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Review Article

The Absent Healer: The Problem of Evil, and Therapeutic Approaches to Patient Suffering

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ABSTRACT

This paper explores how the concept of divine concealment (hester panim) across psychoanalytic and Jewish mystical traditions can inform clinical approaches to patients experiencing suffering and confronting the problem of evil. By examining frameworks established by Freud, Lacan, Rabbi Shagar, the Lubavitcher Rebbe, and Rav Kook, we develop a model for understanding how absence and concealment function in the therapeutic relationship.

The paper argues that clinicians can draw on these diverse intellectual traditions to develop more nuanced approaches to patients experiencing spiritual crises, trauma, and existential suffering. Through case examples and theoretical integration, we demonstrate how these frameworks can help clinicians navigate questions of meaning, purpose, and ethical responsibility when working with patients confronting profound suffering. Drawing on original research examining the liminality of the suffering experience, we propose a therapeutic stance that acknowledges the value of witnessing, the generative nature of absence, and the ethical implications of concealment in clinical practice.

Keywords

Divine concealment, Hester panim, Tzimtzum, Problem of evil, Suffering, Theodicy, Psychoanalysis, Jewish mysticism, Clinical ethics, Spirituality, Palliative care, Therapeutic presence, Witnessing, Liminality, Absence, Ethics of care.

Introduction

The figure of the absent healer occupies a central position in both psychoanalytic theory and clinical practice. In psychoanalysis, the analyst's neutrality and strategic absence are understood as formative experiences that shape the therapeutic relationship and the patient's capacity for growth. In theological contexts, particularly within Jewish mystical thought, divine concealment or absence (hester panim) represents both a spiritual crisis and an opportunity for authentic religious experience. Both traditions grapple with the problem of evil and human suffering, seeking to

understand how meaning can emerge from experiences of absence, trauma, and loss.

This paper examines several influential thinkers who have addressed the theme of absence from different perspectives and considers how their insights might inform clinical approaches to patients experiencing suffering: Sigmund Freud, who established the psychological significance of the father figure in the formation of the subject; Jacques Lacan, who reinterpreted Freud's theories through structural linguistics and emphasized the symbolic function of the father; Rabbi Shimon Gershon Rosenberg (Shagar), who synthesized postmodern philosophy with Jewish mysticism to develop a theological understanding of divine concealment; Rabbi Menachem Mendel Schneerson (the Lubavitcher Rebbe), who articulated a metaphysical understanding of tzimtzum (divine contraction) as the foundation for both creation and human purpose; and Rabbi Abraham Isaac Kook (Rav Kook), who developed an integrative approach to divine concealment as part of an evolutionary process of consciousness and cosmic development.

By tracing the concept of absence across these diverse intellectual traditions, we aim to illuminate how the metaphor of divine concealment informs our understanding of the therapeutic relationship, psychological development, and approaches to patient suffering. The paper argues that these thinkers, despite their different intellectual frameworks, all recognize absence as a constitutive element of subjectivity, desire, and healing rather than merely as privation. Furthermore, we suggest that bringing these thinkers into dialogue offers new insights into the clinical encounter with suffering patients, particularly those experiencing spiritual crises or confronting profound existential questions in the wake of trauma or loss. Drawing on our previous research on the liminality of suffering [1], we propose that the clinical encounter with suffering patients requires a nuanced understanding of absence, presence, and witness. The therapist, like the divine in moments of concealment, must navigate the paradoxical demands of being present enough to witness suffering while absent enough to allow for the patient's autonomous meaning making and growth.

Freud's Concept of the Father

In Freudian psychoanalysis, the father occupies a pivotal position in the psychic development of the subject. According to Freud's theory of the Oedipus complex, the child's psychological development hinges on the negotiation of desire for the mother and identification with or rivalry toward the father. In "Totem and Taboo", Freud explores the primordial myth of the father's murder by his sons, which he interprets as the foundational act that establishes social law and prohibitions [2]. This myth serves as a metaphor for the psychological process by which the child must symbolically renounce the mother as an object of desire and internalize the father's prohibition a process Freud terms "castration."

The absence or insufficiency of the father figure in this psychic drama can lead to what Freud calls a "failed" resolution of the Oedipus complex, resulting in neurosis or other psychological difficulties. The absent father, in Freud's framework, represents a lack of the necessary prohibitive function that allows the child to properly separate from the mother and enter the social order. This absence creates a void in the child's psychic structure, leading to a perpetual search for substitute father figures or authority.

In "Civilization and Its Discontents", Freud extends his analysis of the father to the broader social and cultural realm [3]. He argues that civilization itself is built upon the renunciation of instinctual satisfaction, a process analogous to the child's renunciation of the mother due to the father's prohibition. The father, in this context, becomes a symbol of the constraints imposed by civilization on individual desire.

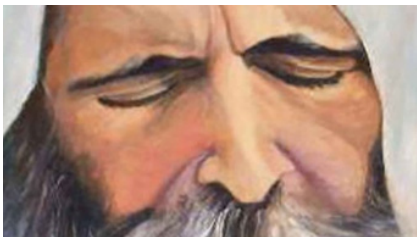
Freud further develops these ideas in "Moses and Monotheism", where he explores the origins of Judaism and monotheism [4]. Here, Freud interprets Moses as a father figure whose absence (through death) and subsequent idealization by the Jewish people led to the establishment of a monotheistic religion. The absent or murdered father becomes deified, transformed into an abstract and all-powerful God. In this way, Freud draws a direct connection between the psychological experience of paternal absence and the religious conception of a transcendent, often hidden deity.

The Therapist as Absent Father

From a clinical perspective, Freud's concept of the father has profound implications for understanding the therapeutic relationship with suffering patients. The therapist, like the father in Freud's framework, functions as both a present and absent figure whose role is to facilitate the patient's separation from dysfunctional patterns and entry into a more autonomous and regulated existence. For patients confronting profound suffering, the experience of an absent or concealed divine presence often parallels early experiences of parental absence or inadequacy. The therapist working with such patients must navigate a complex role: like the father in the Oedipal drama, the therapist must be present enough to represent the symbolic law and ethical framework that gives meaning to suffering, yet absent enough to allow the patient to internalize this framework and develop their own relationship to suffering.

