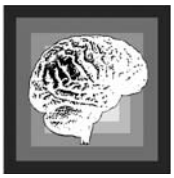

*History of Psychiatry*, 20(3): 360–376 Copyright © 2009 SAGE Publications
(Los Angeles, London, New Delhi, Singapore and Washington DC) www.sagepublications.com
[200909] DOI: 10.1177/0957154X08337278

# Some aspects of a medical anthropology: pathic existence and causality in Viktor von Weizsäcker

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*'Life is not only an "event" that happens – but also something that is suffered'; this is the core principle of what Viktor von Weizsäcker (1886–1957), the German physician and founder of a 'Medical Anthropology', called the 'pathic' dimension. The personal voice of the human being himself becomes a constitutive principle within the medium of science. Concepts of cause and effect are no longer applicable in the customary functional sense of aetiology. Even the intellect or spirit (*Geist*) can no longer be regarded as unscathed. In order to handle pathic 'causality' Weizsäcker introduced his 'pathic pentagram'. The interplay of five modalities – must / may / want / should / can – creates a ground or reason of psychological and/or somatic explanation. Necessity and freedom of a person appear interwoven in a constitutive manner.*

***Keywords**: causality; freedom;* Geist *(spirit); medical anthropology; pathic existence; Viktor von Weizsäcker*

Viktor von Weizsäcker, a medical doctor and a seminal thinker in what he called 'anthropological medicine', is not known to the same extent as, for instance, Karl Jaspers. So I will first give some details of his biography.[1] Weizsäcker was born on 21 April 1886 in Stuttgart, the son of Karl Weizsäcker who was then prime minister of the state of Württemberg in Bismarck's Germany.[2]

In 1904 Viktor began studies in medicine at Tübingen University, and then continued in Freiburg and in Berlin. He finished with the state examination in medicine at Heidelberg University and a dissertation on the question of the velocity of blood circulation in cases of anaemia. After seven years as an

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assistant under Ludolf von Krehl in Heidelberg – interrupted by research work with Johannes von Kries in Freiburg and with Archibald Vivian Hill (later a Nobel laureate) in Cambridge – he did his habilitation post-doctorate in internal medicine in 1917, with a thesis on the energetics of the cardiac muscle. In 1920 he became head of the Department of Neurology founded by Wilhelm Erb in the Clinic for Internal Medicine in Heidelberg. In 1941 he was appointed, as successor of Otfrid Foerster, to the most prestigious chair in Neurology in Germany at the University in Breslau. In 1945 the Heidelberg Medical School established a chair in General Clinical Medicine especially for him. In 1952, ill with Parkinson's, he requested early retirement.

After befriending Franz Rosenzweig in 1906, Weizsäcker had a lifelong and very intense interest and involvement with philosophy and theology, in addition to his training as a medical doctor and researcher. His studies under Wilhelm Windelband and Jonas Cohn, and encounters with Martin Buber, Hans Ehrenberg, Romano Guardini, Eugen Rosenstock and Max Scheler, among others, contributed significantly to the establishment of medical anthropology as Weizsäcker con-ceived it. His first explicitly programmatic publications on this subject were his 'Stücke einer medizinischen Anthropologie'. They appeared in 1926 and 1928 in the journal *Die Kreatur*, on which he served as a co-editor, with Martin Buber and Joseph Wittig (Weizsäcker, 1926 and 1928: 7–66).

Weizsäcker developed an early interest in Freudian psychoanalysis, which was decisive for a psychological and physical-organic understanding of human disease and the state of 'being ill'. He also observed with great interest the epistemological crisis in modern physics and contemporary existentialism. With these preconditions as a framework, even what is researched and taught from a purely natural-scientific and physiological perspective falls, in Weizsäcker's approach, under the revealing light of an engaged encounter with the living breathing human being. 'Whoever wants to investigate living creatures must take part in life' was his core principle.[3] Weizsäcker never tried to postulate some sort of immovable objectivity of living matter behind the personal and historically determined character of this standpoint.

He died in 1957 in Heidelberg. In 1994 the Viktor von Weizsäcker Society was established, and is now quite active.[4] None of his works seems to be available in English translation.

## The crisis of cause and effect

What does the concept 'causality' mean in such a conception of life? Or, to put it in a more concrete context: in what way do we have to think when we inquire into cause and effect in the interplay between falling sick and recovering health as a dynamic process? Initially, it is crucial to see the human being in his fundamental dual nature. On the one hand, he is a subject of knowledge and simultaneously an object of an objectifying functional analysis, such as in the established disciplines of physiology or psychology. On the other, the

human being is a person experiencing and suffering life. Weizsäcker's distinctive contribution is not that he discovered this duality of existence, since many did that before him, but that he seeks a bridging between the two aspects, and in such a fundamental way that sometimes it seems to be almost impossible to distinguish between them in the fusion. In so doing, Weizsäcker wishes to bring the personal voice of the researcher on life or the physician himself to the fore to be heard in the medium of science. *Inter alia*, this means that the distance between the persons involved, such as between the patient and therapist, must, despite its importance, be repeatedly charted and surveyed anew.

