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Beyond Theodicy: The Physician's Existential Crisis

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Abstract

This paper examines the tension between ontological and epistemological approaches to understanding spiritual crises within the therapeutic context. Drawing on neurophysiological research, Jewish mystical thought, and existential philosophy, I explore how the hemispheric division of the brain serves as both metaphor and mechanism for understanding different modes of engaging with transcendence. The paper argues that effective therapeutic practice requires practitioners to navigate their own inner spiritual conflicts in order to create authentic healing spaces for patients—a process involving the integration of rational analysis and intuitive understanding. Through autobiographical reflection informed by contemporary neuroscience and religious philosophy, this study contributes to emerging discourse on spirituality in clinical settings.

Keywords: Hemispheric specialization, therapeutic relationship, tzimtzum, medical ethics, neurophysiology, existential crisis, post-Holocaust theology, Jewish mysticism, McGilchrist, right hemisphere, left hemisphere, Buber, Soloveitchik, panentheism, Divine hiddenness, Lurianic Kabbalah, therapeutic space, tacit knowledge, interhemispheric integration, corpus callosum, midrashic imagination, Hasidism, spirituality in medicine, theodicy, trauma, healing relationship, I-Thou encounter, epistemology, ontology, intergenerational trauma, paradox, integrative medicine, patient-centered care, psychological wholeness

Introduction

Existential questions about the human condition—love, death, freedom, evil, suffering, and suicide—were traditionally approached by existentialist philosophers as ends unto themselves. As Paul Tillich noted, "only the philosophical question is perennial, not the answers"[1]. Similarly, Elie Wiesel observed that "every question possessed a power that did not lie in the answer"[2]. These philosophical perspectives underscore a fundamental principle in therapeutic practice: before clinicians can facilitate spiritual healing for patients, they must first confront their own inner spiritual crises.

This paper builds upon my previous work examining the therapeutic space between doctor and patient, arguing that an understanding of one's own psychological and spiritual barriers is prerequisite to effective clinical engagement [3]. Drawing on contemporary neuroscience, particularly McGilchrist's research on hemispheric lateralization [4]. I propose a framework for understanding how practitioners can integrate both analytical and intuitive approaches to suffering—particularly when addressing existential distress.

Theological Parallels: Adam I and Adam II

The neurophysiological distinction between hemispheric modes of engagement finds a striking parallel in Rabbi Joseph B. Soloveitchik's influential essay "The Lonely Man of Faith," which describes two typologies of religious experience [7]. Soloveitchik's "Adam I," derived from Genesis 1, represents the "majestic man" focused on creativity, control, and mastery over the world through technological and intellectual means. "Adam II," based on Genesis 2-3, embodies the "covenantal man" seeking relationship with the divine and meaning beyond material existence.

This theological framework aligns remarkably with McGilchrist's neurophysiological model: Adam I corresponds to left-hemispheric dominance with its emphasis on analysis, categorization, and control, while Adam II reflects right-hemispheric orientation toward relationship, contextualization, and lived experience[8]. As Soloveitchik notes, modern individuals often experience existential loneliness due to the difficulty in balancing these dual aspects of identity—a struggle that mirrors contemporary concerns about hemispheric imbalance in modern society [7,9].

Personal Context: Trauma and Theological Questioning

The theological questions emerging from the Holocaust demand particular attention when considering the physician's role in healing trauma. Born five years after the Shoah to a survivor from Vienna, my childhood was shaped by profound questions of theodicy—how to reconcile the existence of evil with a benevolent deity. As Elie Wiesel articulated, the essential theological question after Auschwitz is not simply academic but existential: "how is it possible to believe in God after what happened?" This question resonates deeply with healthcare practitioners confronting extreme suffering.

Eliezer Berkovits' concept of "faith after the Holocaust" provides a framework for understanding the physician's crisis. Berkovits argues that after Auschwitz, traditional beliefs about a redeeming God active in history require radical reconsideration, yet rejecting Divine Providence entirely would represent "a victory for Hitler." For physicians treating severe

trauma, this tension manifests in the daily struggle between medical intervention and the limits of healing. The clinician must simultaneously acknowledge both human agency in causing suffering and the boundaries of medical power to alleviate it.

Richard Rubenstein's theological response further illuminates the clinician's dilemma. Rubenstein explored "what the nature and form of religious existence could possibly comprise after Auschwitz," suggesting that traditional theological frameworks prove inadequate when confronting evil "on a previously unimaginable scale." Similarly, physicians witnessing profound suffering must navigate their own inner crisis of meaning, often finding conventional medical narratives of "healing" and "cure" insufficient in the face of intractable trauma.