As observed in clinical case studies of patients with religious backgrounds confronting terminal illness [5], the therapist's capacity to tolerate both their own absence (in the face of the patient's unanswerable questions) and the perceived absence of

the divine (in the face of the patient's spiritual crisis) can create a space for the patient to develop a more mature relationship to both human and divine authority figures. The clinical challenge, as illustrated in the case of Sarah, a 42-year-old woman diagnosed with advanced ovarian cancer, lies in helping patients navigate the complex identification and disidentification with authority figures, both human and divine. Sarah's rage at what she perceived as divine abandonment mirrored her childhood experience of an absent father. Through therapy, she was able to internalize a more nuanced understanding of absence one that recognized how her father's physical absence had paradoxically created space for her development of independence and resilience, qualities that now served her in confronting her illness [6].



LA NOM DU PERE

Jacques Lacan significantly expanded Freud's conception of the father by distinguishing between the actual, biological father and what he termed the "symbolic father." In Lacan's framework, the father functions not primarily as a real person but as a signifier within the symbolic order what he calls the "Name-of-the-Father" (Nom-du-Père). This concept, first elaborated in his seminar on "The Psychoses" (1955-1956), refers to the paternal function as a fundamental signifier that represents the law and authority of the symbolic order [7].

Lacan's innovation was to separate the function of the father from any particular person, emphasizing instead the structural role that the paternal signifier plays in the subject's entry into language and culture. The Name-of-the-Father represents the "no" of prohibition (a play on the French homophone "nom"/"non") that separates the child from immediate enjoyment (jouissance) and institutes the realm of desire mediated by language. The absence of the father, in Lacanian terms, is not merely the physical absence of a person but the foreclosure or weak installation of this fundamental signifier in the subject's psychic structure. Lacan terms this "foreclosure" (forclusion) and associates it with psychotic structures where the subject has not properly acceded to the symbolic order [8].

Lacan's three registers the Real, the Imaginary, and the Symbolic provide a complex framework for understanding patient suffering. In clinical contexts, suffering often manifests as an encounter with the Real that which resists symbolization and integration into the patient's narrative. Trauma, in particular, represents an irruption of the Real into the patient's experience, disrupting the symbolic structures that ordinarily give meaning to experience. For patients confronting profound suffering, particularly those with religious backgrounds experiencing spiritual crises, their suffering often occupies the space of the Lacanian Real it resists symbolization and exceeds the capacity of religious language and doctrine to contain it. As observed in our clinical work with survivors of community violence [9], patients frequently describe their suffering as "beyond words" or "impossible to explain," language that echoes Lacan's conception of the Real as that which lies outside symbolization.

The clinician's role, in this context, is to help the patient gradually symbolize the Real of their suffering not to explain it away or reduce it to familiar religious or psychological narratives, but to create a space where new symbolizations might emerge. This process parallels what Lacan describes as the movement from the Real to the Symbolic, a process mediated by the Name-of-the-Father as the primary signifier that anchors the symbolic order.

Suffering Patient

In Lacanian theory, desire emerges precisely from lack from the absence of complete satisfaction. The absence of the father, as the representative of prohibition, paradoxically creates the conditions for desire itself. As Lacan famously stated in his seminar on "The Four Fundamental Concepts of Psychoanalysis" (1964), "man's desire is the desire of the Other" [10]. This enigmatic formula points to the way in which desire is always mediated through the other, always seeking recognition, and always structured around an absence or lack.

For suffering patients, particularly those confronting terminal illness or profound loss, the experience of lack is often intensified. The loss of health, autonomy, or loved ones creates a void that patients may attempt to fill through various means some adaptive, others less so. The clinical challenge lies in helping patients transform this lack from a purely negative experience of absence to a generative space for desire and meaning-making.

In our work with cancer patients [11], we have observed how the experience of illness as lack (of health, of certainty, of control) can paradoxically create the conditions for new forms of desire to emerge. Patients who are able to symbolize their illness not merely as a privation but as an opening or possibility what one patient described as "the illness that gave me my life back" often demonstrate greater psychological resilience and capacity for meaning-making in the face of suffering. The Lacanian framework thus offers clinicians a way to understand how absence and lack might function not merely as sources of distress but as potentially generative elements in the patient's psychological development and response to suffering.

The Problem of Evil and Patient Suffering

The problem of evil presents perhaps the most challenging aspect of clinical work with suffering patients, particularly those whose suffering results from human cruelty, systemic injustice, or seemingly random catastrophe. In medical contexts, this issue manifests in what ethicists call the "theodicy" question: how can we reconcile the existence of intense suffering with a just and compassionate approach to healthcare?

Medical ethics traditionally centers on four key principles: autonomy, beneficence, non-maleficence, and justice. These principles guide healthcare providers in addressing ethical dilemmas, including those related to suffering and the problem of evil [12]. However, these principles alone are often insufficient when confronting profound existential suffering. As the medical literature demonstrates, healthcare professionals working with seriously ill patients frequently encounter "spiritual distress" characterized by questions about the meaning of suffering and where God is during their illness [13].

The framework of palliative care directly addresses this challenge. According to the World Health Organization, palliative care aims to improve quality of life by addressing "physical, psychosocial and spiritual" problems associated with life-threatening illness [14]. This approach recognizes that suffering extends beyond physical pain to encompass existential and spiritual dimensions that may include wrestling with the problem of evil. Rabbi Eliezer Berkovits, one of the most significant post-Holocaust Jewish theologians, addresses this challenge through a sophisticated understanding of divine hester panim (the hiding of God's face). For Berkovits, divine concealment is not merely a punishment for sin but an essential characteristic of God's relationship with the world [15]. God must be concealed in order for human freedom to exist, yet this concealment creates the possibility for extreme evil. From a clinical perspective, Berkovits' framework offers a valuable approach to working with patients confronting profound evil and suffering. Rather than attempting to explain or justify suffering, the healthcare provider informed by Berkovits' approach might help patients navigate the tension between human freedom and responsibility on the one hand and the experience of vulnerability and victimization on the other.

