Gestaltkreis* as the interaction between one person and another.

## 6. *Gestaltkreis* and Nishida's "Active Intuition" in the Clinical Encounter

Kitaro Nishida's well-known quotation: *That which is made is made in such a way that it makes that which makes; that means, "that which is made" contains the possibility of itself being denied. While there is no such a thing as "that which makes" separate from "that which is made," that which makes qua that which is made goes on making that which makes* [21][10]. If the subject actively interacts with the object, the passively accepted effect from the object will affect the subject. Through this process, the subject itself will be newly regulated. The structure of the subject-established is discussed. This applies to the "listen while you speak" approach in both patient interviews and musical performances. The action and sensation become one, while active and passive are also unified and appear to indicate a structure common to Weizsäcker's Gestaltkreis.

## 7. Clinical Encounter with a Patient with Anxiety about Death

Thus, we return to the question posed at the beginning of this paper. What should the psychiatrist or healthcare professional do when faced with a patient who is "anxious about death?" Death anxiety manifests as common,

ordinary, everyday anxiety. Countermeasures can be instituted, and it is easier to deal with concrete, overt psychiatric symptoms such as depression and anxiety or feelings and actions that the patient acknowledges. Patients who fear the pain and distress that may appear when cancer symptoms progress can also be comforted by dealing with those symptoms. Offering patients information on how current medicine can resolve their symptoms will reassure patients and may allow them to feel more relaxed. There is a great deal of variation on how patients perceive "death" itself, and to what degree the patient's anxiety regarding death appears in the forefront. Patients who are not confronting their death anxiety, need not be forced. Rather than making the patient confront "his own death," direct the patient's attention towards more daily common interests to preserve the patient's will to live. Such adaptive aspects are common, and it is better to respect this psychology, or defense mechanism of adaptive denial.However, the anxiety associated with the concept of "death," namely, fear of the deletion of one's self, may exist behind various interests of patients in their daily lives. Many of them are more or less conscious of the shadow of death and fear it. Death anxiety can at times grow overwhelming, distressing patients. And while limited, some patients will directly ask healthcare professionals about "death anxiety." It appears patients feel less reluctant to discuss psychological or existential issues such as "death" with psychiatrists, compared to other medical doctors or healthcare staff.

Medicine professionals, of course, should not determine life and death of a human being on their own. However, when a potentially life-threatening disease is discovered, the patient will receive treatments that may strongly influence that person's life. It is often in such settings that patients and families are forced to make critical decisions and preparations related to life and death. Most people never thoroughly consider these issues in advance and run the risk of having to make difficult decisions on-the-spot. In my own professional experience, I see that a patient's death anxiety is an unavoidable enigma that we, that is, psychiatrists and other healthcare professionals, must learn to confront.[11] [12]

## 8. A Patient

Consider the example of an interaction with a patient from my own clinical experience.[13] To accurately portray the interpersonal situation, the first-person singular is used.

The patient was a man in his sixties. Two and a half years ago, he underwent surgery after the discovery of gastric cancer. In spite of adjuvant chemotherapy with antineoplastic agents after surgery, hepatic metastases were discovered less than a year after the operation. Anticancer drugs initially proved effective, and the tumor did shrink at one time, but six months later, more hepatic metastases appeared. Chemotherapy was no longer effective and discontinued. Treatment was attempted with another anticancer drug, but the tumor continued to grow, and so the chemotherapy was discontinued. Next, molecularly-targeted therapy was attempted, but after about 4 months, the tumor continued to grow, and the molecularly-targeted therapy also failed.

The patient's attending physician had explained that any further attempts to continue treatment with anticancer drugs would only increase the patient's physical burden and suggested that he might wish to focus on palliative care to reduce any suffering and pain instead. At this point, his only symptoms were mild gingivitis, continuous mild diarrhea, and some occasional mild abdominal pain. Other than these symptoms, the patient was experiencing no physical discomfort.

His attending physician consulted me, the facility's psychiatrist, because the patient was highly anxious.

