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Divine Concealment and the Clinical Limits of Theodicy

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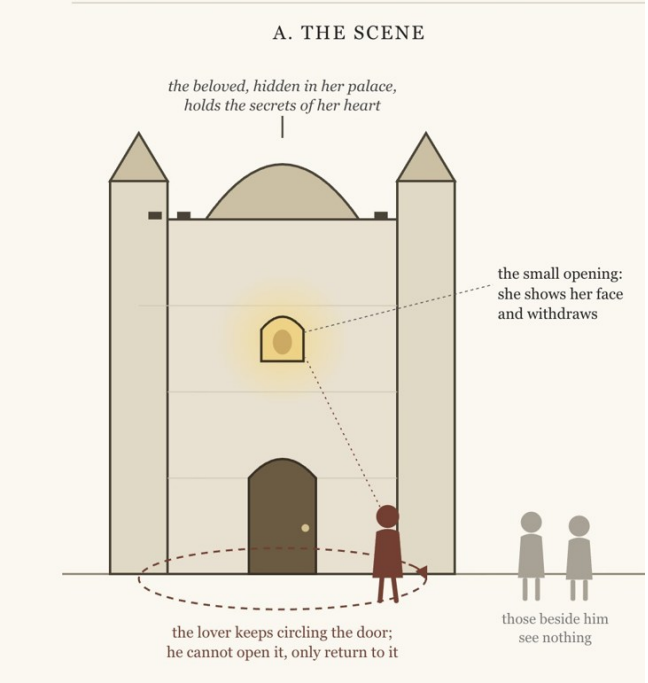
Abstract

Patients facing catastrophic illness often ask a question medicine cannot answer: not how this happened, but why it happened to them. Two familiar responses fail. The first resolves the question by supplying a providential meaning; the second abandons it by treating the question as outside clinical scope. This essay proposes a third posture, holding the resolution: the clinician neither supplies nor forecloses a final meaning, but keeps open the possibility that one exists while refusing any authority to declare it. The argument is developed through a close reading of the beloved-maiden parable in the Zohar's Sava de-Mishpatim (Zohar II 99a–b), read against a selected trajectory in the author's published clinical theology, from concealed presence toward anti-theodicy, irreducible antinomy, and faithful nonsurrender. Four features of the passage carry the argument. Disclosure belongs to the beloved and is never seized by the lover. Knowledge of the stranger's soul comes through one's own estrangement rather than penetration of the other. The old man refuses to close his discourse when his listeners declare themselves satisfied. Most important, the culmination of face-to-face disclosure returns the lover to the plain sense of the text, to which nothing may be added and from which nothing may be taken away. From these features the essay derives four bedside disciplines and a criterion, the peshat test: any meaning offered at the bedside must leave the patient's own words standing unaltered. The proposal does not suspend causal inquiry, treatment, or accountability for error, and it makes no empirical claim of efficacy. It offers a normative account of what a clinician may claim about the meaning of another person's suffering, and of what remains owed when that meaning is withheld.

Keywords: anti-theodicy, holding, Zohar, Sava de-Mishpatim, peshat, therapeutic presence, hermeneutic medicine, spiritual care, clinical ethics, unresolved tension.



Background: a question that exceeds the chart

A mother sits beside her daughter's bed after the second MRI. The tumor has grown through radiation. She has understood the explanation of the cell type, the location, and why surgery was never possible. Then she asks, not about the tumor, why God would do this to a child. The physician who answered the first set of questions competently is now facing a question of another kind. Mechanism, prognosis, and treatment belong to medicine. Justification does not.

Cassell's account of suffering as a threat to the integrity of the person explains why a technically complete account of disease can leave the central distress untouched [1]. Charon's narrative medicine and Kleinman's distinction between disease and illness direct clinicians toward the person whose illness must be heard and interpreted [2,3]. Neither, however, answers the question this essay addresses: what may a clinician say when a patient's request for meaning reaches the place where every available meaning would require someone's devastation to be justified?

Two responses are common and both fail. The first resolves the question. It offers a providential frame: everything happens for a reason, God has a plan, suffering refines. Such answers can console, and some patients seek them. When a clinician supplies them on a patient's behalf, however, they convert another person's catastrophe into a means toward an end the clinician has no standing to assert. Post-Holocaust Jewish thought named this move theodicy and refused it; Braiterman's term anti-theodicy describes the refusal to justify, explain, or accept the relation between God and catastrophe [4]. Levinas put the ethical stake more sharply: the justification of a neighbor's pain is the source of all immorality [5].

The second response abandons the question. It treats the patient's why as outside clinical scope, refers it to the chaplain, and returns to the treatment plan. This is often offered as humility. In practice it can leave the patient alone with the question at the moment it is asked, and it communicates that the physician's presence ends where explanation ends.

This essay proposes a third posture, which I call holding the resolution. The clinician neither supplies a final meaning nor declares that none exists. The possibility of meaning is kept open, but held in reserve: not the clinician's to disclose, not the clinician's to deny, and never required of the patient as a condition of care. The difference between holding and resolving is not merely one of tact. It is a claim about who has authority over the meaning of suffering, and about what that authority leaves standing.

The argument is developed through a single text. In the photographed page of the Zohar that prompt-

ed this essay (Zohar II 99a, from the Sava deMishpatim, the discourse of the old man), Torah is imagined as a beloved woman hidden in a palace who discloses herself in stages to a lover who will not stop circling her door [6]. The parable is about the interpretation of Scripture, not about illness. Its clinical use is an appropriation, and that change of register must remain visible throughout. Yet the passage contains, with unusual precision, the structure this essay needs. A resolution exists in the parable. It is promised. And it is held, by the beloved, in a way that does not let the lover take it. When it finally comes, it does not replace the text it illuminates. As Wolfson has shown in his study of peshat and sod in Zoharic hermeneutics, the culmination of secret disclosure in this passage returns the reader to the plain sense [7]. That return supplies the essay's central criterion.

Method, terms, and the trajectory of a corpus

This is a conceptual and hermeneutic essay. It is not a systematic review and makes no empirical claim about the efficacy of spiritual care. It proceeds in three steps: a purposive rereading of selected publications in my clinical theology, to locate the problem this essay inherits; a close reading of one Zoharic passage, attending to details that general discussions of the parable usually pass over; and a translation of those details into bedside disciplines, tested against composite clinical vignettes and against objections. The clinical vignettes are composites; no identifiable patient is described.

Holding is not the same as not knowing

Several established concepts lie near the one proposed here, and the distinctions matter. Keats's negative capability, the capacity to remain in uncertainty and doubt without irritably reaching after fact and reason, names a disposition toward the unknown [8]. Bion's counsel that the analyst approach each session without memory or desire names a discipline of attention [9].