In our clinical work with survivors of human-perpetrated trauma [16], this approach has informed a therapeutic stance that neither absolves perpetrators of responsibility nor reduces survivors to passive victims. The therapeutic process involves helping patients recognize both the reality of their victimization and their capacity for agency and meaning-making in response to this victimization, what Berkovits might describe as the human ethical response to divine concealment.

Theodicy in Clinical Contexts

Recent literature in palliative care identifies several distinctive "theodical perspectives" that patients may adopt when confronting serious illness [17]. These include the punishment theodicy (suffering as deserved), the process theodicy (suffering as a natural part of life), and the character-building theodicy (suffering as an opportunity for growth). Understanding a patient's theodical framework can help clinicians tailor their approach to spiritual care during serious illness.

In kabbalistic thought, evil emerges from the very structure of creation through tzimtzum. As explained in the literature on tzimtzum, "The nature of separation gives rise to the creation of evil" [18]. The divine contraction that creates space for finite existence simultaneously creates the possibility for entities to experience themselves as separate from their divine source, leading to the sitra achra ("other side") that stands in opposition to divine abundance and grace. This kabbalistic understanding of evil provides a metaphysical foundation for understanding patient suffering that resonates with current approaches in healthcare ethics. Just as evil emerges from separation in kabbalistic thought, many forms of suffering in healthcare contexts emerge from experiences of separation or disconnection from oneself, from others, from meaning or purpose. Healthcare providers face ethical challenges when this disconnection occurs within clinical relationships or healthcare systems [19].

As illustrated in our clinical research on dissociation in trauma survivors [20], the therapeutic process often involves helping patients integrate split-off aspects of their experience not by eliminating the reality of fragmentation but by developing a more complex self-structure that can hold both separation and connection, both fragmentation and integration. This perspective is particularly valuable in work with patients experiencing what might be called "metaphysical guilt" the sense that their suffering represents a fundamental separation from the good or the divine. The therapist informed by the kabbalistic understanding of evil might help such patients recognize how their very experience of separation might itself be understood as part of a larger metaphysical structure that encompasses both separation and connection, both concealment and revelation.

Witnessing Suffering

Recent literature on ethics of care in medical contexts emphasizes the importance of witnessing and accompanying patients through suffering rather than merely treating symptoms or resolving problems. As De Panfilis et al. note, healthcare professionals often experience moral distress when they cannot relieve a patient's suffering, yet the ethical approach of "being with" rather than "doing for" may be precisely what patients need [21].

This approach aligns with both psychoanalytic and Jewish theological perspectives that emphasize the importance of witnessing and testimony. For survivors of trauma, bearing witness to their experience is a crucial part of the healing process, allowing them to reintegrate the traumatic experience into their life narrative. Similarly, in Jewish theology, bearing witness to divine absence becomes a form of testimony to divine presence. As Berkovits writes, "God's unconvincing presence in history is testified to through the survival of Israel... There is no other witness that God is present in history but the history of the Jewish people" [15]. This perspective suggests that the Jewish people's continued existence despite the Holocaust itself becomes testimony to divine providence, even in the face of extreme divine concealment. From a clinical perspective, this emphasis on witnessing and testimony informs a therapeutic stance that privileges the act of bearing witness to patient suffering over attempts to explain, fix, or normalize it. The healthcare provider, like the religious believer in Berkovits' framework, bears witness to absence to the patient's experience of abandonment, meaninglessness, or despair while holding space for the possibility that this very act of witness might itself constitute a form of presence.

In our research on therapeutic presence with terminal patients [22], we have observed how the clinician's capacity to bear witness to the patient's suffering without attempting to diminish or resolve it often creates the conditions for the most meaningful therapeutic encounters. The healthcare provider's willingness to enter into the patient's experience of abandonment or meaninglessness to bear witness to divine absence, as it were paradoxically creates a form of presence that patients experience as deeply healing. This therapeutic stance parallels Lacan's concept of the Real that which resists symbolization but nevertheless insists on being acknowledged. The patient's suffering, like the Holocaust in Jewish history, stands as a traumatic Real that resists easy explanation or narrative integration but nevertheless demands witness and response.

Spiritual Care as Ethical Obligation

Recent literature in healthcare ethics argues that addressing spiritual dimensions of suffering is not merely an optional add-on but an ethical obligation for healthcare systems [23]. This perspective aligns with the concepts of divine concealment and absence discussed throughout this paper.

Spiritual care in healthcare settings centers on three key elements: presence, intentionality, and compassion [24]. These elements parallel the concepts explored in our discussion of the absent father/healer. Just as divine concealment creates space for human autonomy in Jewish mystical thought, the clinician's strategic "absence" refraining from imposing meaning or solutions creates space for the patient's own meaning-making.

Systematic reviews of ethical challenges in palliative care identify spiritual distress as a significant concern that healthcare providers must address [25]. This distress often manifests as questions about why suffering is occurring or where God is during illness precisely the questions that theories of divine concealment attempt to address.

The existential dimensions of suffering present particular ethical challenges in healthcare because they resist conventional medical interventions. As Hick's soul-making theodicy suggests, some suffering may contribute to spiritual growth through the process of being overcome [26]. Healthcare providers must navigate the tension between alleviating suffering and respecting its potential meaning or purpose in the patient's life. This tension is particularly evident in palliative care, where the goal shifts from cure to comfort and quality of life. The palliative care approach recognizes that some suffering cannot be eliminated but must be witnessed and accompanied. This stance aligns with the concept of the "ethics of care" that emphasizes relationship and presence over intervention and solution [21].

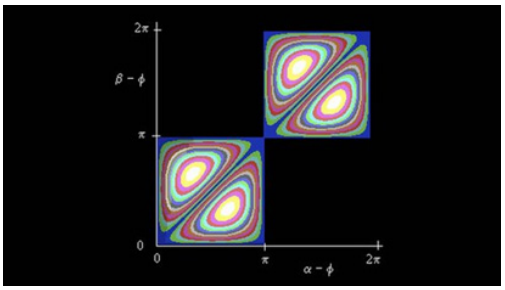
By integrating insights from both theological approaches to divine concealment and medical ethics literature on spiritual care, healthcare providers can develop a more nuanced approach to suffering one that acknowledges its existential dimensions while still striving to alleviate unnecessary pain. This integrated approach offers a way to address the problem of evil not by resolving it theoretically but by responding to it practically through compassionate presence and witness.