During our first interview, I introduced myself to the patient and explained that his attending physician had consulted me about his anxiety. The patient said that he had requested this meeting. I discussed his treatment history, primarily to explain that I understood his current situation. After surgery for gastric cancer, the cancer had metastasized, and despite several attempts with chemotherapy, it had continued to progress. His physician had suggested he stop aggressive cancer treatment and focus on palliative therapy. I asked him how he felt.

The patient answered with a firm yet heavy

tone to his speech,

"I've done chemotherapy, but the cancer just keeps getting bigger. They say it's not working ..."

"I've been told it would be better not to try any further treatment ..."

Silence filled the room.

"... I'm ... afraid ... to die ..."

Those few short words, unexpected and powerful, struck me as if someone had suddenly stabbed me in the chest. I didn't know how to answer or what to say, but did reply, "So, you're afraid to die." Repeating the patient's words back to him, reiterating a statement, is a common, standard technique in patient interviews, but it would sound empty and hollow, so I hesitated to use such a technique. In the silence, I searched for an answer. "What should I say ...?"

No matter what I said, they would be no more than empty words of comfort. Expressions such as, "That's true," and "I understand," were also too facile, and lacked genuineness. I could have explained, "Our experience and expertise in palliative care has improved over the past years. Should you experience any form of discomfort in the future, please rest assured that medical treatment options are available," and followed up with realistic therapeutic solutions, but that would not get to the root of the patient's profound and serious "fear of death."

A heavy misery permeated the silence ...

I thought, "Here sits this man, struggling with a fear of death and I am powerless." I am beset by a palatably unpleasant feeling, as if I am licking sand, in the midst of a bleak landscape. Overcome by a bitter sense of helplessness, I feel as if this horrible feeling is going to continue forever.

And then, as a person and as a clinician, I realize that I am not standing alone in the desolate landscape. The patient, here in front of me, is also standing there, right by my side ... and then ... I begin to feel that what I sense is connected to what this patient is experiencing. I feel that the patient is no doubt experiencing something similar, being unable to fend off a relentlessly approaching death, together with my own sense of helplessness. A forsaken world spreads out between the patient and myself, and it feels as if we are standing there together ...[14]

After a while, the patient's expression revealed something moving within him. It felt as if his emotions were in sync with my own. As the patient watched me, I could sense that some communication, a connection, had been made.

Although this was a grave and bitter situation, there was a sense that we were not alone and isolated, that on some level we were connected by some thread in this austere world.

The patient did not speak much after the initial encounter. I told this patient what I had just experienced, both my physical sensations and the psychological landscape I saw. I told him how I could sense that he was in a very difficult situation. I was honest and told him that while I wished I could believe that I shared a small part of the fear that he carried as he stared death in the face, I confessed that I was nowhere near approaching how he must feel. The patient simply answered, "Thank you." His expression, quite grim when the session first began, had softened and become somewhat more peaceful.

Later in the interview, we discussed practical matters. I spoke of his course of therapy from this point forward, explained palliative care, and described what treatment options would be available to him and where.

I only spoke with the patient this one session.

Later, the patient decided to try another anticancer drug, but he was immediately forced to discontinue treatment, due to gastrointestinal side-effects. The patient transferred from our facility to receive palliative care at a local hospital, but before he left, he had extended his thanks to me via a nurse on his ward.

## 9. Empathy and Understanding in the Clinical Encounter

I had been unable to give this patient, mentioned above, advice on how to lessen his fear of death or to provide any concrete measures to ease his suffering. All I had done was listen to the patient confess his "fear of death." As I listened, struck silent by a heavy sense of helplessness, a dreary landscape had spread out between the patient and myself.