Simone Weil's philosophy of affliction (malheur) provides additional insight into the physician's predicament. For Weil, affliction is "something apart, specific, and irreducible" that "takes possession of the soul and marks it through and through with its own particular mark." She distinguishes physical suffering from affliction, which includes "social, psychological, and physical" dimensions that together create a state that "scourges the very soul." This multidimensional understanding of suffering challenges the clinician to address not merely physical symptoms but the existential crisis that accompanies profound trauma.

The documentary project "The Cup Half Full," which chronicled my father's wartime experience, forced me to confront this inherited trauma in new ways. The clinical precision required to narrate historical details of my grandparents' and aunt's deportation and murder at Sobibor created a tension between objective analysis and emotional response—a tension that parallels the broader challenge for clinicians treating trauma survivors. This tension demands that physicians develop what might be called a "dual consciousness"—simultaneously maintaining analytical precision while cultivating the capacity for empathic engagement with suffering that transcends conventional medical frameworks.

For today's physician attempting to heal Holocaust survivors or others experiencing profound trauma, this inner crisis involves reconciling professional detachment with deep compassion. As contemporary thinkers from Camus and Arendt to Wiesel, Rubinstein, and Pope John Paul II have recognized, understanding "evil on a previously unimaginable scale" requires more than theoretical frameworks. It demands an integration of hemispheric approaches—the analytical precision of left-brain thinking with the relational, contextual understanding facilitated by right-brain processes. Only through this integration can clinicians create authentic healing spaces that honor both the measurable dimensions of illness and the existential significance of suffering.

Midrashic Imagination and Hermeneutic Approaches

My scholarly trajectory led me through various hermeneutic approaches to religious texts, particularly through the influence of Michael Fishbane's work on the "midrashic imagination"[12]. Fishbane demonstrates how mythic elements are embedded in Jewish tradition and how, rather than suppressing these myths, Jewish interpretation has often deepened and expanded them through rabbinic literature and Kabbalah [12,13].

This interpretive approach enabled me to explore how rabbinic parables encode trauma beneath the surface of sacred texts, particularly in midrashic commentaries to the Book of Lamentations[14]. The parable form allowed for theological protest and questioning within a traditional framework—a strategy that would later be developed in Hasidic thought, which navigates the tension between reverence for the divine and critical engagement with faith traditions [15].

Tzimtzum and Divine Presence/Absence

The Lurianic kabbalistic concept of tzimtzum (divine contraction) provides a particularly rich framework for addressing the paradox of divine presence and absence in the face of suffering[16]. According to Isaac Luria's formulation, before creation "the sublime and simple light filled all of reality," requiring divine contraction (tzimtzum) to create "an empty place and a vacant space" in which creation could exist [17,18].

The interpretation of this concept became a subject of controversy among early modern kabbalists and Hasidic masters. While some understood tzimtzum literally—affirming that God genuinely withdrew from a portion of reality—virtually every Hasidic teacher adopted a non-literal reading, arguing that divine contraction was only apparent and that God never truly withdrew from any part of reality [19,20].

This seemingly abstract distinction becomes critically important when addressing divine absence in historical catastrophes, particularly the Holocaust. In the writings of Rabbi Nachman of Bratslav, the paradoxical nature of tzimtzum—God being simultaneously present and absent—allows for holding apparently contradictory theological claims [21,22]. This paradox, resolvable only "in the future," requires the right-hemispheric capacity to embrace contradiction and ambiguity.

Panentheism and Post-Holocaust Theology

The philosophical position emerging from these mystical traditions approximates what Karl Christian Friedrich Krause termed "panentheism" (πᾶν ἐν θεῷ, pān en theō, "all in god") [23]. This conception, which influenced transcendentalist thinkers like Ralph Waldo Emerson and was later appropriated by Gershom Scholem to describe Hasidic theology, maintains that the world exists within God, God is present in all things, and yet God remains transcendent beyond the universe [24,25].

This panentheistic framework allows for a more nuanced theodicy that acknowledges divine immanence in suffering while preserving divine transcendence. Particularly significant is the theology developed by Rabbi Kalonymus Kalman Shapira (the Piaseczna Rebbe) in the Warsaw Ghetto before his murder at Treblinka in 1943 [26]. His collection of homiletic essays, Esh Kodesh (Sacred Fire), articulates a theology of divine suffering in which God's pain would destroy the world were it not mediated through sacred textuality [27]. The notion that God weeps in "inner chambers" over human suffering provides a powerful response to theodicy that acknowledges divine presence within, rather than beyond, human anguish.

The Eclipse of God and Divine Withdrawal

Biblical texts acknowledge divine hiddenness, with God taking responsibility for withdrawing: "I will surely hide My face on that day, because of all the evil they have done in turning to other gods..." (Deuteronomy 31:17-18). Martin Buber's concept of "The Eclipse of God" offers a more nuanced perspective on divine absence, suggesting that "an eclipse of the sun is something that occurs between the sun and our eyes, not in the sun itself"[28]. This formulation distributes responsibility between human perception and divine reality, creating space for both ontological and epistemological approaches to divine hiddenness.