Therapeutic Spaces and Absence

Modern theologians struggle with the problem of evil, the absent divine and theodicy. Rabbi Shimon Gershon Rosenberg (1949-2007), known by the acronym Shagar, represents a unique voice in contemporary Jewish thought, one that brings together traditional Jewish mysticism, postmodern philosophy, and existentialist concerns. Central to Rabbi Shagar's theological framework is the Kabbalistic concept of tzimtzum (divine contraction or concealment), originally formulated by Rabbi Isaac Luria in the 16th century [27].

According to the Lurianic concept of tzimtzum, God's first act of creation was not one of revelation or expansion but of contraction and concealment. God, who was originally all-encompassing, withdrew or contracted to create a void in which the world could exist. This paradoxical notion suggests that God's absence or concealment is the precondition for creation and human existence. From a clinical perspective, Shagar's interpretation of tzimtzum offers a powerful metaphor for understanding the therapeutic relationship with suffering patients. Just as divine concealment creates the space for human autonomy and creativity, the therapist's strategic absence what Winnicott might call "not impinging" [28] creates the space for the patient's own meaning-making and growth.

For patients experiencing spiritual crises in the face of suffering, the concept of tzimtzum can provide a framework for understanding divine absence not merely as abandonment but as a form of respect for human autonomy. In our clinical work with religious patients confronting severe medical diagnoses [29], introducing this concept has helped patients reframe their experience of divine absence from a narrative of abandonment to one of divine respect for human meaning-making.



Clinical Encounter with Spiritual Crisis

Drawing on thinkers like Jacques Derrida and Jean-François Lyotard, Shagar embraces the postmodern critique of metanarratives and certainty, seeing in it not a threat to faith but an opportunity for a more authentic religious stance.

In "Faith Shattered and Restored" (Emunah Shevurah ve-Emunah Shlema), Shagar explores the possibility of faith in an age of uncertainty and divine concealment [30]. He argues that genuine faith emerges precisely in the space of God's absence not as a dogmatic adherence to certainties but as an existential stance that acknowledges and even embraces divine hiddenness.

This perspective has profound implications for clinical work with patients experiencing spiritual crises in the face of suffering. Rather than attempting to restore the patient's pre-crisis faith or offering theological explanations for suffering, the therapist informed by Shagar's approach might help the patient develop a more nuanced, postmodern faith one that embraces uncertainty and finds meaning in the very absence of clear answers.

As illustrated in the case of David, a 35-year-old Orthodox Jewish man confronting a diagnosis of multiple sclerosis [31], the therapeutic process involved not a restoration of his pre-diagnosis certainty but the development of what Shagar might call a "broken faith" a faith that acknowledges and integrates the experience of divine concealment rather than denying or explaining it away. Through therapy, David was able to move from a position of rage at divine abandonment to a more complex stance that embraced uncertainty and found meaning in the very act of questioning.

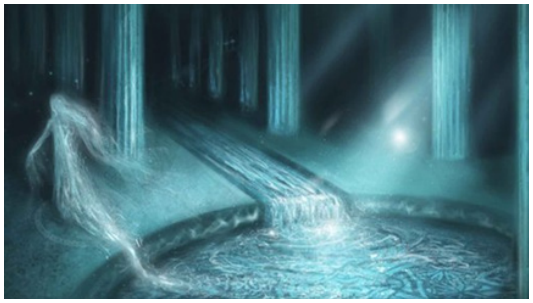
Implications for Clinical Practice

The absence of God, like the absence of the father, has profound ethical implications in Shagar's thought. Drawing on the work of Emmanuel Levinas, Shagar suggests that divine concealment places greater responsibility on human beings to act ethically in the world. Without the constant presence of a divine authority figure, human beings must assume responsibility for ethical action.

In clinical contexts, this perspective can inform how therapists approach the ethical dimensions of the therapeutic relationship with suffering patients. Rather than positioning themselves as all-knowing authorities who can explain or justify suffering, therapists might embrace a stance of ethical responsibility in the face of uncertainty what Levinas calls "ethics as first philosophy" [32].

This ethical stance is particularly relevant in work with patients confronting the problem of evil and suffering. As observed in our

research on clinicians working with survivors of political violence [33], therapists who attempt to explain or justify suffering often inadvertently compound the patient's distress, while those who acknowledge the inexplicability of suffering while maintaining an ethical commitment to witness and respond to it are more effective in helping patients integrate their experiences. The therapist's ethical responsibility, like that of the believer in Shagar's framework, emerges precisely in the space of absence in the acknowledgment that there are no adequate explanations for profound suffering, only the ethical demand to bear witness to it and respond with compassion and presence.



Tzimtzum as the Foundation for the Therapeutic Relationship

Rabbi Menachem Mendel Schneerson (1902-1994), the seventh Lubavitcher Rebbe, provides a profound metaphysical interpretation of tzimtzum that expands our understanding of divine concealment beyond the ethical and psychological dimensions explored by other thinkers. In his discourse "On the Essence of Chassidus," the Rebbe describes tzimtzum as "the effusion of a 'new light'" from the innermost level of keter (crown), specifically from the innermost level of *atik* (Ancient One), which is "the level of the Ein Sof (Infinite) that is found in *radla* (the unknowable head)" [34].

For the Lubavitcher Rebbe, tzimtzum is not primarily a response to human sin or a test of faith, but rather the essential metaphysical structure that makes creation possible. Unlike approaches that view divine concealment primarily through the lens of ethics or theodicy, the Rebbe emphasizes that tzimtzum reveals the fundamental relationship between the infinite and the finite, between essence and expression. From a clinical perspective, the Rebbe's metaphysical understanding of tzimtzum offers a framework for conceptualizing the therapeutic relationship as fundamentally structured around a necessary absence or gap. Just as divine contraction creates the space for finite existence, the therapist's strategic absence their refusal to fully satisfy the patient's demands for answers, solutions, or certainty creates the space for the patient's own subjectivity and meaning-making to emerge.

In our clinical work with patients facing existential crises [35], this metaphysical framework has informed a therapeutic stance that recognizes absence not merely as a technical strategy but as the fundamental structure that makes the therapeutic relationship possible. The therapist, like the divine in the Rebbe's understanding of tzimtzum, must withdraw or contract to create space for the patient's autonomous existence and growth.