Here is a key difference when Weizsäcker is compared with Karl Jaspers. For Weizsäcker, 'to take part in life' means to extend into one's own self as doctor and researcher the dynamics of sickness and recovery as experienced in the other person. Professionally defined, scientific 'demands of Reason … necessitate him to the insight that you cannot speak truthfully about organism and life without stating that life is not *only* an "event" that happens – but also something that is suffered.' (Weizsäcker, 1950: 312–13).[5] In his view, a person can seek out the traces of truth only if he/she is ready to take the risk of an *experience of unity* that pushes forward to the very boundary of science and therapy. When this sort of approach is used, both science and therapy are always endangered, but only in order to prove the value of both from their 'ground' or foundation up. This 'ground' also encompasses what we are looking for here: it designates the locus to which the question of cause and effect must be addressed in order to expect an answer.

> The cause [*Ursache*] is not a thing [*Sache*] here. The German prefix 'Ur' before *this* thing fortunately comes to designate not only an action but also points toward a beginning. It meant origin … But biological genetics cannot dispense with this concept of an origin. (Weizsäcker, 1950: 314)[6]

Let us attempt to understand his conception better. Weizsäcker's empirical basis lies in numerous clinical observations, and most particularly in experiments on the physiology of sense perception. According to this – and I limit myself initially only to the clinical aspect – it is not possible to distinguish with accuracy, either in connection with illness or recovery, between those parts of something living which are in the process of falling ill or recovering, and those not affected by this.[7] This observation is fundamental and is not in conflict with the pragmatic insight that says, in many cases, that it is almost necessary and quite helpful to draw a borderline between parts affected and not affected. Thus, if you have a cold, as a rule you are satisfied with some treatment for the upper respiratory system, or if your bone is broken, with the fracture being set. You will not worry much about this becoming a disease affecting other parts of the body, or even your mental make-up and psyche. There is a similar pragmatism in operation when, say for reasons of insurance law, health is largely equated with a person's 'fitness', i.e., capacity to work; we tend to judge both sickness and restoration from the criterion of such 'fitness' for the job. That is

crucial for the capacity to work in general and in each special case. Experience confirms the correctness of this pragmatism. There is no doubt, for example, that reintegration back into everyday vocational life has the meaning of being well and healthy, especially in the case of the handicapped or mentally ill.

As long as this distinction between affected and non-affected parts is viewed as valid, one can also speak with the same right of cause and effect. Against the backdrop of the functional theory, which has become dominant in medicine over the course of the last 150 years, this means: what in a concrete individual case can be localized as the *source* of a dysfunction, in the context of a general biological functional analysis (say of the respiratory system, the limbs, socio-psychological make-up) will then be regarded as the *cause* of the illness. Correspondingly, if you remove this cause or eliminate its effect, you can with a certain justification expect the health of the patient to improve.

Yet the following has to be taken into account here: all these cases of a pragmatic distinction or drawing of a borderline between affected and non-affected, sick and healthy parts of the organism, are only medically meaningful because ultimately they have consequences for the physical and mental well-being of a human being *as a whole*. As a direct result of this, the drawing of a borderline relativizes itself implicitly, and leads back in turn to reflection on basic principles. It confirms, through its actual impact on the total picture – in a favourable case with good results – that in terms of the theory of principles, the boundary between sick and healthy, between parts that are recovering and other parts not recovering, must remain indeterminate, fuzzy.

As long as success continues, that may be regarded as unimportant. But on the other hand, there are numerous and statistically increasing difficulties with causal and functional aetiology and therapy of chronic as well as acute maladies. These are only two tips of an iceberg, so to speak. Here, to draw a line between healthy and sick parts contributes little that is helpful. It may even worsen the sickness considerably through its therapeutic consequences.[8] So drawing a pragmatic boundary is sometimes successful, sometimes harmful. In view of this, is it still possible to adhere to the notion of a critically testable unity of medicine? If one does not wish here to make the accident of success a principle, then one has to recognize a basic indeterminacy of the boundary between sickness and health, according it a place in the notion of the unity of medicine.

This doubtless will engender a very palpable sense of insecurity. In this instance, the concepts of cause and effect are no longer applicable in the customary functional sense; it becomes somewhat unclear whether they can be operationalized in clinical procedures of diagnosis and therapy at all. Because with a fundamental indeterminacy, the criterion and the measure (where quantitative distinctions play a role) doubtless threaten to be lost when it comes to a big question: where and how can we distinguish precisely between sick and healthy, and how this can be measured? Because criterion and scale of measurement can only be clearly determined, that is part of their

definition, as contrasted with a questionable variability. But even that is no longer valid for the central organ of human judgement in forming criteria and norms, the intellect or spirit, or in German, *Geist*. Where total well-being is in question, of course the *Geist* can no longer be regarded as unscathed. In order to single out and emphasize this problem, Weizsäcker raises once again the concept of 'mental illness', sickness of the *Geist*, and does so in a very fundamental way: the *Geist* is also in danger of falling ill, and not just in the case of the classic 'mental illnesses' (Weizsäcker, 2007: 125–8). Every sickness also affects *Geist*; but to what degree? In each single case, that question looms anew, and cannot be answered a priori. If we phrase it in connection with the crisis of cause and effect – *aitía* and symptom – it is something like this: if the power of human judgement itself is in doubt, then its ability to deal in a critically accountable way with cause and effect crumbles away. Discourse about cause and effect in general threatens to become meaningless.