Boss's ambiguous loss describes grief that cannot resolve because the loss itself remains unclear, and argues that the clinical task is to tolerate the ambiguity rather than force closure [10]. Winnicott's holding environment describes the reliable presence within which an infant, and later a patient, can bear what cannot yet be integrated [11].

Each of these concerns the clinician's relation to uncertainty. Holding the resolution adds two claims they do not make. The first is a claim about location: whatever resolution exists is not the clinician's possession. It is held elsewhere, by the patient as author of their own life and, for patients who speak theologically, by God. The second is a claim about form: a genuine resolution, if it comes, leaves the patient's plain account intact rather than replacing it with a deeper story. Table 1 sets the three postures side by side.

Table 1. Three postures toward the patient's question of meaning

	Resolving	Abandoning	Holding the resolution
What the clinician says about meaning	Supplies one (plan, test, reason)	Declares it outside scope	Neither supplies nor denies it
Where meaning is located	In the clinician's framework	Nowhere in the encounter	With the patient, and for believers with God; not with the clinician
What happens to the patient's words	Reinterpreted into the framework	Left unanswered	Received and returned unaltered
Typical failure	Imposed theodicy; protest pathologized	Isolation at the moment of asking	Drift into vagueness or mere technique
Status of continued care	Implicitly tied to acceptance	Unchanged but disconnected	Explicitly unconditional

The trajectory the essay inherits

The selection that follows traces changes in my own treatment of divine concealment. The developmental account is interpretive; earlier papers do not all state the later position, and a sequence of publications is not evidence of clinical effect.

In Primordial Silence and Therapeutic Presence, the Talmudic scene of Moses seeing Rabbi Akiva's martyrdom serves as a model for the coexistence of interpretive access and divine opacity [12]. The paper draws therapeutic consequences from the failure of an answer to catastrophe. Yet its theological language also associates concealment with primordial divine intention, and treats absence and presence as participating in a structure that enables healing. The Dialectical Divine makes the constructive ambition explicit by locating suffering within divine presence-in-concealment and linking that framework to therapeutic transformation [13]. Divine Suffering, the Hermeneutics of Reading and the Clinical Encounter, written with Wolfson's Lurianic analysis and the Netziv's reading of Exodus 33, insists that the integration does not resolve the question of suffering but turns it into a practice; it nonetheless describes the clinical encounter as a theophany [14].

These papers bequeath a tension. If silence is already read as a mode of presence, theology may have resolved the absence whose force it first acknowledged. A cosmology that makes room for suffering can become a justification of suffering once it is translated into a claim about a particular patient.

The later work sharpens the problem. Neither Object Nor Abyss stages the encounter between an addressable God and mystical depth [15]. The Wound as Altar prohibits explaining the Shoah through its victims' failings or redeeming it through a larger story [16]. Neither Answered Nor Absorbed revisits and partly recants an earlier reconciliation of personal address and impersonal infinity, arguing that the honest posture is to inhabit an antinomy that cannot be closed [17]. The Heart Cannot Reach the Spring concedes that apophatic restraint alone cannot generate an obligation to preserve the finite person, and supplies a normative premise: a person must not be made expendable to an explanatory system [18]. The Third Grammar gathers these into three rules: detachability of practice from doctrine, unsynthesized antinomy, and the indexical rather than predicative use of the divine name [19]. When Surrender Fails defines faithful nonsurrender, in which omnipotence is relinquished, assent is withheld, and address is kept, and argues that what cannot be performed on demand cannot be prescribed [20].

Alongside these, several papers bear directly on holding. The Sacred Epistemology of Not-Knowing defends uncertainty as a form of clinical integrity [21]. Illness as the Demonic II argues against explanations whose real function is to relieve the explainer of responsibility [22]. Blackstar, Withdrawal, and the Refusal of Consolation takes up the refusal of consolation as a stance to be understood rather than corrected [23]. A Remedy Travels Alone develops the detachability test on which the clinical portion of this essay depends: a practice may be offered only if it can travel without the doctrine that would make the suffering necessary [24].

What these papers have not yet supplied is a positive account of the thing they protect. They specify what the clinician must not claim. They say less

about what remains in place of the claim. The Zoharic passage offers a candidate: a resolution that is real, promised, and held in a way that forbids seizure.

The text: Zohar II 99a–b

The Sava de-Mishpatim is a long narrative unit of the Zohar on the portion Mishpatim. Two companions meet an old donkey driver on the road who turns out to be a master, and who expounds the laws of the Hebrew slave as a doctrine of the soul [6]. The page photographed for this essay begins middiscussion and contains, in sequence, a teaching on the stranger's soul, a brief image of Moses entering the cloud, the companions' tearful response, the old man's refusal to stop, and the opening of the parable of the beloved. Its continuation on 99b completes the parable. A working translation of the photographed page is given in the Appendix. Figure 1 summarizes the parable and its stages.

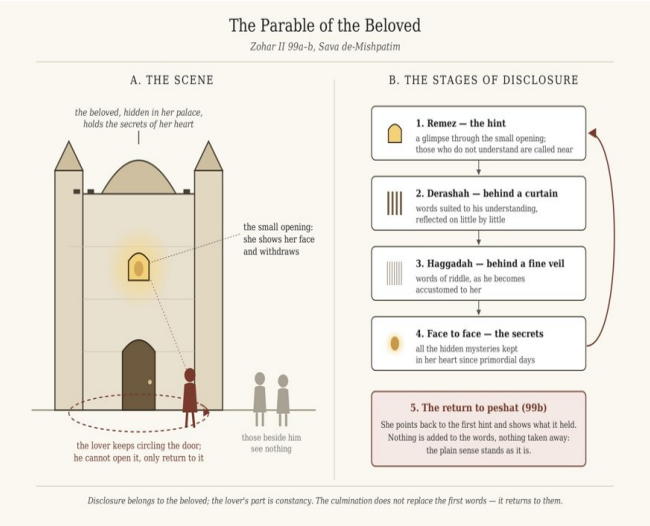


Figure 1. The parable of the beloved (Zohar II 99a–b).

A. the beloved shows her face at a small opening while the lover circles the door; those beside him see nothing.
B. the four stages of disclosure and the return to the plain sense on 99b. Original illustration by the author.