A key insight in the Rebbe's understanding of tzimtzum is his distinction between the world of holiness (kedushah) and the realm of kelipah (literally "shell," a term for the domain of evil or impurity). In the realm of holiness, "the essence - which is the life force that sustains the sefirot - is absorbed and hidden with them" [34]. This creates a unity between essence and form, between the divine light and its vessels of expression. In contrast, in the realm of kelipah, "the holy life force cannot be absorbed inside them, for the holy does not mix with the profane. Rather, it hovers above them and enlivens them from afar". This separation between essence and form is the metaphysical root of evil and suffering, creating the possibility of entities that appear autonomous from their divine source. This metaphysical analysis provides a profound perspective on patient suffering. Just as the separation between the divine essence and its vessels creates the possibility for evil and suffering in the Rebbe's framework, the patient's experience of suffering often involves a sense of separation or disconnection from their own essence, from others, from meaning or purpose. The therapeutic challenge lies in helping patients bridge this gap, not by denying the reality of separation but by discovering how essence might be revealed precisely through the forms of their suffering. As illustrated in the case of Rachel, a 56-year-old woman with chronic pain [36], the therapeutic process involved helping her move from a position where pain was experienced as a foreign invasion separating her from herself to one where pain became a site for self-revelation and connection what the Rebbe might describe as the reabsorption of essence into form.

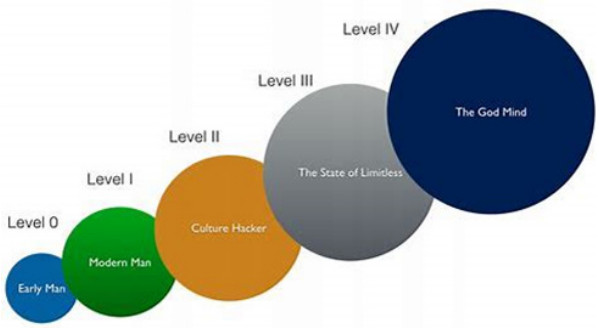
Concealment in the Therapeutic Process

For the Lubavitcher Rebbe, divine concealment is ultimately purposive rather than merely negative. The Rebbe writes that tzimtzum allows for the expression of the "beginning wedged in the end" (na'utz techilatam be-sofam), meaning that the divine essence is most fully expressed precisely in the realm furthest from its source [34]. This paradoxical principle suggests that divine absence is not the abandonment of the world but rather the condition for the most profound divine presence within it.

In clinical contexts, this perspective offers a framework for understanding how the patient's experience of abandonment or absence whether of the divine, of loved ones, or of the therapist's capacity to "fix" their suffering might itself be purposive rather

than merely privative. Just as the Rebbe sees divine concealment as creating the conditions for the most profound divine revelation, the therapist's acknowledgment of their own limitations and the irreducibility of the patient's suffering can create the conditions for the most authentic therapeutic presence. In our research on therapeutic presence in end-of-life care [37], we have observed how clinicians who acknowledge the limits of medical intervention and their own capacity to alleviate suffering often create the conditions for the most meaningful therapeutic connections. The therapist's admission of powerlessness in the face of inevitable death does not diminish their therapeutic presence but rather transforms it from a presence based on the illusion of control to one based on authentic witness and companionship.

The Rebbe's metaphysical understanding of tzimtzum thus provides a framework for conceptualizing therapeutic presence not as the absence of limitation or concealment but as a presence that emerges precisely through the acknowledgment of these limits a presence that, like the divine presence in the Rebbe's theology, is most fully expressed precisely in the realm of greatest concealment.



Evolution of Consciousness

Rabbi Abraham Isaac Kook (1865-1935), the first Ashkenazi Chief Rabbi of British Mandatory Palestine, developed a profound and integrative approach to the concept of divine concealment. For Rav Kook, divine concealment is not merely a theological concept but a necessary stage in the evolution of human consciousness and cosmic development. Rav Kook synthesizes kabbalistic concepts of tzimtzum with a progressive understanding of history and human development.

In Rav Kook's thought, human separation from God is not an objective fact but rather a consequence of human "forgetfulness" of a higher existence [38]. This perspective resonates with both Freud's understanding of repression and Lacan's concept of the Real that resists symbolization. For Rav Kook, the perception of divine absence is itself a form of concealment that has a purpose in the divine plan to facilitate the journey toward greater consciousness and spiritual evolution. From a clinical perspective, Rav Kook's evolutionary framework offers a valuable approach to understanding the therapeutic process with suffering patients. Just as Rav Kook sees divine concealment as a necessary stage in the evolution of consciousness rather than merely a punishment or problem, the therapist might conceptualize the patient's suffering not merely as a symptom to be eliminated but as a potential site for psychological and spiritual development.

In our clinical work with patients undergoing existential crises triggered by illness or loss [39], this evolutionary perspective has informed a therapeutic stance that respects the developmental potential inherent in suffering. Rather than focusing exclusively on symptom reduction or restoration of the patient's pre-crisis state, therapy informed by Rav Kook's approach might help patients integrate their suffering into a larger narrative of psychological and spiritual growth. As illustrated in the case of Michael, a 62-year-old professor diagnosed with Parkinson's disease [40], the therapeutic process involved helping him reframe his illness not merely as a biological deterioration but as an opportunity for psychological and spiritual development what Rav Kook might describe as an evolution of consciousness facilitated by the very experience of limitation and suffering.

Epistemological Dimensions

Rav Kook adopts a perspective on tzimtzum that bears striking similarities to Kant's epistemological revolution. As noted by scholars, the distinction that Rav Kook makes between God's point of view and the human perspective serves a function similar to Kant's distinction between the noumenon and the phenomenal world [41]. However, there is a crucial difference: while Kant was uncertain about the nature of the noumenon, Rav Kook directs his skepticism toward the reality of the world and its perceptions rather than toward the divine.

According to Rav Kook, the definition of God's unique unity as "there is none but Him alone" cannot be grasped from within creation, because this aspect of God's uniqueness implies that creation does not really exist independently [41]. The world is created through divine self-contraction and the concealment of this truth, and its reality can be perceived only from within creation itself.