## The 'contact' between function and pathic experiencing

Let us look at a concrete example: in the framework of a set of case studies of definite, not accidentally neurotic heart ailments, Weizsäcker wonders inter alia about the reason behind these maladies (and I also read the word 'reason', as I said, as 'cause'). His intention is to derive pathways to recovery through this discussion. In many cases, a physiological causal analysis can find no reason for the illness beyond the initial diagnostic findings. For that reason, Weizsäcker, supplementing physiology, looks in the personal history of suffering of the patient, i.e., in what he calls 'pathic experiencing', to find some reason. The question then is whether, after this supplement, a causal hypothesis (if expanded) can be formulated anew: is there then a new insight into *aitía* and symptom, diagnostically and therapeutically capable of being operationalized – one which does justice both to pathic experiencing and to the physiological diagnostic findings? This is a precarious demand in terms of the logic of knowledge, because neither physiology nor conscious experiencing and narration by the patient are adequate authorities in this case. Why? Because even in the 'consciousness of the patient', the reason of the illness sought – the '*leading* element', as Weizsäcker says – is 'not given in accord with the nature of the crisis'; and above all else: it 'cannot be a given'. He continues: 'But favourable circumstances can bring it to the fore, and *in contact with symptom* and with consciousness.' (Weizsäcker, 1932: 113; see also Creuz, 1999: 51).

We have arrived at a key concept in his thinking, namely 'contact'. The 'contact' between a 'leading element' and 'symptom and consciousness' is what is supposed to facilitate a correct correlation between pathic experiencing and the functional hypothesis. He mentions the fact that, independent of the state of consciousness and epistemological disposition of both the patient and the therapist, there are observable bridges between the reason and the phenomenon, between *aitía* and symptom. Even more: the 'contact' signifies the

pathically and ontologically fundamental establishing of this fact itself. He thus instals here nothing less than the general possibility of being able to judge about cause and effect in an expanded form. According to Weizsäcker, life as a whole appears as a consequence of such 'contact' events, as a continuously prolonged interaction (*Umgang*) between functional and pathic elements.

Let us pause for a minute. We cannot deny that Weizsäcker's reports about 'favourable circumstances' which give rise to such 'contacts' are based on long years of clinical experience. But at least as a first step, to think about this experience in a strict manner demands critical distance: are we not dealing here with a sort of mystification, in the form of a rhetoric of unity or event which covers over and conceals the aporia of a tension that cannot be illuminated? Is it not first necessary, before trusting such 'contact' experiences, that initially we take the two elements, the 'leading element' and 'symptom and consciousness', and look at each one separately, investigating its disposition for establishing contact? Weizsäcker gives a great deal of importance, maybe too much, to the 'favourable circumstances'. In contrast, critical reason cannot attribute much more to them than that they are the last small plus, the bit that only brings to completion what was basically present already. Only then, it would seem, if it is possible to draft the possibility of contact moving from the clarified pre-requisites for each of these, would it be permissible to agree with its subsequent realization – without suspicion of false pretence, insanity or hallucination.

But it is precisely that which has no success; it does not work. The sceptical criticism now founders on the rocks of an irresolvable ambiguity within the object itself. The elements in question, both the 'leading element' and 'symptom and consciousness', are in themselves ambiguous. In both, pathic experiencing and the functionally determinable element appear side by side, and yet remain impossible to combine. As far as the 'leading element' is concerned, Weizsäcker's personal tendency is to give more emphasis to pathic experiencing. The abundance of his examples for biographically 'pathic' aetiologies seems to indicate this. But it is clear: the 'pathic' hypothesis retains its epistemic value only as long as the competing hypothesis remains a real alternative, namely: that a pathic event is not 'leading' here, but rather a specific functional logic. The problem of the 'leading element' has, Janus-like, two faces. This remains valid in terms of the critique of knowledge, even if the dire need to find an answer forces us to take the risk of giving preference to one of the two views. It is and remains a risky venture because relegating one or the other motive to secondary status cannot be justified using means grounded on the logic of knowledge. Let us now take a look at the opposite side of 'symptom and consciousness'. Depending on which of the two interpretative motifs was given preference on the side of the 'leading element', the other one appears here as the opposite number, counterposed. The unavoidable ambiguity inherent in the 'leading element' returns here in a kind of mirror image. Either functionally determined sequences are considered a symptom (if a pathic experiencing was largely determined to be the 'leading' element), or passionate-pathic experiences are

considered a symptom (if functional mechanisms were largely determined to be the 'leading' element). Research on cause and effect cannot provide more than this groundwork for a decision that is always risky. A dispute between competing hypotheses remains.