Regardless of one's background or standing, it is difficult to offer a pat "solution" to a person struggling with the reality of his impending

death. For medical professionals who see patients without a strong religious background, the best we can do is to empathize with the fear and despair of a person facing death, to share in the distress, and to accompany the patient's passage down that road. Perhaps this may be the most that one can hope for. A common bond may be forged between the patient and therapist at these times. No longer will the patient need to struggle alone as he suffers and dies. Perhaps the patient may sense that something, however subtle, has changed for him. Of course, it is possible that the psychiatrist is the only one feeling this way, and the clinician can only presume how the patient experiences this process. At the very least, however, the patient will sense the medical professional striving to understand how badly the patient struggles with his fear of dying.

## 10. Phenomenology of Intersubjectivity and *Gestaltkreis* in the Clinical Encounter

Before an interview, a psychiatrist will have pertinent information on the patient's symptoms, treatment history, prognosis, family situation, and life history. The clinician will formulate some idea of how the patient may be feeling, and those predictions will often be going through his head. However, it is only after all those preconceptions are removed, that the therapist can meet and sense how the patient is actually feeling for himself. Only then can the therapist finally gain some insight into that patient. During an interview, if one strives to free oneself of preconceptions and speculations and goes beyond merely trying to infer or picture the feelings and experiences of the patient, the therapist could see and experience the patient's view of life; this view would appear of itself between the conversants. At those times, something occurs between two people, the patient and therapist, something that goes beyond the boundaries of logical thought. Empathy is a vital concept and method used in psychotherapy, and it seems to be a phenomenological matter. Through the practice of *Gestaltkreis* in psychotherapy, by honing his senses to face and accept what is expressed by the patient/client, the psychotherapist can experience the common landscape that unfolds spontaneously between the patient/client and the therapist/physician.

Medical anthropology comprises various ideas that include the *Gestaltkreis* of Weizsäcker. The interaction between subject and object and how these are established become the issue. Focus is placed on the relationship between cognition and act, active and passive, connecting both thought and action to the platform that is the main theme in phenomenology. Weizsäcker himself did not use phenomenology as an academic approach, and he was not a phenomenologist by his own reckoning. In spite of this, Weizsäcker's insight and awareness of issues is thought to have influenced many of the academics who conduct phenomenological research for this very reason. The German psychopathologist W. Blankenburg[9][15]and Japanese psychopathologist Kimura Bin[2][10][11] are two academicians who have led the development of phenomenological psychopathology inspired by the ideas of Weizsäcker.

When interacting with those who fear death, when any words of comfort or reasonable suggestions of palliative measures sound contrived and empty, a heavy, bitter sensation develops between oneself and the other person, and one feels that this is where a true connection can be established where patient and therapist could actually connect. This is the realm of intersubjectivity that is discussed in phenomenology. Maurice Merleau-Ponty suggests that empathy may include corporeal feelings.[24][25] It is also that state where one is physically open to another and what Hermann Schmitz proposed as the "lived body state of being" (*leibliches Befinden* in German). [26][27][28] This corresponds in a broader sense to the realm of physical communication. Thomas Fuchs, a current German psychiatrist and phenomenological psychopathologist, stressed that interactive connectivity preceding the separation of the object and the subject in self and non-self, based on the philosophy of intersubjectivity and intercorporeality by Merleau-Ponty, invokes the system theory of autopoiesis, where people interact through "intercorporeal resonance," allowing establishment of an "overcrossing corporeity." Fuchs also proposes an ecological concept: "Intercorporeality [is] embodied in the human body." [29]

Understanding others and the intersubjectivity and intercorporeality of self and non-self is a hard philosophical concept, and calling for an immediate solution to philosophical theory is not within the scope of this article. We can instead confirm the following: The experience described in the case above is not that of a clinician trying to surmise the feelings of the patient. Rather, in the patient-therapist interation, something unfolds spontaneously between the patient and the therapist and appears to open of itself. [16]

## 11. Life, Death and Pathos

People who must live with a life-threatening illness experience various forms of both physical and mental anguish. No living creature can avoid the agony of death and disease, regardless of what he wishes. The experience of living with the knowledge of having a life-threatening illness is something that the person suffers passively, as a part of life and the world. In a word, this end of life experience expresses *pathos*.[31]

In the foreword to "*Gestaltkreis"*, Weizsäcker wrote: "Death is not the opposite of Life. It is a counterpart of reproduction and birth." Further, he wrote that "Life is both birth and death."[32] These passages mean that people "live" the entire course of their lives from birth to death, and so "death" is not the opposite of "life."