The parable has received sustained scholarly attention. Scholem read it as an early statement of the layered meaning of Torah that later tradition systematized [25]. Halbertal placed it within the history of Jewish esotericism, where concealment both protects a teaching and intensifies desire for it [26]. Wolfson's study of peshat and sod in Zoharic hermeneutics, which takes its title from the riddle of a beautiful maiden without eyes with which the old man's discourse opens, argues that in this literature the secret does not lie behind the literal sense as a second meaning, but is the literal sense itself, seen from within [7]. My clinical reading depends on that observation, though the clinical use is my own and should not be attributed to him.

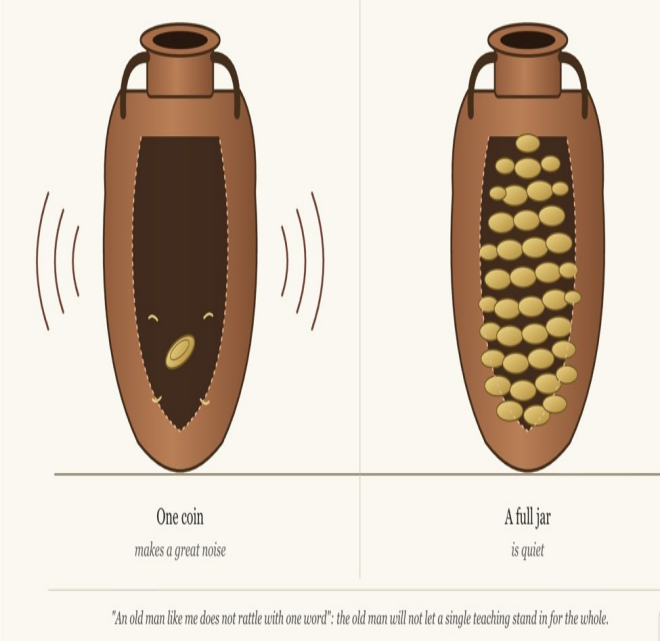
What follows attends to four features of the passage that are easy to pass over when the parable is quoted on its own.

The stranger's soul: knowledge through estrangement

The page opens with a verse that "emerges from its sheath" and immediately re-clothes itself. Exodus 23:9 reads: "You know the soul of the stranger, for you were strangers in the land of Egypt." In the Zohar's reading, the first clause shows itself and the second clause covers it at once, so that no one notices what has appeared. The old man then distinguishes two souls. The holy soul knows the matters of the higher world. The stranger's soul knows the matters of this world. And the holy soul comes to know this world only through the stranger's soul.

Two things in this short teaching bear on the clinic. The first is the source of knowledge. The verse does not say that one knows the stranger's soul by

studying the stranger. It grounds that knowledge in one's own estrangement: you know because you were strangers. Knowledge of another's suffering is not obtained by penetrating the other; it is borrowed, partially and provisionally, from one's own remembered exile. The second is the direction of learning. The higher soul learns this world through the lower. If one transposes this, carefully, into the clinical encounter, the direction is reversed from the usual one: theology learns about suffering from the sufferer, not the sufferer from theology.



The companions weep, and the old man will not stop

After a compressed teaching on Moses entering the cloud, clothed in a garment given him by the rainbow, the companions fall before the old man and weep. Had they come into the world only to hear these words, they say, it would have been enough.

The old man does not accept their satisfaction. He tells them he did not begin for this alone, and that an old man like him does not rattle with a single word. The idiom recalls the Talmudic proverb that a single coin in a jar makes a great noise (Bava Metzia 85b) [27]: one word, alone, is noise rather than teaching.

This small exchange is the first act of holding on the page. The companions have received something real and declare it sufficient. Their dayeinu is sincere. It is also premature. The teacher declines the closure his listeners offer, not because what they received was false, but because stopping there would make a fragment stand in for the whole. Clinicians meet this moment constantly, on both sides. A patient seizes on a first consoling word and asks to rest there; a clinician, relieved to have said something that helped, is tempted to rest there too. The old man shows a third possibility: to honor what has been received while refusing to let it close the account.

The beloved who discloses

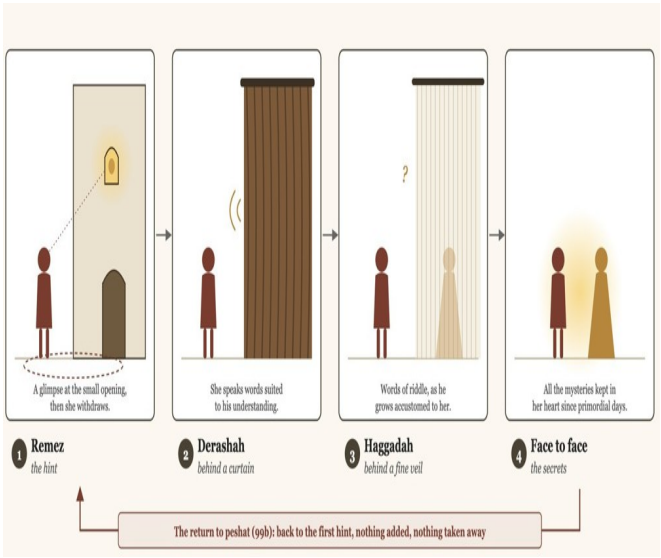
The parable proper begins with an observation that frames everything after it.

Torah calls to people every day in love, and they do not turn their heads. When a word of Torah shows itself and withdraws, it does so only for those who know and recognize it.

A beautiful woman is hidden in a palace. She has one lover, known only to her. Out of love he passes her door continually and looks in every direction. She opens a small opening, shows her face, and withdraws. No one with him sees it. He alone does, and his inner being, heart, and soul go out after her.

Three features of this scene carry the clinical argument. First, the initiative is hers. The lover's only act is constancy: he keeps circling the door. He cannot open it, demand it, or earn a particular disclosure. Second, the disclosure is singular. Those standing beside the lover see nothing. What is shown to one person is not public evidence and cannot be generalized. Third, the disclosure is par-

tial and withdrawn. She shows her face and conceals herself again. The glimpse does not become a possession.



Four stages and the return to the plain sense

The parable then describes a progression. At first Torah gives a hint. If the person understands, well. If not, she sends for him and calls him simple (Proverbs 9:4), and speaks with him from behind a curtain in words suited to his understanding; this is derashah. Then she speaks from behind a fine veil, in riddles; this is haggadah. Then, when he has become familiar with her, she reveals herself face to face and tells him all the hidden secrets kept in her heart since primordial days [6].

If the parable ended there, it would be a narrative of ascent from surface to depth, and a clinical reading would be tempted to model the encounter as the progressive uncovering of a hidden meaning in the patient's suffering. The continuation on 99b prevents that reading. When the lover has received everything, the beloved points back to the first hint she gave him and shows him what secrets were in it. Then he sees that nothing may be added to those words and nothing taken from them. Then the plain sense of the verse stands as it is, without a single letter added or removed [6,7].