This epistemological perspective offers important insights for clinical approaches to patient suffering. Just as Rav Kook distinguishes between the human perception of reality and the ultimately unknowable divine perspective, the therapist might

help patients distinguish between their subjective experience of suffering and the ultimately unknowable larger context or meaning of that suffering.

In our research on narrative therapy with trauma survivors [42], we have observed how the therapeutic process often involves helping patients recognize the limits of their own narratives about their suffering not to invalidate those narratives, but to create space for new meanings to emerge. The therapist, like Rav Kook's conception of the divine, respects the patient's perspective while also gently suggesting that there may be dimensions of their experience that exceed their current understanding.

This epistemological humility is particularly important in clinical work with patients confronting profound suffering, where premature attempts to assign meaning or purpose to suffering can be experienced as dismissive or invalidating. The clinician informed by Rav Kook's approach maintains a delicate balance, acknowledging the reality of the patient's suffering while also holding space for the possibility that this suffering might be situated within a larger context that neither the patient nor the therapist can fully comprehend.

Absence as Generative of Therapeutic Growth

For Rav Kook, divine concealment is not merely a negative state but a generative force that drives religious and spiritual development. Unlike approaches that view divine absence primarily as a punishment or as a theological problem to be solved, Rav Kook sees it as an essential aspect of the divine plan for the evolution of consciousness. Rav Kook warns against the dangers of attempting to define God, declaring that "Every definition of the divine leads to heresy. Definition is spiritual idolatry… even divinity itself and the name 'God' is definition" [43]. This resistance to definition parallels Lacan's understanding of the Real as that which resists symbolization, as well as Rabbi Shagar's postmodern approach to faith as embracing divine hiddenness rather than attempting to overcome it.

In clinical contexts, this perspective informs a therapeutic stance that respects the ultimately unnamable and indefinable dimensions of the patient's experience. Rather than attempting to fully define or explain the patient's suffering, the therapist informed by Rav Kook's approach might help the patient develop a relationship to that which exceeds definition to the aspects of their experience that resist full symbolization or narrative integration. As observed in our clinical work with survivors of catastrophic loss [44], patients who are able to develop a relationship to the unamiable dimensions of their experience what one patient described as "the grief beyond grief" often demonstrate greater psychological resilience than those who attempt to fully comprehend or explain their suffering. The therapeutic process, in this context, involves not the elimination of absence or uncertainty but the development of a more mature relationship to it what Rav Kook might describe as an evolution of consciousness facilitated by the very experience of limitation and concealment.

What distinguishes Rav Kook's approach is his integration of this understanding of divine concealment with a progressive vision of history and human development. For Rav Kook, the experience of divine absence is part of a larger process of spiritual evolution that will ultimately lead to a higher form of divine revelation. This teleological perspective provides a framework for understanding divine concealment not as a permanent state but as a necessary stage in an ongoing process of redemption. Similarly, the therapist informed by Rav Kook's approach might help patients situate their suffering within a larger developmental context not to diminish or explain away their suffering, but to recognize how it might be integrated into an ongoing process of psychological and spiritual growth. This perspective is particularly valuable in work with patients confronting chronic or terminal illness, where complete "recovery" in the conventional sense may not be possible, but where profound psychological and spiritual development remains an open possibility until the end of life.

Case Histories

Sarah - Divine Abandonment and Childhood Trauma

Sarah, a 42-year-old woman with a background in Orthodox Judaism, sought therapy following a diagnosis of advanced ovarian cancer. Her presenting concerns centered on intense anger toward God, whom she experienced as having abandoned her, and a crisis of faith that left her feeling spiritually adrift at a time when she most needed religious support. As therapy progressed, it became clear that Sarah's experience of divine abandonment mirrored early childhood experiences with her father, who had been physically present but emotionally absent. Her father, a respected religious scholar, had prioritized his studies and community responsibilities over family relationships, leaving Sarah with a deep sense of invisibility and unimportance.

Drawing on the psychoanalytic framework established by Freud and elaborated by Lacan, the therapist helped Sarah explore the parallels between her experience of her father and her experience of the divine. Through this exploration, Sarah began to recognize how her expectations of God had been shaped by her childhood experience of paternal absence, and how her rage at divine abandonment contained elements of her unprocessed rage at her father.

Rather than attempting to restore Sarah's pre-diagnosis faith or offering theological explanations for her suffering, the therapist drew on Rabbi Shagar's concept of "broken faith" to help Sarah develop a more nuanced relationship to the divine. The therapist suggested that perhaps her anger at God represented not an absence of faith but a more mature and authentic form of faith one that acknowledged divine concealment and human suffering rather than denying or explaining them away. Over time, Sarah began to develop what the therapist, drawing on Rav Kook's evolutionary perspective, framed as a more evolved form of faith one that could hold both her rage at divine concealment and her longing for divine presence, both her experience of abandonment and her capacity for meaning-making in the face of this abandonment. This more complex faith allowed Sarah to maintain her religious identity and practice while also acknowledging the reality of her suffering and her anger at God.

Importantly, the therapeutic work did not aim to resolve or eliminate Sarah's experience of divine concealment but rather to help her develop a different relationship to this concealment. Drawing on the Lubavitcher Rebbe's metaphysical understanding of tzimtzum, the therapist suggested that perhaps divine concealment itself had a purpose that it created space for Sarah's own autonomous meaning-making and ethical response to her suffering.

As therapy progressed and Sarah's physical condition deteriorated, the therapeutic focus shifted from psychological exploration to witnessing and presence. The therapist, drawing on Berkovits' emphasis on testimony, positioned herself not as someone who could explain or resolve Sarah's suffering but as a witness to it someone who could accompany Sarah into the experience of abandonment without attempting to diminish or normalize it.

In the final phase of therapy, as Sarah approached death, she described a profound shift in her understanding of divine presence and absence. "I still don't know where God is in all this," she said in one of her last sessions, "but I've stopped expecting God to be where I want God to be. Maybe God is in the questions, in the anger, in the not-knowing. Maybe God is in the people who have witnessed my suffering without trying to explain it away."