In the very limited realm of medicine, healthcare professionals encounter people who are at major turning points or crises (*Krise*) [33] in their lives. What then can a healthcare professional do to be of use, no matter how small his or her contribution? What can one do to support someone, so that the patient can live out his or her life in the manner that he or she wishes, from "birth" until "death"? Clinicians must continue to deliberate such questions in their daily practice.

## 12. Conclusion

The cyclic act of "Listening as you speak" is an essential and vital part of the psychotherapeutic interview. This has the exact same structure as the wholeness of the sensation and act of living, described by Weizsäcker, V.v. as "*Gestaltkreis*" (circle of form/ formative cycle). If the clinician succeeds in "Listen as you speak" (*Gestaltkreis* in a psychotherapeutic session), sharpening his senses to perceive and accept what unfolds between the patient and himself, then the therapist's preconceptions may diminish, allowing mutual understanding and empathy to develop. Being open to such intersubjective receptiveness that allows for a reduction of one's preconceptions is an essential starting point for psychotherapists and other healthcare professionals, who strive to understand and support the anxious patient.

**References**


[1] National Cancer Center, Japan, Center for Cancer Control and Information Services, Newest cancer statistics.http://ganjoho.jp/reg_stat/statistics/stat/summary.html) (Updated September 20, 2017: Accessed November 24, 2017)

[2] Kimura, B., *Aida (Between),* Kobundo, 1988. In Japanese. (French translation: Kimura, B*., L'Entre,* translated from Japanese into French by Claire Vincent, Editions Jérôme Millon, 2001.)

[3] Weizsäcker, V.v., *Gestaltkreis − Theorie der Einheit der Wahrnehmen und Bewegen,* 5. unveränderte Aufl. Georg Thieme Verlag, pp.168-169, 1986 (*Gestaltkreis (Circle of Form/ FormativeCycle) — Theory on the Unity of Perception and Movement*. 5th edition). In German. (Japanese translation of the 4th edition by Kimura, B. and Hamanaka, T. Misuzu Shobo, pp.275-276, 1975.)

[4] Weizsäcker, V.v., *Der kranke Mensch − Eine Einführung in die Medizinische Anthropologie, Viktor von Weizsäcker Gesammelte Schriften 9,* Suhrkamp Verlag, 1988. In German. (Weizsäcker, V.v., *Sick Person − An introduction to medical anthropology. Collected Works of Viktor von Weizsäcker 9,* Suhrkamp Verlag, 1988. In German.) (Japanese translation by Kimura, B., *Sick Person-An Introduction to Medical Anthropology*, Shin Yo Sha, 2000.)

[5] Janz, D., Viktor von Weizsäcker als Begründer der Psychosomatischen Medizin (Viktor von Weizsäcker, a founder of psychosomatic medicine), *Fortschr. Neurol. Psychiatr.* 69, suppl 1: 28-33, 2001. In German

[6] Ten Have, H.T., The anthropological tradition in the philosophy of medicine, *Theoretical Medicine*

16: 3-14, 1995.

[7] Perlitz, V., Petzold, E.R., Vom Gestaltkreis zur Synergetik: Die Bedeutung irreversibel-struktureller und dynamisch-funktioneller Kopplungen (From the Gestaltkreis to synergetics: irreversible structural and dynamic functional couplings), *Psychother. Psychosom. Med.Psychol.* 57: 197-205, 2007. In German.

[8] Martinsen, E.H., Solbakk J.H., Illness as a condition of our existence in the world: on illness and pathic existence, *Med. Humanit.* 38: 44-49, 2012.