This is the decisive turn. The culmination of intimacy does not replace the text with a deeper text. It returns the lover to the words he began with, now seen fully, and forbids any alteration of them. The secret was not elsewhere. It was in the hint, and the hint remains exactly what it was. Wolfson's reading makes this the hermeneutic center of the passage: sod does not abolish peshat; it consummates it [7]. My earlier readings of the patient as parable attended to the mashal's power to carry meaning into the clinical encounter [28,29]. This passage adds a constraint on that power: the deepest reading must leave the first words standing.

What the parable does not license

Three restrictions follow before any clinical use is made of the passage.

The first concerns intention. In the parable, concealment serves to awaken love. Transferred directly into theodicy, this would make catastrophic illness a divine strategy for intensifying devotion. That transfer must be refused. An image can inform an ethic without every element of its plot becoming a claim about providence.

The second concerns promise. The lover is promised face-to-face disclosure. A scriptural account of growing intimacy with a text cannot guarantee that a parent will understand a child's death. The parable's promise will therefore not be borrowed as a promise to patients. What will be borrowed is narrower: the structure by which a resolution, if there is one, is held by another and does not displace the plain account.

The third concerns eros. The passage is frankly erotic, and Wolfson's broader work shows how deeply Kabbalistic hermeneutics is bound to the

erotic imagination [30]. The clinical relationship is not a courtship, and the imagery must not become a model of professional intimacy or of pursuing disclosure for its own sake. I have elsewhere considered the place of delight in healing without collapsing it into desire [31]. Here the useful feature of the image is receptivity to an opening, bounded by consent.

Holding versus resolving

Three senses of holding

The phrase holding the resolution is meant in three senses at once, and each corresponds to a feature of the passage.

To hold is first to hold back: to keep in reserve. The beloved holds her secrets in her heart "since primordial days" and discloses them on her own terms. A resolution held back is not denied. It is simply not spent.

To hold is second to be held by another. The lover does not possess the secrets; she does. In the clinic, whatever meaning a person's suffering may come to have belongs first to that person, and, for those who speak theologically, to God. It does not belong to the clinician, whose professional authority extends to diagnosis and treatment but not to the significance of another's devastation.

To hold is third to sustain: to keep a question alive without dropping it or closing it. This is the sense Winnicott gave to holding [11]. The lover keeps circling the door. The clinician keeps returning to the bedside. What is sustained is not an answer but the relationship within which a question can go on being asked.

Holding in these three senses differs from hiding. The clinician who holds the resolution conceals nothing they know. They decline to claim what they do not know, and they decline to claim it even when they believe something about it privately.

The peshat test

The return to the plain sense on 99b supplies a criterion that the earlier trajectory of my work lacked. I will call it the peshat test:

- Any meaning offered at the bedside must leave the patient's own words standing. Nothing may be added to them and nothing taken away.

The test is easiest to see in its violations. A patient says: I am furious with God. One response adds: Your anger shows how much you still love Him. Another subtracts: I don't think you're really angry; I think you're frightened. Each may be sincere, and either may contain some truth. Both alter the plain sense. The first converts protest into devotion; the second dissolves protest into a symptom. In both cases the clinician has supplied a deeper text and allowed it to displace the one the patient spoke.

A response that passes the test returns the words: You are furious with God. It may go further, by asking what the anger is like, what it wants, whether it has been allowed to be said elsewhere. But each further step is a way of seeing the patient's sentence more fully, not of replacing it. This is what the beloved does on 99b: she shows the lover what was already in the first hint, and the hint remains as it was.

The peshat test cuts in both directions, and this matters. It forbids subtracting from redemptive testimony as firmly as it forbids adding redemption to protest. A woman with advanced ALS says that her

illness has brought her closer to God than she has ever been. A clinician committed to anti-theodicy may be tempted to hear this as denial, or as a coping strategy to be gently questioned. That too alters the plain sense. Her words stand. What the test forbids is not meaning; it forbids the clinician's meaning overwriting the patient's.

The test also clarifies a theme in my recent work on the difference between the archived text and the text that is worn and bloodied in use [32], and on the patient's two accounts in Life of Pi, where the question "which story do you prefer?" does not license erasing the other story [33]. Frank's typology of illness narratives makes the same point from another discipline. The chaos narrative, told by a person for whom no plot is available, cannot be heard by a listener who insists on converting it into restitution or quest; it must be witnessed as told [34]. Hermeneutic medicine has often described the patient as a sacred text [35]. The Zohar adds the scribal rule that governs sacred texts: no letter added, no letter removed.

Knowledge through estrangement

The opening of the enclosed text grounds knowledge of the stranger in one's own having been a stranger. This constrains clinical empathy in a useful way. The clinician does not know the patient's suffering by penetrating it. They know something adjacent to it, borrowed from their own experiences of exile, loss, and fear. That borrowed knowledge is real and permits solidarity. It does not permit mastery. A clinician who says I know what you are going through has usually forgotten the second clause of the verse, which reminds the knower where their knowledge came from and how partial it is.

The teaching about the two souls points in the same direction. The holy soul learns this world through the stranger's soul. Transposed to the clinic, theology must learn suffering from the sufferer. When a theological framework, however profound, arrives at the bedside already knowing what the patient's suffering means, the direction of learning has been reversed.

Holding the resolution keeps it running the right way.

Declining the dayeinu

The old man's refusal to stop at one word supplies the temporal dimension of holding. A resolution held is a resolution not closed prematurely, including when the patient asks for closure.

This needs care. Patients are entitled to consolation, and a clinician who withholds every comforting word in the name of rigor has confused discipline with coldness. The point is narrower. A first consoling meaning, whether the patient's or the clinician's, may be honored as real without being made final. Meanings change. A person may speak of gratitude in March and of rage in June, and both

are the plain sense of their life in its moment. Holding means not letting the March sentence be entered as the verdict.

Greenberg's working principle for post-Holocaust theology, that no statement should be made that could not be made in the presence of burning children, functions here as a test of closure [36]. Many consoling sentences pass it in one moment and fail it in another. Holding the resolution keeps every such sentence provisional.

Epistemic and normative restraint

Two kinds of restraint must be kept distinct. Epistemic restraint says: I do not know why this happened. Normative restraint says: my not knowing does not give me permission to fill the gap with a story that makes this necessary. The first is a fact about the clinician's knowledge. The second is a rule about the clinician's speech. Neither settles the ultimate nature of providence, and holding the resolution requires both. A physician need not pronounce on whether a final divine understanding exists in order to decline to prescribe one. Levinas's judgment that the justification of a neighbor's pain is the source of immorality is a statement of normative, not merely epistemic, restraint [5].