Indeed, dispute seems to be the final word here, and it is impossible to avoid it. The provocative point of that lance of disagreement lies in the observation that ambiguity is itself a *fact*. It does not designate confusion or a logical error of interpretive reflection, but is a *factum brutum*. Medical anthropology only knows ambiguous life experiences. So the critical question bounces back all the more urgently: where is the justification to take a risk – based on this fragile fact? The answer appears to be pretty banal: the justification lies in the consequences of the effort. Justification is based on success in exactly what, seen with the means of the reflective power of judgement, could never arise except from a constitutively ambiguous ground, and repeatedly can so arise. This is a knowledge which grows during the personal duration of a human life: it is thus life experience, its fruit. Whoever has it knows: there has always been this ambiguity, and new contact events have always arisen from a decided one-sidedness in interpretation and action. So there is new hope that likewise in the current emergency, such a 'contact' will come to pass and take us further. Its basis of experience lies in the fact that the way into the present necessarily had to pass over a rocky road of numerous risks of a similar kind. In this way, the constitutive twilight of elements loses its destructive character. The logical impossibility to clarify can be accepted. The successes in contact justify the twilight of its sources.

The previous constellation of problem and solution is now reversed. The original genesis of the problem dealt with here, including the question of cause and effect, lay initially in the experience of our fragile life, oscillating between aspects not reconciled and opposed. This immediately present experience of suffering now always presupposes successful contact; the concrete experience of life over time also shows this. We thus stand before a hermeneutic circle. The very problem itself from which medical anthropology emerges is a retro-oriented construction, a memory consisting of elements of things that have already succeeded. The problem, and with it the insecurity in life, does not therefore hover in the air above an absolute lack of knowledge and experience, but rather stands on solid ground, and always has. However, this kind of memory, and that is one independent autonomous step in reflection, must be conceived as part of the problem. What is important is to be able to establish a relation to its ground by seeing what lies ahead. To know this 'ground relation' or 'basic relation' (*Grundverhältnis*), as Weizsäcker calls it, provides the basis for the sobriety of his anthropological discipline, which, given the two-faced character of the element, is otherwise hardly understandable. Where such a knowledge does not stand firmly in the background, all the descriptions of what is fragile and ambiguous have a tendency towards morbidity, enamoured of crisis.

## Coincidental correspondence

So contact events form the prerequisite for new contact events. One could regard that as a *petitio principii*, a presupposing of what is to be expected later as a result. In fact, the work of transformation is in basic terms precisely that. Within what has already been accomplished, in remembrance of its relation to the ambiguity presupposed to it, it digs up or excavates the reason or cause for new success that leads on further. To phrase it differently, more in terms of method: success that leads further is an interpretive commentary on what has already succeeded, looking to the future. In the formulation of the classical philologist August Böckh in the nineteenth century, it is knowledge of what has come to be known, *Erkenntnis des Erkannten*.[9] The genesis of the new 'contact' cannot be interpreted causally. It is not in a functional relation to the presupposed ground, but is the experience of an astounding and yet not unexpected change in the situation, and this is what stands behind Weizsäcker's 'favourable circumstances'. The ambiguities of the 'leading element' discovered in the ground and those of 'symptom and consciousness' become intermediate knowledge. That knowledge recedes into the background at the moment of success.[10] The contrary dispositions of knowledge that are bound together in strife now fall together. Indeed, one can say, thinking of the old formula of *coincidentia oppositorum*: they fall into each other, coincide. Their contrast thus disappears. The crisis of illness which was the motor of the problem, and its quest already bears it within as a negative impetus. 'Contact' brings it into visible being qua phenomenon in a positive way. In another connection, Weizsäcker called this contact phenomenon the 'mystics of incarnation', which brings life into visible being and manifestation (Weizsäcker, 1949: 299 ff.).

A pupil and colleague of Weizsäcker, Alfred Prinz Auersperg, coined the concept of 'coincidental correspondence' (Auersperg, 1954).[11] He took the decisive step in the 1930s, together with Helmut Sprockhoff and Harry Buhrmester Jr, through his Heidelberg experiments on the physiology of the senses (Auersperg and Buhrmester, 1936; Sack, 2005: 69–74). His focus was on dynamic forms in the relation between experienced perception and their physical correlate. For example, a subject looked at a square painted on a round disc. Then the disc was sent spinning, faster and faster. The gestalt figure which the subject *actually sees* goes through several phases of change as the disc accelerates. The original square is no longer seen as such. But again and again, after intermediary phases of indeterminacy experienced as a kind of crisis, there are finally clear perceptions of the gestalt, to an extent as the terminal phase figure, in a stable state, as a 'square with an inscribed cross' (Auersperg and Buhrmester, 1936: 279; Sack, 2005: 70).[12] So there are repeated 'contacts' between the physical spinning movement and the gestalt-shaping vision as perceived of the subject. The summary conclusion in the study published at the time was: 'Living happening and a physical sequence touch one another on a numerical temporal axis.' (Auersperg and Buhrmester, 1936: 300;

Sack, 2005: 72). This means: in the course of the chronometrically determined time, 'on a temporal numerical axis', contacts occur, termed 'coincidences'.[13] It is these 'coincidences' that point in retro to a correspondence of the two elements which touch each other here. Only this correspondence is specifically noted as such. In contrast, an explicit (meta)physical interpretation is avoided.