[9] Blankenburg, W., *Psychopathologie des Unscheinbaren (Psychopathology of the Inconspicuous),* Parados Verlag, 2007. In German. (Japanese translation by Kimura, B., Ikuta T., Kobayashi, T., Suzuki, S., Watanabe, T., and Wada, M., Misuzu Shobo, 2012.)

[10] Kimura, B., *Collected Works of Bin Kimura 1-8,* Misuzu Shobo, 2001. In Japanese.

[11] Kimura, B., *Kankei To Shite No Jiko (Self as Relationship),* Misuzu Shobo, 2005. In Japanese.

[12] Maruhashi, Y., Muhen No Kanata He − Ishii Seishi Wo Yomu (Beyond the infinite − Reading Seishi Ishii), *UH CNAS, RINCPC Bulletin* 14: 5-8, 2001. In Japanese.

[13] Ishii, S., Religious death and medical death – for radical experience of death, *Ann. Japan. Association for Philosophical and Ethical Researches of Medicine* 17: 1-10, 1999. In Japanese.

[14] Ishii, S., History of the ill person, *Annals of the Japanese Association for Philosophical and Ethical Researches of Medicine* 19: 83-98, 2001. In Japanese.

[15] Ishii, S., [Third report] Current state of caregiving and issues, *Annals of the Japanese Association for Philosophical and Ethical Researches of Medicine* 21: 209-221, 2003. In Japanese.

[16] Maruhashi, Y., Basic concepts of medical anthropology. A study of the origin of Viktor von Weizsäcker's medical ethics, *Annals of the Japanese Association for Philosophical and Ethical Researches of Medicine* 30: 40-51, 2012. In Japanese.

[17] Meinel, K., *Bewegungslehre (Theory of Movement),* Volk und Wissen volkseigener Verlag, 1960. In German.

[18] Kaneko, A.,, *The Handing Down of Waza (Art),* Meiwa Shuppan, 2002. In Japanese.

[19] Kaneko, A., *Movement Theory of Sports—Analysis of the Perception of the Body,* Meiwa Shuppan, 2009. In Japanese.

[20] Varela, F.J., Thompson, E., Rosch, E., *The Embodied Mind: Cognitive Science and Human Experience,* 6th ed. MIT Press, 1991.

[21] Nishida, K. *Active Intuition*. In: *Nishida Kitaro Zenshu (Complete Works of Kitaro Nishida)*, Iwanami Shoten, vol.8, pp.548, 1948. In Japanese.

[22] Ministry of Cultural Affairs, Mutual Affairs Division, Japan, *Religion Yearbook (2016 edition) Part 2 Religion Statistics,* p. 35, 2017. http://www.bunka.go.jp/tokei_hakusho_shuppan/hakusho_nenjihokokusho/shukyo_nenkan/pdf/h28nenkan.pdf (Accessed August 25, 2017)

[23] Husserl, E., *Die Krisis der Europäischen Wissenschaften und die Transzendentale Phänomenologie. Eine Einleitung in die Phänomenologische Philosophie,* 1936. Ed. Walter Biemel. *Husserliana* 6, Martinus Nijhoff, 1954. (Japanese translation by Hosoya, T., *Sekai No Meicho 62, Blentano・Husserl,* Chuokoron-sha, 1980) *The Crisis of European Sciences and Transcendental Phenomenology*: *An Introduction to Phenomenological Philosophy,* translated by Carr, D. and Evanston, IL., Northwestern University Press, 1970.

[24] Merleau-Ponty, M., *Le Philosophe et Son Ombre (The Philosopher and His Shadow),* Editions Gallimard, 1959. In French (Japanese translation by G. Kida and S. Takiura. Misuzu Shobo, 2001.)

[25] Washida, S., *Merleau-Ponty ― Kagyakuei (Reversibility)*, Kodansha, pp.230-232, 2003. In Japanese.