Why holding is not a covert theodicy

An obvious objection follows. If the clinician keeps open the possibility of a resolution, are they not still promising, quietly, that the suffering will turn out to mean something? Is holding merely theodicy deferred?

The return to the plain sense answers this. Theodicy offers a resolution of a specific kind: a further fact, a purpose or plan or reward, that would make the suffering acceptable. That resolution adds to the text. It says: you were sick, and also it was for this. The resolution the Zohar imagines is of a different form. At the end of all disclosure, nothing has been added to the words. The lover does not learn a further fact that justifies the hint. He sees the hint fully.

Applied to suffering, a resolution of this form could not convert a catastrophe into a good. At most it would let the person's own account, including their protest, be seen completely and without alteration. Whether such seeing will ever be given, by God or by anyone, the clinician does not know and does not say. But even its promise, held in reserve, contains no justification. A resolution that cannot add a letter cannot add a reason. This is why holding the resolution is compatible with antitheodicy, and in fact completes it. Antitheodicy forbids the false resolution [4]. Holding describes what remains when the false resolution is forbidden: not emptiness, but an unspent possibility that, if it is ever spent, will leave the protest standing.

Job Rebuked by His Friends by William Blake, circa 1805, from his series of 21 illustrations of the Book of Job

Clinical translation

Why this belongs in the clinic

The question of meaning is not marginal to serious illness. Anger toward God is common among people facing bereavement and cancer, and has been associated with poorer adjustment [37]. Religious struggle in medically ill older adults has been associated with increased mortality over two years [38]. A systematic review in JAMA concluded that spirituality should be incorporated into the care of patients with serious illness [39], and consensus guidance for palliative care describes a generalist-specialist model in which every clinician attends to spiritual distress while chaplains provide specialist care [40]. The question is therefore not whether clinicians will meet the patient's why, but how they will stand when they do.

The disciplines below do not require the clinician to share the patient's faith, or any faith. They pass the detachability test: each can be practiced without the Zoharic theology from which it was derived, and none requires the suffering to be necessary [19,24].

Four disciplines

Table 2. Four disciplines of holding the resolution

Discipline	Source in the passage	At the bedside	Failure it guards against
1. Circle the door; do not open it	The lover's constancy; the initiative is the beloved's	Ask what the question is for before answering it	Answering a question the patient did not ask
2. Return the words	The return to peshat on 99b	Reflect the patient's own sentence back unaltered before going further	Adding redemption to protest, or subtracting meaning from testimony
3. Decline the premature *dayeinu*	The old man's refusal to stop at one word	Honor a consoling meaning without entering it as the verdict	Freezing a moment's meaning into a permanent one
4. Keep the hand offered	Berakhot 5b: "give me your hand"	Make continued care explicitly independent of acceptance or faith	Care that quietly depends on the patient being consolable

Circle the door. When a patient asks why God has allowed an illness, the question may carry several needs: a theological conversation, an acknowledgment of abandonment, information about cause, or reassurance that the clinician will not leave. The lover in the parable does not force the door; he keeps returning to it and looks. The first clinical act is similar: to ask, in some form, what would help most right now: to talk about God, to talk about what caused this, or just to have someone hear how unfair it is? Asking is not evasion. It allows the patient to open what they want opened.

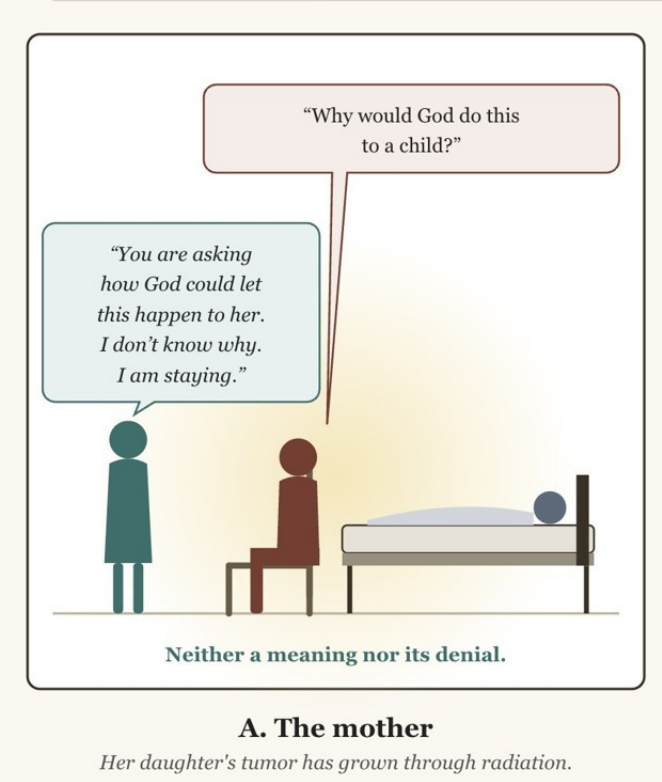
Return the words. Before interpreting, the clinician says back what was said, in the patient's own terms. You are furious with God. You feel that He has turned His face away. You believe this has brought you closer to Him. This simple act does more than demonstrate listening. It enacts the peshat test, and it gives the patient a chance to correct the record before anything is built on it.

Decline the premature dayeinu. When a patient, or the clinician, reaches a meaning that consoles, it can be received gratefully and held lightly. The clinician might say: That sounds like something real. If it changes, I want to hear that too. This keeps the door open for a different sentence tomorrow without discounting today's.

Keep the hand offered. In the Talmudic narratives of Berakhot 5b, a sage who is ill is asked whether his sufferings are dear to him. He answers that he wants neither them nor their reward, and the visitor says, give me your hand, and raises him [41]. The refusal of suffering's supposed benefit does not

end the relationship or disqualify the sufferer from help. The fourth discipline makes this explicit at the bedside: whatever the patient concludes about God or meaning, care will continue unchanged. Back, Arnold, and Tulsky describe the communicative task in serious illness as balancing honesty with empathy and hope [42]. Holding adds that hope may be offered but never required.