This latter attitude, the reticence vis-à-vis a metaphysical hypothesis, is of great importance. It too has a history that tells us much. Just how difficult it was to maintain this reserve in the face of a long tradition of metaphysical hypothesizing can be seen in a minor but characteristic circumstance. Auersperg and Buhrmester had not yet spoken in their 1936 essay about 'coincidental correspondence'. Rather, the term they used was 'coincidental parallelism' (Auersperg and Buhrmester, 1936: 300; Sack, 2005: 72);[14] and this is precisely where Weizsäcker targeted his criticism. As early as 1940, in the first edition of his *Der Gestaltkreis*, he writes that Auersperg 'recognized the danger of all "parallelistic" formulas, but the word has not disappeared yet from his terminology either' (see Weizsäcker, 1950: 293). It is important here that 'coincidence' is not prepared or its path paved by a psycho-physical or other type of parallelism. This means that the possibility is no longer available to link up with all those concepts of cause and effect that people had long associated with the hypothesis of psycho-physical parallelism.[15] It is impossible to name any kind of structured symmetry between body and soul, physiological function and pathic experience, or some other ontological foundation which eliminates the ambiguity of the elements lying at the base (ground) of the phenomenon. Auersperg and his colleagues were already guided by this insight in 1936, but some preparation time was needed until they finally, in 1954, came up with the critically precise designation in the term 'coincidental correspondence' (Auersperg, 1954). This did not change anything in terms of the thing itself. Weizsäcker had already linked up with and referenced this in 1940. In *Der Gestaltkreis*, he writes:

> Experience and objective stimulus [and we are allowed here, transposed to the context above, likewise to say 'symptom' and 'leading element' instead] enter into a series of coincidental correspondences. This series is not a 'parallel', but something like a double-linked chain. (Weizsäcker, 1950: 293)

Each link is a manifestation of that contact which generates 'favourable circumstances', as he noted in his 1932 work on the heart. The reality of life moves in 'coincidences'. The apt general formulation of Andreas Hanses (1999: 109) applies: 'Real is what becomes possible in the individual case.'

The historical *ur*-concept for this was found in the Greek '*kairos*' (see Auersperg, 1965: 26, title of ch. IV). This derives from the way, akin to the problem of diagnosis and therapy, that in 'kairos' 'propitious circumstances' also combine with the call to take action. In the words of Leopold Schmidt, a classical philologist: for the Greeks, the future was always 'uncertain'. And

for that reason, it was considered a 'great ingratitude to allow, in an attitude of indifference, those moments to pass in which the Gods clearly showed their benevolence', i.e. to fail to act in such moments. This is the wellspring for the great 'weight' accorded 'kairos': in kairos, 'the concepts emerged of favourable opportunity and the opportune moment, fused in an inseparable unity' (Schmidt, 1882, Vol. 2: 76). Consequently, for medical anthropology, it is important to conceive illness as a 'kairos'. Seen as a 'contact' event between function and pathics and at the same time as 'kairos', it constitutes the gateway leading into practice. In sickness, an active new shaping is being prepared; it is the 'offering of a knowledge of truth' (Weizsäcker, 1928: 65). No less, but also no more. Health is never something you 'have' or possess, it is '*only* present where it is created anew in every second of life' (Weizsäcker, 1930: 94).[16] Health is dynamic. This 'only' contains the call to seize the opportunity to make use of the 'contact', thus a claim to constant motility.

Against this backdrop, let us look once more at the question of cause in the clinical situation. Weizsäcker (1950: 297) introduces it in this way:

> It is pleasant when we can explain a paralysis by a rupture in the nerve path, a loss of weight by an increase in metabolism. But then we get these conditions and events where the process of life seems to break out of the prescribed trajectory of the chaining of cause and effect.

In the context of the reflections above, these are events in which the boundary between affected and unaffected part of some living ensemble fails: then it is no longer possible, guided by critically framed criteria and norms, to isolate the strand of a dynamic operative causality. Often, Weizsäcker continues,

> what happens is that the sequence of definite orders is interrupted more or less suddenly, when an extremely stormy event occurs. With or through this happening, we can see the genesis of a totally different picture, whose stable order once again then has the more transparent, explainable structure which permits a new causal analysis (p. 297).

But it is impossible to derive this new condition from the earlier one. 'For that, it would be necessary to explain the crisis precisely as a middle connecting ligament between the first and third condition, and that precisely is not possible'. In this connection, not all 'deficiencies and gaps … in the chain of causal explanation', which otherwise 'also exist in plenitude', are the problem. What is important are 'gaps of a particular kind. The patient himself namely is the one who gets the strongest impression of it. More than usual, he has the feeling of being overwhelmed, torn apart internally, being engaged in an incomprehensible jump' (p. 297). It is this unavoidable inclusion of what is pathic (unavoidable for the sake of medicine) that interrupts the correlation of cause and effect in principled terms. This is not true just for pathological cases but also holds for 'a bad nervous breakdown or dizziness, or change in consciousness, as in schizophrenia, poison or depression', and likewise for numerous phenomena

of a healthy, intensified feeling of vitality, for 'ecstasy', 'voluptuousness', 'rapture' (p. 297). Extremely instructive for Weizsäcker were:

> individual patients who appear to give information to a high degree on just what is happening in and with them in the crisis they are experiencing. These are persons who seem to have an enhanced inner perception which allows them to live and perceive the critical process, far beyond what is customary. Not only do they change – they also experience change as such.