[26] Schmitz, H., Die Angst ― Atmosphäre und leibliches Befinden, *Zeitschrift für Klinische Psychologie und Psychotherapie* 21: 5-17, 1973. (The anxiety-atmosphere and corporeal sensation. *Journal of Clinical Psychology and Psychotherapy* 21: 5-17, 1973) In German. (Japanese translation by T. Ogawa. In: Ogawa, T. ed. *Phenomenology of Body and Emotion*. Sangyo-Tosyo, pp.95-122, 1986.)

[27] Schmitz, H., Über leibliche Kommunikation, *Zeitschrift für klinische Psychologie und Psychotherapie* 20: 4-32, 1972. (On Bodily Communication. *Journal of Clinical Psychology and Psychotherapy* 20: 4-32, 1972.) In German.

[28] Kajitani, S., Schmitz ―*Gensyogaku no Konpon Mondai – Shintai to Kanjou karano Shisaku* (*Basic Problems of Phenomenology by Schmitz. Thoughts from Body and Emotions*), Kyoto University Press (Kyotodaigaku-Syuppan-Kai), pp.264-275, 2002.

In Japanese.

[29] Fuchs, T., Wege aus dem Ego-Tunnel. Zur gegenwärtigen Bedeutung der Phänomenologie, *Deutsche Zeitschrift für Philosophie* 63: 801-823, 2015. (Ways Out of the Ego-tunnel. For current significance of phenomenology, *German Journal of Philosophy* 63: 801-823, 2015.) In German. (Japanese translation by Wada, M., Bunmei to Tetsugaku (Civilization and Philosophy) 9: 276-296, 2017.)

[30] Weizsäcker, V.v., Über Medizinische Anthropologie (*On Medical Anthropology),* 1927, *Viktor von Weizsäcker Gesammelte Schriften (Collected Works of Viktor von Weizsäcker)* 5: 189, 1987. In German.

[31] Weizsäcker, V.v., *Gestaltkreis − Theorie der Einheit der Wahrnehmen und Bewegen,* 5. unveränderte Aufl. (*Gestaltkreis (circle of form, formative cycle) − Theory on the Unity of Perception and Movement,* 5th edition), Georg Thieme Verlag, pp.182-187, 1986. In German. (Japanese translation of the 4th edition by Kimura, B. and Hamanaka, T. Misuzu Shobo, pp.290-296, 1975.)

[32] Ibid., p.5. (Japanese translation pp.3-4)

[33] Ibid., pp.170-171. (Japanese translation pp.273-275)

## Endnotes

1 A major portion of this paper was previously published as "Living with Cancer" by Makoto Wada in *Between Life and Death—Aspects of Clinical Philosophy* edited by Kimura, B. and Noe, K., pp 154-170, 2017 (in Japanese).

2 In designated cancer hospitals in Japan, it is currently required that psychiatrists provide psychiatric and psychological support to suffering patients and families. They are expected to provide support not only on psychiatric matters in a narrow sense, but also on psychological and existential matters in a broader context.

3 In Japan, the relative survival rate of people who survive 5 years after a diagnosis of cancer (compared to the percentage of overall Japanese who survive 5 years. i.e., reduced 5-year survival in those diagnosed with cancer) is 59.1% in men and 66.0% in women.

(Cancer regardless of site.) (Cases diagnosed between 2006 and 2008.) The lifetime risk of developing cancer (the risk of someone developing cancer during their lifetime) is 63% in men and 47% in women. (Based on data from 2012) [1]

4 Bin Kimura has also written how this structure resembles a musical ensemble. He has taken it even further, delving into the intersubjective noesis-noema correlation and the intersubjective "Aida"(between-ness).[2]

5 The fundamental importance of "listening" during a musical performance is not based merely on my own limited experience. Many famous performers have spoken of it, too many to list in full here. For example, Japanese cellist and music educator Hideo Saito, Japanese conductor Seiji Ozawa, Hungarian singer Julia Hamari, American jazz pianist Herbie Hancock, and American jazz organist Lonnie Smith, to name just a few.