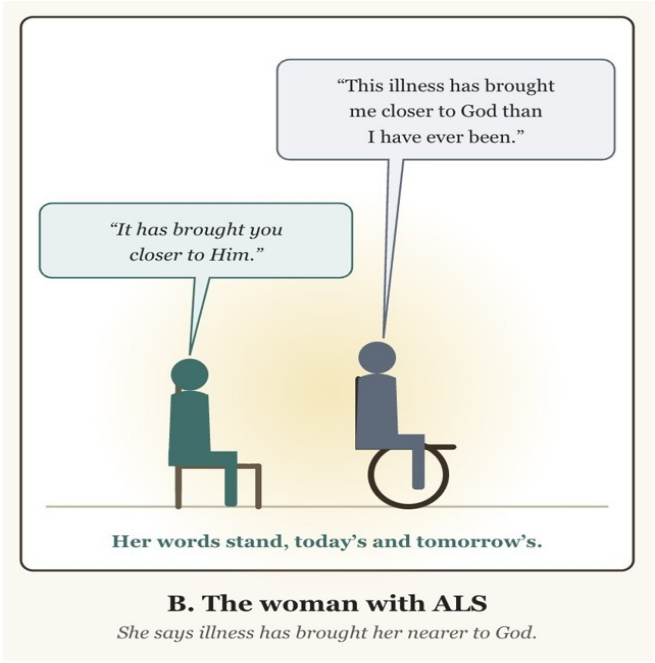
Three composite vignettes



A. The mother

Her daughter's tumor has grown through radiation.

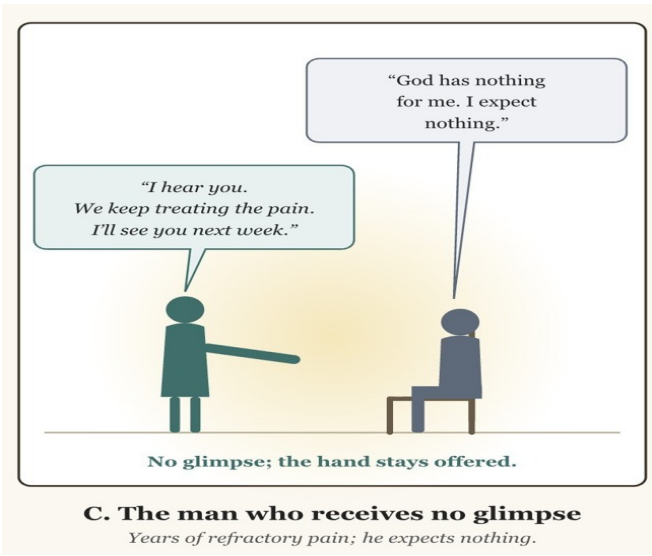
The mother. The mother from Section 1 asks why God would do this to a child. A resolving response says that God has a plan, or that her daughter is a special soul. An abandoning response says that this is a question for the chaplain. A holding response begins by asking what she needs, then returns her words: You are asking how God could let this happen to her. If she wants to talk about God, the clinician may say honestly that they do not know why, and that they will not pretend to, and that they are staying. If she wants the chaplain, the referral is made as an addition to the clinician's presence, not as a handoff. The clinician does not say that her daughter's illness has a meaning. Nor do they say that it has none.



B. The woman with ALS

She says illness has brought her nearer to God.

The woman with ALS. She tells the team that her illness has given her a nearness to God she never had in health. A resident later comments that this sounds like denial. The peshat test applies to the resident. Her words stand. The team may explore what this nearness is like for her, and may watch for distress that her testimony does not express. But they do not subtract from what she has said, and they do not generalize it into a lesson about what illness is for. If, weeks later, she says she feels abandoned, that sentence also stands. The disciplines do not choose between her sentences.



C. The man who receives no glimpse

Years of refractory pain; he expects nothing.

The man who receives no glimpse. A man with refractory neuropathic pain after spinal cord injury has prayed for years. He says that God has nothing for him and that he no longer expects anything. He is not seeking consolation and does not want a conversation about faith. Here the parable's limits are clearest. The lover in the story receives a glimpse; this man reports none. A reading that made disclosure the measure of devotion would judge him a failed lover. Faithful nonsurrender gives him a better description: he has relinquished control, withheld assent, and, by telling his physician, kept a form of address [20]. The clinician does not try to produce a glimpse. They keep treating his pain, keep returning, and keep his words exactly as he gave them.

What holding does not suspend

Holding the resolution concerns ultimate justification. It does not suspend causal inquiry or practical accountability. No appeal to mystery excuses incomplete investigation, untreated symptoms, avoidable harm, or failure to disclose error. Some suffering is preventable; some arises from injustice that can be remedied; some reflects clinical failure. To call these inscrutable would be an evasion dressed as humility. My earlier essay on illness and the demonic insisted that explanations which relieve the explainer of responsibility are a form of abandonment [22]. The same holds here: the clinician holds the resolution of the why, and remains fully answerable for the how.

The clinician's own resolutions

Clinicians have beliefs about suffering, and holding does not ask them to pretend otherwise. It asks them not to carry those beliefs into a domain where they have no standing, a discipline I have elsewhere described as not carrying [43]. It also asks something of the clinician's interior. To hold a question open for another person, one must be able to bear holding it open oneself, which requires a practiced contraction of the need to know and to fix [44], and a willingness to stay in the unresolved present of the encounter rather than flee into explanation or activity [45]. The parable's limits apply here too: the clinician's access to the patient's interior is by consent, opened by the patient and not obtained by pursuit [46].

Objections and replies

- **Objection 1:** Holding the resolution is still a promise, and therefore a theodicy by another name. Section 4 answered the theoretical form of this objection: a resolution that adds nothing to the plain sense cannot supply a justification. The practical form is harder. A patient may hear in the clinician's openness a quiet assurance that it will all make sense one day, and that assurance can become its own burden. The reply is that holding is silent about content. The clinician does not voice the held resolution, does not predict it, and does not offer it as comfort. The possibility of meaning is held in the way the lover holds the door: by staying, not by describing what lies behind it. If a patient asks directly whether it will ever make sense, the honest answer is I don't know, followed by what the clinician does know: I am not going anywhere.
- **Objection 2:** Most patients do not share this theology. The disciplines do not depend on it. Asking what a question is for, returning a patient's words, declining premature closure, and making care unconditional can all be taught and practiced without reference to the Zohar. This is the detachability test [24]. The Zohar supplies the reason the disciplines hang togeth-

er and a criterion, the peshat test, that a clinician can check against a transcript of their own words. It is not a condition of their use.