Through an almost 'sensual perception of the structure of crisis', they translate eventfulness 'back … into the language of common graphic concreteness' (p. 297), *Anschaulichkeit* in German. Thus, for example, symbolically 'a certain spatial structure is experienced in a transformed way, which spatially and in terms of perception is no longer possible at all. That is the case, for example, when a patient has the fantasy that', as the transcript of a case study puts it, he 'must "straighten out" the kink in a curve "to make it a sphere"' (p. 298). Mathematically or mechanically, that would be:

> impossible without bending or lengthening other parts of the curve … The task only centred on the locus of the kink cannot be solved, it forces a transformation. Because a straight line would only return on itself in infinity in order to satisfy the demand of the sphere. Only after the figure were expanded into infinity or the imaginary, is it possible to bring it back to a perceptible magnitude, and into the realm of the perceivable, what is graphically concrete [*anschaulich*]. It must reverse, as it were, transformed in an infinity, it must upend itself in the transcendental, in order once again to appear. So the *compulsion for the impossible* which the patient experiences is the presentation of the critical condition. The crisis is a passage of the unstable finite plane, through a transcendence, to the constancy of a finite condition.[17] (p. 298; italics added)

The psychological and physical accompanying phenomena (side effects) are sometimes threatening: 'anxiety, fainting, catastrophes in motion, a storm of movement or paralysis, etc.'. This 'threat to the ego' shows:

> that the most essential thing about the crisis is not only the transition from one order to another, but the surrender of the continuity or identity of the subject. The subject is what is destroyed in the crack or tear, if transformation does not occur (p. 298).

## Narrative and pathic pentagram

So our initial question comes to a kind of head: how should we conceive such dramatic changes, so full of suffering and pain? Are there possibilities for causal therapy? A functional cause-effect relation seems impossible. And thus it would be mistaken to insinuate, possibly along philosophical lines, that the 'intellect [i.e., *Geist*] as mediator between object and subject now

comes onstage and solves all the problems' (Weizsäcker, 1950: 310). Rather, the *Geist* itself, as was shown, is affected by the crisis. There is 'no elevated spot that from the bird's eye view allows us to oversee the composition of all acts; we have to get ourselves entangled again and again in the movement of life, in order to comprehend even bits and fragments of it' (p. 311). What remains is the empirical evidence of the coincidental correspondence mentioned earlier, i.e., the knowledge that pathic experiencing and those functional-objectified circumstances, both of one's own body and the environment, meet in individual contacts. What does this portend for the question of cause and effect?

Initially, a precise knowledge of the physical elements of contact permits us to limit the spectrum of the forms, which appears almost unbounded from the pathic side, in a manner appropriate for the body and the environment. 'Anatomy and physiology describe as accurately as possible the conditions under which an external effect can have any influence whatsoever on the organs in a congruent form, and this alone entails a decisive selection and limitation' (p. 311).

Correspondingly, from the other side 'the self-locomotion [*Selbstbewegung*] of the organism must shape such movements which are in keeping with the conditions of the surrounding world. In this way, a successful act accommodating to these conditions is accomplished' (p. 311). But between the contact events lie the dizzying ruptures of the crisis. It is what 'leads on from one [contact] to the next'. How then does a 'continuity that prevails in and through the discontinuities' come about (p. 311)? The answer appears almost too simple: repetition, the further forming of contact that springs from previous contact events and spins on as life; the generally valid fact of coincidental correspondence itself is 'what constitutes continuity. Because where subject and object correspond one to the other in a kind of mirror imaging in their encounter, there the ego is safe and secure in its environment' (p. 312). The physical existence of the 'environment' which is counterposed to pathic experiencing, becomes here a supporting girder and source of security, indeed the basis of trust of pathic experiencing as such. In this way, what is pathic comes to participate in the continuity of being as recognizable in natural laws.

If then the ego can know that it is 'safe and secure in its environment' via the elements that can be objectified, then it is permissible to recognize the functionality of the cause-effect relation valid as a symbol, a heuristic compendium or guide for the interpretation of life movement (*Lebensbewegung*) as a whole. This relation cannot be more than a symbol or a heuristic compendium, because the performance of life encompasses the pathic aspect. The functional relation has no validity here. But the relation is also a symbol in a positive creative sense, since it suggests to the researcher the need to search for purely pathic contexts of motivation. It cannot be grasped functionally and objectively, but is grounded on knowable reasons. So the mode in which pathic 'causality' – or, better, pathic foundation – must be presented is necessarily different from function. It is the foundational narrative, and not only in relation to man, but

in biology more generally. Simply the 'so-called pure description of the building of a nest, an animal community', amounts in the end 'to a narrative … and thus to an event, happening' (p. 313). The foundational rules of narrative plausibility are valid. 'Biology is as a matter of fact genetic, or it is nothing. For that reason, life descriptions, biographies, even if more incomplete, are nonetheless more biological than biochemistry or biophysics' (p. 313).