6 Weizsäcker believes that the subject is established at the interface between the living being and the environment.[3]

7 In Weizsäcker's Gestaltkreis, this refers to crisis (*Krise* in German) and mutual occlusion.[3] [4]

8 In the field of motion theory in sports (movement theory of sports), Meinel of Germany used Weizsäcker to explain the importance of sensation in movement.[17] In Japan, Akitomo Kaneko was inspired by Meinel to look at the importance of perception, and he developed the movement theory of sports that emphasizes the unity of movement and perception. Kaneko introduced phenomenology at that time to provide the foundation for this movement theory of sports. [18] [19]

9 As Weizsäcker said, there is an interaction, a unity, between the subject and environment, behavior and perception, activity and passivity where the perspective of intentional cognition that was later further developed by Varella et al. whereby cognition is considered an embodied act, namely, enactivism, and extrapolates to embodied cognitive science.[20]

10 The quotation from Nishida is translated from Japanese into English by Prof. Michiko Yusa at Western Washington University.

11 Since the Meiji era (1868-1912), medicine in Japan has remained clearly distinct from religion. Religious activity is only allowed to play a direct role in medicine in a very limited number of medical facilities with religious affiliations. At most medical facilities in Japan, it is very rare that patients and families receive support from someone with a religious background. Even if the matter comes up in discussion, very rarely will patients reach out for this form of help. Not a few patients build a barrier, expressing resistance towards becoming actively involved in religion. Furthermore, as the cancer and symptoms progress, it becomes increasingly harder for a patient to reach out to pastoral care and supportive people with religious backgrounds because they lack both the emotional and physical energy to do so.

12 The majority of Japanese believe in either Buddhism or Shintoism.[22]

13 Publication of this research including the case presentation has been approved by the Ethics Committee of the Osaka International Cancer Institute: Approval No.1706089015, June 8th 2017.

14 This experience with interviews reminds me of a

similar personal experience from my college days. While I had been reading Edmund Husserl's *The Crisis of European Sciences and Transcendental Phenomenology*[23], I saw that the knowledge and theories accumulated and constructed by Western academia were threatened by a critique of its fundamental hypothesis, and then I suddenly felt as if the earth under my feet had crumbled and fallen.

15 Signs of Weizsäcker's influence can be seen in many parts of Blankenburg's papers, even in those cases where Weizsäcker had never actually addressed those issues.

16 Weizsäcker himself used the concept of "therapeutic Gestaltkreis" to describe how *the patient is integrated through subsumption of the physician* (*der Patient durch Umfassung des Arztes integriert werde*).

> <excerpt from Weizsäcker[30]> Some form of Gestaltkreis also exists in therapy. Discussed above is the hand of the therapist who tries to touch the patient. The person receiving therapy is the object in Gestaltkreis. Let us call it "therapeutic *Gestaltkreis*." *It encompasses the physician and the patient*. In other words, it is *a two*-person man (*ein zwei*samer Mensch), *a* person comprising two personalities (*ein* bipersoneller Mensch). *This* is the "wholeness" (Ganzheit) of the therapeutic process and *it* is supported by the basic underlying principle in medicine of treating the "patient as a whole" (des "ganzen Menschen"). In other words, a therapeutic Gestaltkreis is established between physician and patient. This does not mean that the patient as a whole becomes the object, but rather that the patient *is integrated through subsumption of the physician* (der Patient *durch Umfassung des Arztes integriert werde*. In German).

In the psychotherapeutic interview presented by the author, if we are to follow these discussions of Weizsäcker, a patient is integrated under the subsumption of the physician. To rephrase, it is through mutual subsumption of physician and patient that both are integrated. (The author referred to the interpretation of "mutual" subsumption by Prof. Yutaka Maruhashi, who organizes "PATHOSOPHIA", a study group on Viktor von Weizsäcker in Japan.) Phenomenologically, this acknowledgment by Weizsäcker is an issue that will require further study and elucidation in terms of intersubjectivity.