- **Objection 3:** This is negative capability with Hebrew citations. The overlap is real and acknowledged in Section 2. Two differences remain. Negative capability describes a disposition toward uncertainty; holding the resolution adds a claim about where authority over meaning lies. More practically, the peshat test is determinate in a way a disposition is not. One can review a recorded conversation and ask, sentence by sentence, whether the clinician added to or subtracted from what the patient said. Ricoeur argued that evil defeats speculative resolution and calls instead for a response in thought, action, and feeling, including the lament that may become complaint against God [47]. The peshat test is one way of making the clinician's part in that response concrete.
- **Objection 4:** The erotic and gendered imagery is unsuitable for clinical ethics. The passage is erotic and its gender roles belong to its own world. Wolfson's work has shown how far Kabbalistic eros is shaped by assumptions that should not be adopted uncritically [30]. Two points limit the force of the objection here. First, the essay borrows a structure, not a relationship: receptivity bounded by the other's initiative. Second, within the parable, the agency belongs to the beloved. She decides when, how much, and to whom she is disclosed. If anything, the image models the patient's authority over their own disclosure, which is the opposite of the paternalism the objection fears.
- **Objection 5:** An apophatic theology cannot speak of a resolution "held by God" without saying too much. This objection deserves care, because it comes from the tradition of thought on which this essay most depends. If the divine exceeds every predicate, to say that a resolution is held by God may already claim knowledge of a divine content. The reply is that holding names a location of authority, not a content. It says not mine to give, and points away from the clinician without describing what lies at the other end. This is consistent with the indexical rather than predicative use of the divine name proposed in The Third Grammar [19]. It is also suggested by the reading of the passage I have relied on: if the secret is the plain sense seen fully rather than an additional meaning [7], then what is held is not a hidden proposition about suffering. I offer this as a clinician's use of that reading, and not as a correction of it.
- **Objection 6:** The clinician becomes the beloved, dispensing glimpses. This is the most practical danger. A clinician skilled in presence can begin to experience moments of connection as their own gift to the patient, and to manage disclosure accordingly. The parable forbids this assignment. The clinician is never the beloved. At most they are a companion of the lover, standing beside a patient who may or may not receive a glimpse that the clinician cannot see. I have argued elsewhere that the clinician is not the fulcrum on which the patient's balance turns [48], and I have since revised my own account of therapeutic contraction [49]. Holding the resolution is subject to the same scrutiny: a posture of restraint can itself become a performance.

Limitations and conclusions

The argument is a selective rereading of one author's corpus and a constructive appropriation of a medieval mystical text written for another purpose. It cannot represent the range of Jewish mysticism,

establish anything about providence, or show that the disciplines improve clinical outcomes. The vignettes are composites and illustrate rather than test. The peshat test is offered as a normative criterion; whether clinicians can apply it reliably, and whether patients experience its application as helpful, are empirical questions that would require study, for example through analysis of recorded clinical conversations about meaning. The working translation in the Appendix is not a critical edition.

The earlier trajectory of my work arrived at a set of prohibitions: do not justify, do not synthesize what must remain in tension, do not prescribe a surrender that cannot be performed. Those prohibitions remain. What this essay adds is an account of what stands in the place they clear.

The Zohar's beloved holds a resolution. It is real, and she discloses it on her own terms, to one person, in stages that no one else sees. Its culmination does not replace the first words with deeper ones; it returns the lover to the plain sense, to which nothing is added and from which nothing is removed. Around that parable the photographed page sets three smaller lessons: the stranger's soul is known through one's own estrangement; the higher learns this world through the lower; and a teacher declines his listeners' premature satisfaction.

Translated with care, these yield a clinical posture distinct from both resolving and abandoning. The clinician holds the resolution in three senses: holding it back, recognizing that it is held by another, and sustaining the relationship within which the question can go on being asked. Four disciplines follow: circle the door without opening it, return the patient's words, decline premature closure, and keep the hand offered whatever the patient concludes. One criterion governs them: any meaning offered at the bedside must leave the patient's own words standing.

That criterion is the essay's main contribution. It is what makes holding compatible with anti-theodicy rather than a gentler version of theodicy. A resolution that cannot add a letter cannot add a reason. Whether such a resolution will ever be given, the clinician does not know and does not say. What they can do is keep the protest, the gratitude, the silence, and the question exactly as the patient spoke to them, and stay.

Addendum: The therapeutic space as an unresolved space

The essay has argued that the clinician holds the resolution of a patient's question rather than supplying or foreclosing it. This addendum turns from the question to the place where it is asked. Many patients do not bring a single question that can be held and then set down. They bring a suffering that will not resolve: a degenerative illness, pain that outlasts every treatment, a grief that has no end point. For them the therapeutic space is not a room where an unresolved question waits for its answer. It is itself unresolved, and it remains so for as long as care continues.

What is unresolved

Three things remain open in such a space, and they should be distinguished.

The first is the illness. Much of neurology, oncology, and palliative care is the care of conditions that will not be cured. The clinician's work continues, often for years, without the closure that a cure would bring.

The second is the meaning. A patient with progressive disease may revisit the question of why many times, answer it differently each time, or stop asking. The meaning of the suffering is not settled once and then carried forward. It is renegotiated with each loss.

The third is the relationship itself. The clinician cannot fix what is wrong, and both people know it. What binds them is not a shared expectation of resolution but a shared willingness to keep meeting without one.

The space has the shape of the parable

The parable described in Section 3 gives this space a recognizable shape. There is a door that the clinician cannot open. There is an occasional opening, in which the patient says something true, or allows themselves to be seen, or laughs in the middle of a hard visit, and then withdraws again. There is a circling: the clinician keeps returning to the door at the next appointment, the next admission, the next call. Most of the time nothing is disclosed. The space is kept not by what happens inside it but by the constancy with which both people return to it.

Winnicott's holding environment describes this: a reliable presence within which what cannot yet be integrated can be borne [11]. Boss's account of ambiguous loss describes the patient's side of it: a loss that cannot resolve because it is still happening, and that asks to be tolerated rather than closed [10]. Frank's chaos narrative describes how it sounds: a story told by someone for whom no plot is yet available [34]. In each case, the mistake would be to treat the absence of resolution as a failure of the space. It is the space's normal condition.

Pressures to resolve

The unresolved space is under constant pressure to close, and the pressure comes from three directions.

From the institution. Health systems measure resolution: discharges, completed episodes, goals met. A patient whose suffering continues unchanged can appear, in these terms, as a failure of care, and the clinician who keeps returning can appear unproductive. The space must sometimes be defended against the system that houses it.

From the clinician. Sitting with suffering that will not resolve is hard. Clinicians are tempted to resolve it in the only ways open to them: by escalating treatment past the point of benefit, by offering a meaning, or by withdrawing. The clinician also carries unresolved grief of their own, particularly after a patient's death, and that grief can press toward premature closure [50].