We have arrived at the 'question of causes'. But that is not answered by postulating 'that what appears to be living stems from a process that lies behind it, mental or physical'. As quoted above, 'the cause, the *Ur*-thing [*Ursache*], is not a thing' (pp. 313–14). Pathic experiencing must be presented in a narrative which makes palpable what is real in its motives; that holds most especially for crisis. In the crisis, 'the pathic rises to the heights of an exclusive power' (p. 314). In terms of science, then, we are faced with the following question: are there generally valid narrative structures for the presentation and description of pathic causality? Weizsäcker answers with his theory of the so-called *pathic pentagram*. It postulates that the life of a human being is always at the intersection of five categories: what he must do, is permitted to do, wants to do, should do and can do; the five modalities are: must / may / want / should / can. 'As a living being …, I don't say "I am", but rather: I *would like*, I *want*, or I *can*, *must*, *may*, *should*. Or I don't want to, I mustn't do all this' (Weizsäcker, 1948: 48; cf. Weizsäcker, 2007: 70–97). If we explain human action, a life experience, an event, we narrate a concrete constellation of these categories and regard the event in question as their effect. A human being experiences or does something because a specially configured web of these power factors brought him to the point of that action. The constellation of pathic factors does not generate a function of *causa* and *effectus*, but does create a ground or reason of explanation.

## Freedom and necessity, 'ground relation' (*Grundverhältnis*)

We can make this clear in our own thinking using two categories: *want* and *must*. Their distinctive feature is their salience precisely for the humanly fundamental dialectics between freedom and necessity – a dialectics that is absent in functional relations. The introductory question is: from where does the decision spring that arises in every crisis? The first thing to note is that the path of decision becomes clear in temporal terms only *after* its realization. It cannot be convincingly predicted in the run-up to its becoming reality. Only 'because' in a concrete case *in the end* 'there was a decision for love or hate, was the former or latter the stronger' (Weizsäcker, 1950: 314). In epistemological terms, this means: 'In a genuine crisis, the decision creates itself, is beginning and origin. You cannot explain it. Rather, other things become explainable through it' (pp. 314–15). The second matter of note is that necessity and freedom appear interwoven in a constitutive manner in experiencing. The crisis-ridden decision is at the same time both a 'must' and a 'want', an obligation and a desire. To experience it as a 'must' entails the experience of necessity. To experience it

as a 'want' entails the experience of freedom.[18] In exact terms, it is *not* possible to say that here is a decision between free and necessary action 'dynamically, say by motivations or causal effects … Rather, only after the fact do we learn what wanting *was* actually successful, what sort of must prevailed' (p. 315).

If you wish to derive from this some insight into the origin of the decision, then it is necessary to note: only 'the pathic [itself] can be defined as the origin of desire and obligation, I want to and I must. It created the specific wanting and obligation' (p. 315). In Weizsäcker's view, this already holds for the general 'relations of arbitrary movement' as a whole, and likewise in connection with their obstruction, for example in a 'hysterical paralysis'.[19] If all that were available here was 'natural-scientific causality for an "objective" description … then it would be incorrect for that act.' It is limited:

> to *one* factor, namely that of causal necessity. But this is present in the biological act only to the extent that it is counterposed to freedom. Because, and we repeat, the origin of the act is *decision*, and that is tantamount to a struggle between necessity and freedom, between 'I must' and 'I want'. (p. 316)

But critical reflection pays another call. Isn't this a falling back on the deus ex machina of so-called 'decision' which cuts every Gordian knot? Ultimately the question addresses the difficult basic concept of Weizsäcker's theory of life, the so-called *Gestaltkreis*. It is intended to create an image for the biological act, but it would be mistaken to seek to interpret it directly in terms of imagery. He writes: 'Every biological act is conceived as a circle of Gestalt or configuration, not a link in a chain, not a number in a series, but compared with what went before a transformation, there "before" and here "after", *a revolutio*' (pp. 316–17). In contrast with physical movement, an expression of life is essentially self-movement: 'Life appears where something is moving [itself]' (p. 318). It is a 'spontaneous event. An infant appears, a life is snuffed out, a bird flies or dives down on some prey, a human being wakes up, falls sick.' The concept of origin is intended to respond to this spontaneity, played out in freedom and necessity. Weizsäcker notes: 'biology learns that what is living is always with a *determination whose ground cannot itself become an object*' (p. 318). Thus it is 'behaviour *towards* a ground that cannot be objectified. It is not, as in causality, a relation *between* things that can be known, such as cause and effect.' The 'ground relation' [*Grundverhältnis*]:

> is a power and can be experienced as dependence or freedom. Both can be experienced to the point where they are almost equal in their similarity, and that is why we try to designate this by an expression that encompasses both. However, we are at the boundary of the possibility of expression itself, since ex definitione no objectification is possible any longer. (pp. 318–19)

The theory used for presentation is then itself entangled in a crisis. Nonetheless, whatever can still be said against the suspicion of a deus ex machina

would have to draw its authority from the activity of humans (and doctors) proving themselves in everyday life, and not from some theory.