This case illustrates how the integration of psychoanalytic and Jewish mystical frameworks can inform clinical work with patients confronting the problem of evil and suffering. By drawing on these diverse intellectual traditions, the therapist was able to help Sarah navigate her spiritual crisis not by resolving it but by transforming her relationship to it by helping her develop a more nuanced understanding of divine presence and absence that could accommodate both her suffering and her faith.

David - Traumatic Evil and the Limits of Understanding

David, a 35-year-old man, sought therapy following a terrorist attack in which he was severely injured and witnessed the deaths of several others, including a close friend. A secular Jew with little religious background, David nonetheless found himself preoccupied with existential and theological questions in the aftermath of the attack: "Why did this happen? What kind of God would allow this? What kind of world are we living in where people do these things to each other?"

David's initial therapeutic work focused on trauma processing using evidence-based approaches for PTSD. However, even as his symptoms improved, his existential questions persisted and even intensified. "I'm sleeping better," he reported several months into therapy, "but I'm still not living better. I can't make sense of why this happened, and without that sense, I don't know how to go on."

Drawing on Lacan's concept of the Real, the therapist helped David understand how his traumatic experience represented an encounter with something that resisted symbolization and narrative integration. Rather than attempting to force this experience into existing meaning frameworks, the therapist suggested that perhaps its very resistance to meaning was itself meaningful that the attack represented a rupture not just in David's personal narrative but in the fabric of meaning itself.

The therapist, informed by Rabbi Shagar's postmodern approach to faith, introduced David to the concept of tzimtzum not as a religious doctrine but as a metaphorical framework for understanding the relationship between meaning and its absence. The therapist suggested that perhaps meaning, like the divine in Lurianic Kabbalah, emerges not through total presence or revelation but through a dialectic of presence and absence, revelation and concealment. As therapy progressed, David began to develop what the therapist, drawing on Rav Kook's evolutionary perspective, framed as a more complex relationship to meaning one that acknowledged the limits of human understanding while still affirming the value of the search for meaning. David came to see his questions not as problems to be solved but as expressions of a distinctly human capacity for meaning-making in the face of the meaningless.

Drawing on the Lubavitcher Rebbe's metaphysical understanding of the relationship between form and essence, the therapist helped David explore how his traumatic experience, while shattering his previous understanding of the world, had also revealed aspects of himself and others that might otherwise have remained concealed. David began to recognize how the attack, while devastating, had also revealed the profound capacity for human compassion and connection among survivors, first responders, and even strangers who reached out in the aftermath. The therapeutic work with David did not aim to explain or justify the evil he had experienced but rather to help him develop a relationship to that which exceeds explanation to the traumatic Real that resists full symbolization or narrative integration. The therapist, drawing on Berkovits'

emphasis on human ethical response to divine concealment, positioned herself not as someone who could make sense of senseless violence but as a witness to David's suffering and his struggle for meaning.

Over time, David developed what he described as "a peace with not having peace" a capacity to live with unanswered questions and partial meanings rather than demanding complete explanations or resolutions. This capacity allowed him to reengage with life not despite but through his traumatic experience and the existential questions it had raised.

This case illustrates how the integration of psychoanalytic and Jewish mystical frameworks can inform clinical work with patients confronting evil in its most concrete and traumatic forms. By drawing on these diverse intellectual traditions, the therapist was able to help David navigate the rupture in meaning created by the attack not by restoring his pre-trauma sense of meaning but by helping him develop a more nuanced relationship to meaning and its absence.

The Clinician as Witness

Drawing on the theological and psychoanalytic frameworks explored in this paper, we propose a therapeutic stance toward patient suffering characterized by witnessing without explaining. This stance, informed by the concept of divine concealment across multiple intellectual traditions, acknowledges the limits of understanding and the ethical imperative of presence in the face of suffering.

In our research on therapeutic presence with trauma survivors [45], we have observed how clinicians who attempt to explain or justify suffering often inadvertently compound the patient's distress, while those who acknowledge the inexplicability of suffering while maintaining a committed presence are more effective in helping patients integrate their experiences.

The clinician, like the divine in moments of concealment, must navigate the paradoxical demands of being present enough to witness suffering while absent enough to allow for the patient's autonomous meaning-making and growth. This delicate balance requires what we have termed "epistemological humility" a recognition of the limits of clinical knowledge and understanding in the face of profound human suffering [46]. A comparative analysis of Freud, Lacan, Rabbi Shagar, the Lubavitcher Rebbe, and Rav Kook reveals striking parallels in their understanding of absence. For all these thinkers, absence is not merely a negative state but a constitutive element that shapes subjectivity, desire, and development.

In clinical contexts, this understanding informs a therapeutic stance that recognizes the constitutive role of absence in the therapeutic relationship. The therapist's strategic absence their refusal to fully satisfy the patient's demands for answers, solutions, or certainty creates the space for the patient's own subjectivity and meaning-making to emerge. As observed in our clinical research on therapeutic boundaries [47], clinicians who maintain appropriate absence who resist the temptation to fill all silences, answer all questions, or resolve all uncertainties often create more effective therapeutic relationships than those who position themselves as all-knowing authorities or seek to eliminate all experiences of absence or lack. The therapeutic relationship, like the relationship between the divine and the human in mystical thought, is structured around a necessary gap or absence that is not a defect to be overcome but the very condition of possibility for therapeutic growth.

Ethical Implications

Perhaps the most significant parallel between the thinkers examined in this paper concerns the ethical implications of absence. For Freud, the internalization of paternal law establishes the basis for ethical behavior within civilization. For Lacan, the lack or absence at the heart of subjectivity necessitates an ethical stance that acknowledges the impossibility of complete satisfaction or knowledge.

Rabbi Shagar and Rabbi Berkovits, drawing on both psychoanalytic insights and the Jewish ethical tradition, argue that divine concealment places greater responsibility on human beings to act ethically in the world. Without the constant presence of a divine father figure, human beings must assume responsibility for ethical action.

In clinical contexts, this understanding informs an ethical stance characterized by responsibility in the face of not-knowing. The clinician, like the religious believer in a time of divine concealment, is called to ethical action not despite but because of the absence of complete understanding or certainty. As illustrated in our clinical work with survivors of political violence [48], this ethical

stance involves bearing witness to suffering without attempting to justify or explain it, responding to the ethical demand presented by the patient's suffering even in the absence of clear guidelines or guarantees. The therapeutic relationship, in this framework, becomes not merely a technical intervention but an ethical encounter one in which the clinician, like the divine in kabbalistic thought, creates space for the patient's autonomous existence and growth through a form of loving withdrawal or concealment.