From the patient. Patients may ask for closure as well: a verdict, a prognosis given as certainty, a reassurance that it will make sense. These requests deserve honest answers. They do not require the clinician to pretend that what is open is closed.

Keeping the space open

The four disciplines of Section 5 apply here over time rather than in a single conversation.

The clinician keeps circling the door: continuity of care becomes the main form of holding. Showing up again is itself the communication that the space has not been abandoned.

The clinician returns the words, visit after visit. A patient's sentence from last month is not used to correct their sentence today. If she was grateful in spring and is furious in autumn, both sentences stand.

The clinician declines the premature dayeinu. A good visit is not taken as a sign that the suffering has been resolved, and a bad one is not taken as proof that the space has failed.

The clinician keeps the hand offered. Care continues whatever the patient concludes, including when the patient concludes nothing.

Two further practices belong to the long unresolved space. The first is to share it. A chaplain, a nurse, a social worker, or a family member can hold parts of the space the physician cannot, and the physician's presence and the chaplain's presence are complementary rather than interchangeable [51]. The second is for the clinician to tend their own unresolved burden, through practices of contraction that make room for the patient and of solitude that allow the clinician to stay present without flight [44,45].

The peshat test applied to the space

The peshat test also applies to the space as a whole. It is tempting to describe the long unresolved relationship with a suffering patient in elevated terms: a sacred space, a theophany, a site of tikkun. My own earlier work has used such language [14]. It can be true as a description of what the clinician experiences. It becomes a problem when it is laid over the patient's experience as an added layer of meaning. For the patient, the space may simply be the place where they come to be in pain in front of someone who does not leave. The plain sense of the space is enough. Nothing needs to be added to it.

The therapeutic space with a patient whose suffering will not resolve is not a waiting room for a resolution that will come later. It is where the care happens. What the clinician offers there is not an answer but a continuity: the door returned to, the words kept as they were spoken, and a hand that remains offered whether or not the opening ever comes.

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Appendix:

Working translation of the photographed passage (Zohar II 99a, Sava de-Mishpatim)

This working translation follows the main Aramaic text visible in the photographed page. The page begins and ends mid-discussion. Marginal glosses are excluded. Square brackets supply context. The translation is a working aid, not a critical edition [6].

[Continuing the preceding discussion:] Once it has been revealed, it immediately returns to its sheath and clothes itself there. When Scripture warns concerning the stranger in all those places, a word emerges from its sheath and reveals itself, saying, "You know the soul of the stranger" (Exodus 23:9). Immediately it reenters its sheath, returns to its garment, and conceals itself, as it is written, "For you were strangers in the land of Egypt." Because the verse immediately clothes itself, no one takes notice of it. This is "the soul of the stranger."

The holy soul knows the matters of that world and enjoys them, while the stranger's soul knows the matters of this world and enjoys them. Through this stranger's soul, the holy soul knows the matters of this world and enjoys them.

The old man opened his discourse and said: "Moses entered into the cloud and went up the mountain" (Exodus 24:18). What is this cloud? It is that of which it is written, "My bow I have set in the cloud" (Genesis 9:13). We have learned that this bow removed its garments and gave them to Moses. In that garment he ascended the mountain; through it he saw what he saw and delighted in everything. Thus far.

The companions came and fell down before the old man. They wept and said: "Had we come into the world only to hear these words from your mouth, it would have been enough for us."

He said to them: "If he takes another woman for himself" (Exodus 21:10). Companions, I did not begin for this alone. An old man like me does not make a clatter with just one word.

"How many people in the world are confused in

their understanding and fail to see the path of truth in Torah! Torah calls to them every day in love, yet they do not wish to turn their heads. Although I have said that a word of Torah emerges from its sheath, appears for a little while, and immediately conceals itself, that is certainly so. But when it reveals itself from its sheath and immediately conceals itself, it does so only for those who know it and recognize it.

"To what may this be compared? To a beloved woman, beautiful in appearance and beautiful in form, hidden in secret within her palace. She has one lover, unknown to other people, known only to her in secret.

"Out of the love with which he loves her, that lover constantly passes the doorway of her house and looks in every direction. She knows that her lover is continually circling the doorway of her house. What does she do? She opens a small opening in that hidden palace where she is, reveals her face to her lover, and immediately withdraws and conceals herself.

"None of those who are with the lover sees or takes notice. He alone does; and his inward being, his heart, and his soul go out after her. He knows that, out of the love with which she loves him, she revealed herself to him for a moment, to awaken love for her.

"So it is with a word of Torah: it reveals itself only to its lover. Torah knows that this wise-hearted person continually circles the doorway of her house. What does she do? She reveals her face to him from within the palace, signals a hint to him, and immediately returns to her place and conceals herself. None of those there knows or takes notice. He alone does; and his inward being, his heart, and his soul go out after her.

"Therefore Torah reveals herself and conceals herself, and goes lovingly toward her lover, to awaken love with him. Come and see: this is Torah's way.

"When she first begins to reveal herself to a person, she signals a hint to him. If he understands, well and good. If he does not understand, she sends to him and calls him 'simple.' Torah says to the one whom she sends: 'Tell that simple one to come near, so that I may speak with him.' As it is written, 'Whoever is simple, let him turn in here'; 'one who lacks understanding' (Proverbs 9:4).

"He comes near her. She begins to speak with him from behind a curtain that she has spread for him, words suited to his understanding, until little by little he reflects upon them. This is derashah [interpretive exposition]. Afterward she speaks with him from behind a delicate covering, words of riddle; and this is haggadah [here, enigmatic or allegorical telling]. Afterward, once he has become accustomed to her, she reveals herself to him face to face and speaks with him about all the hidden mysteries and all the hidden paths that have been concealed in her heart since primordial days…"

The passage goes on to describe the lover, now fully initiated, as a complete person and master of the house, from whom nothing is withheld. The beloved points back to the first hint she gave him and shows him what secrets it contained. He then sees that nothing may be added to those words and nothing taken from them, and the plain sense of the verse stands as it is, without a single letter added or removed [6,7]. This return to the plain sense is the basis of the peshat test in Section 4.2.

Translator's note. Ger can mean a stranger or a convert; the opening belongs to a preceding discussion of souls and their garments. "Sheath" and "garment" preserve the passage's overlapping images of concealment. The Aramaic moves between a "word of Torah" and Torah personified as the beloved; the English follows that movement. "Simple" renders peti, a person still lacking understanding, not a moral accusation. The old man's "clatter with just one word" (literally kish kish) echoes the proverb of the single coin rattling in a jar at Bava Metzia 85b [27]. The glosses on derashah and haggadah are provisional and specific to this passage.