In closing, I would just like to take a brief look at the contour which Weizsäcker tries to give the 'ground relation' in this realm of practical everyday affairs. The experience of a 'law' or path of living is important here; on the one hand it has features that are generally valid and, on the other, it speaks to reality which is always determined by a situation as a special 'commandment'. This internal voice of a law becoming a concrete commandment has to be heard. He talks about this for the first time in one of his earlier essays entitled 'Case history' (Weizsäcker, 1928: esp. 60–3). In it he describes how a doctor and patient, together exploring the path of suffering which has brought the patient to the doctor, meet – but how they also miss each other, even in the encounter. He asks: 'How can they both educate themselves to maintain the actual case history, stay close to it constantly, return to it if they deviate?' (p. 60). Once again what is important is to recognize the 'leading element' in the mutual interpenetration of pathic and functional elements. This has its consequences in 'symptom and consciousness'.

Here 'neither an ethical postulate nor one of energetics can help' (p. 60). Sickness is not a concept of guilt, not some sort of ethical failure or messing things up, no defect in a physiological system. 'The first of the tasks to be solved is that something *real* must be described and made real in consciousness, not something forbidden' (p. 60). Nonetheless, there is a valid norm: finally what is 'real' proves to be what is commanded, and one has, so to speak, to track down, search out this commandment, this obligation, which as a norm also represents freedom. So this does not involve some anarchic principle or some sort of a breaking loose, either from the biological-physiological structure, or from the historical conditioning factors of human life. Nonetheless, the decision about the reality given to these forms is always open: 'We know that form and law can be both something forbidden and something commanded. It can involve its fulfilment but also its rupture' (p. 61). There is no theoretical anticipation possible here. What remains accessible to knowledge is the ground of trust of the way of decision itself. 'The capacity for knowledge is not hostile to the invisible forces of drive, impulse and urge, and the visible forces of the norms and laws. Rather, it is native: true intelligence wants the same thing' (p. 61). In the 'use of *this* intelligence' (p. 61), a power of judgement, which in the human experience of everyday life encompasses equally both what is pathic and what is functional, medicine retains its indispensable basis of humanity.

## Notes

1. See Rainer-M. E. Jacobi's biographical introduction to the brochure of the Suhrkamp Verlag (Frankfurt a.M.) for the volumes of Weizsäcker's *Gesammelte Schriften* (published autumn 2006).

2. The family name Weizsäcker is very well known in Germany. Viktor was the uncle of Richard von Weizsäcker, who was president of West Germany from 1984 to 1994, and of Carl Friedrich von Weizsäcker, the controversial nuclear physicist and philosopher. He was the brother of Ernst von Weizsäcker, a major diplomat in the Third Reich.
3. This is the first, and later much repeated, sentence in Viktor v. Weizsäcker's main methodological work *Der Gestaltkreis* (Weizsäcker, 1950: 83, 295, 303). He attempts here to describe the unity of movement and perception.
4. http://www.viktor-von-weizsaecker-gesellschaft.de/
5. Unless otherwise stated, italic words in translated quotes are as in the original.
6. At this point, Weizsäcker considers the concept of origin to be 'unfortunately drained, spent'. Presumably this refers especially to Heidegger, possibly also to Marburg's Neo-Kantianism. Nonetheless, he thinks it is impossible to manage without that concept.
7. To make a positive definition out of this negative formulation, such as that in every illness there are physical and mental elements at play and mutually interacting, would be the first step towards a psychosomatics. Weizsäcker was very reserved in his statements on this, even though he is often called one of the founding fathers of psychosomatic medicine.
8. See the detailed case studies in Weizsäcker, 1941, 1947, 1951: esp. Part I: 325–482.
9. This is also August Böckh's methodological definition of his discipline: classical philology was basically a 'knowledge of what has come to be known' (*Erkenntnis des Erkannten*); Böckh, 1886: 10.
10. See the theories of a 'relative nothing' in knowledge in the work of Hermann Cohen und Franz Rosenzweig.
11. The most generalized interpretation of this theorem is in Auersperg, 1965: 26–32.
12. Cf. similar consequences with respect to experiments, conducted by Paul Vogel, in Weizsäcker, 1933: 40 f.
13. An important alternative concept is 'coherence'; see Weizsäcker, 1933: 35 ff.
14. See Sack, 2005: 73 for references to Weizsäcker's reception of 'coincidental parallelism' (Weizsacker, 1950: esp. 291 ff.).
15. See the differentiated criticism by König, 1978: 208 and esp. 211–17.
16. Quoted a number of times in Lamprecht and Johnen, 1994; see, e.g., Uexküll, 1994: 32.
17. *ein Durchgang des unstetigen Endlichen durch eine Transzendenz zur Stetigkeit eines Endlichen.*
18. I leave aside for the moment the associated sceptical psychodynamic question as to whether and when one can in general want something, and further links of pathic categories.
19. Currently classified as 'dissociative stupor'.

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