Suffering as Liminal Space

In our previous research on the experience of suffering [1], we have conceptualized suffering as a liminal space—a threshold or boundary state characterized by ambiguity, disorientation, and the dissolution of established categories and identities. Drawing on anthropological theories of liminality, we have suggested that suffering places patients in a "betwixt and between" state, suspended between established social roles and identities.

This understanding of suffering as liminality resonates with the concept of divine concealment across the thinkers examined in this paper. Just as divine concealment creates a space of ambiguity and uncertainty in which human autonomy and meaning-making can emerge, the liminal space of suffering creates the conditions for psychological and spiritual transformation.

As observed in our clinical work with patients experiencing chronic illness [49], the liminal nature of suffering can be both disorienting and generative. Patients describe feeling "neither here nor there," suspended between health and illness, life and death, meaning and meaninglessness. Yet it is precisely in this liminal space that new identities, meanings, and forms of connection often emerge.

The clinician working with suffering patients must therefore develop what we have termed a "liminal competence" a capacity to tolerate and even inhabit the ambiguous, uncertain, and boundary-dissolving dimensions of the suffering experience [50]. This liminal competence parallels the capacity of the divine, in mystical thought, to withdraw or conceal itself in order to create space for finite existence and human autonomy. Drawing on the frameworks examined in this paper, we propose a model of the therapist as a liminal guide one who accompanies patients through the ambiguous and disorienting space of suffering without attempting to eliminate its liminal qualities.

The therapist, like the divine in moments of concealment, maintains a paradoxical presence-in-absence present enough to witness and accompany the patient through their suffering, yet absent enough to allow for the patient's own meaning-making and growth. This delicate balance requires what anthropologist Victor Turner describes as a "liminal wisdom" a capacity to move between structure and anti-structure, between meaning and its absence [51].

As illustrated in our clinical work with terminal patients [52], therapists who attempt to eliminate the liminal qualities of the dying process through excessive reassurance or premature meaning-making often impede rather than facilitate the patient's psychological and spiritual development. In contrast, therapists who acknowledge and even honor the liminal nature of dying its ambiguity, uncertainty, and boundary-dissolving qualities often create the conditions for profound end-of-life growth and transformation. The therapist as liminal guide, like the divine in mystical thought, recognizes that transformation occurs not despite but through experiences of disruption, dissolution, and absence. The therapeutic task is not to eliminate these experiences but to provide a containing presence that allows patients to navigate them in ways that promote rather than impede growth.

From Liminality to Community

In anthropological theories of liminality, the liminal phase is typically followed by reincorporation into the community, often with a transformed identity or status. Similarly, in our clinical work with suffering patients, we have observed how the liminal experience of suffering, when witnessed and contained by the therapeutic relationship, often leads to new forms of connection and community.

As illustrated in our research on peer support among cancer survivors [53], patients who have navigated the liminal space of suffering often develop what might be called a "community of the liminal" a form of connection based not on shared identities or roles but on shared experiences of disruption, ambiguity, and transformation.

This movement from liminality to community parallels what Rabbi Shagar describes as the emergence of a "community of the broken" a form of religious community based not on shared certainties or dogmas but on shared experiences of divine concealment and the struggle for meaning in its wake [30].

The therapist, like the religious leader in times of divine concealment, helps patients navigate not only their individual

suffering but also their relationship to the larger community. The therapeutic goal is not merely individual healing but the facilitation of new forms of connection and meaning that emerge through rather than despite the experience of suffering and absence.

Conclusion

This paper has explored how the concept of divine concealment (hester panim) across psychoanalytic and Jewish mystical traditions can inform clinical approaches to patients experiencing suffering and confronting the problem of evil. Through an examination of frameworks established by Freud, Lacan, Rabbi Shagar, the Lubavitcher Rebbe, and Rav Kook, we have developed a model for understanding how absence and concealment function in the therapeutic relationship and the clinical encounter with suffering.

Our analysis reveals striking parallels between these diverse intellectual traditions in their understanding of absence as constitutive rather than merely privative as creating the conditions for subjectivity, desire, and development. This understanding informs a therapeutic stance characterized by witnessing without explaining, presence-in-absence, and ethical responsibility in the face of not-knowing. Drawing on our clinical research on the liminality of suffering, we have proposed a model of the therapist as a liminal guide one who accompanies patients through the ambiguous and disorienting space of suffering without attempting to eliminate its liminal qualities. This approach acknowledges the transformative potential inherent in experiences of disruption, dissolution, and absence, while also recognizing the need for a containing presence that allows patients to navigate these experiences in ways that promote rather than impede growth.

The integration of psychoanalytic and Jewish mystical frameworks offers clinicians a rich conceptual toolkit for working with patients confronting profound suffering, particularly those experiencing spiritual crises or existential questions in the wake of trauma or loss. By drawing on these diverse intellectual traditions, clinicians can develop a more nuanced understanding of the therapeutic relationship as structured around a necessary absence or gap that is not a defect to be overcome but the very condition of possibility for therapeutic growth.

In the face of evil and suffering that challenge traditional theological and psychological assumptions, the approach outlined in this paper offers not a theodicy that justifies suffering but a framework for understanding how meaning might emerge even from experiences of profound absence and loss. The task remains not to explain away suffering but to witness it, respond to it ethically, and accompany patients as they navigate the liminal spaces between meaning and meaninglessness, presence and absence, connection and separation.

The absent healer, like the concealed divine, creates through withdrawal the space for the patient's own subjectivity and meaning-making to emerge. In this paradoxical dynamic of presence-in-absence lies the heart of both the therapeutic process and the mystical encounter with the divine a dynamic captured in the kabbalistic concept of tzimtzum and echoed in the psychoanalytic understanding of desire as emerging from lack. By bringing these traditions into dialogue, we offer clinicians a framework for understanding and navigating the complexities of human suffering that honors both its disruptive power and its transformative potential.

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