David Weiss Halivni, an Auschwitz survivor and scholar, argues that Jewish history is bookended by two diametrically opposed "revelations": Sinai representing divine presence and Auschwitz embodying divine absence [29]. Halivni's thesis maintains that Auschwitz represents not merely divine "hiding" but an actual ontological withdrawal (tzimtzum) from human history [30]. This position resonates with certain strands of contemporary philosophy, including Slavoj Žižek's reading of Hegelian Christianity.

Žižek and Atheistic Theology

Žižek's interpretation of Christ's crucifixion—"Father, why have you for-

saken me?"—centers on the concept of divine abandonment [31]. He suggests that instead of "the transcendent God guaranteeing the making of the universe," we encounter "a God who abandons this transcendent position and throws himself into his own creation" [32]. This movement from transcendence to immanence leaves humanity with "the terrible burden of freedom and responsibility for the fate of divine creation."

This philosophical position parallels Halivni's conception of divine withdrawal occurring not at creation but within history, culminating in Auschwitz [29,30]. Both approaches acknowledge a ruptured relationship between the divine and human that creates space for human autonomy while preserving the possibility of relationship. Such perspectives require integrating both hemispheric approaches: the left-hemispheric capacity for analytical critique and the right-hemispheric openness to paradox and relational knowledge.

Neurophysiological Foundations

Recent neurophysiological research has demonstrated that the division of the brain into two hemispheres facilitates incompatible yet complementary versions of reality with distinct priorities and values [4,5]. According to McGilchrist, the right hemisphere provides a broad, holistic perspective focused on interconnectedness, empathy, social bonding, and intuitive understanding. In contrast, the left hemisphere offers a narrow, focused view that excels at analyzing details and manipulating isolated elements, linked to logic, language, and analytical thinking [4].

This hemispheric distinction has profound implications for mental health. As McGilchrist and others have documented, hemispheric imbalances and disconnections underlie many prevalent forms of psychological distress, including schizophrenia, depression, autism, psychopathy, alexithymia, and various personality disorders [5,6]. Beyond clinical pathology, however, this neurophysiological model provides insight into spiritual experience and the human capacity to engage with transcendence.

The Divided Brain in Therapeutic Practice

The interhemispheric model provides a valuable framework for understanding the therapeutic encounter. The left hemisphere employs reason and logic, potentially recognizing an intelligent design while rejecting notions of divine benevolence on logical grounds given the realities of suffering, evolution, and history. This hemisphere might accommodate a Spinozian pantheism or Jungian archetypal understanding of the divine, but resists personalized conceptions of transcendence [33,34].

In contrast, the right hemisphere allows for intuitive engagement with transcendence, facilitating an I-Thou relationship with the divine as described by Martin Buber [35]. This hemisphere perceives coherence and meaning in suffering, interpreting pain as part of an unfolding spiritual process that invites human maturation and connection with transcendence.

The corpus callosum, connecting these hemispheric perspectives through approximately 200 million axonal projections, allows minimal but essential communication between these different modes of knowing [36]. This neuroanatomical reality mirrors the existential challenge of integrating analytical and intuitive approaches to suffering—both for patients and clinicians.

Toward an Integrated Therapeutic Approach

Effective therapeutic practice requires balancing these hemispheric pulls, honoring both rational analysis and intuitive understanding. Until clinicians recognize and navigate these tensions within themselves, they cannot fully attend to patients' suffering or perceive the deeper dimensions of their narratives [37,38].

This integration demands acknowledging what Michael Polanyi termed "tacit knowledge"—the understanding that "we know more than we can tell"[39]. In therapeutic contexts, this means recognizing both the explicit, articulated symptoms presented by patients and the implicit, embodied suffering that may elude verbal expression. By engaging both hemispheric modes of knowing, clinicians can create healing spaces that address both the measurable, objective dimensions of illness and the existential, spiritual dimensions of suffering [40].

Conclusion

The tension between ontological and epistemological approaches to transcendence—between Transcendent "Higher Power" as abstract concept and an imminent "my Higher Power" as lived relationship—mirrors the neurophysiological division between hemispheric modes of engagement. Effective therapeutic practice requires navigating this tension, integrating both analytical precision and intuitive understanding.

My personal journey through inherited trauma, theological questioning, and professional practice demonstrates how these different approaches to transcendence can be held in productive tension. By acknowledging both the left-hemispheric drive for clarity and the right-hemispheric openness to relationship, clinicians can create therapeutic spaces that honor the full complexity of human suffering.

The minimal yet vital connections between hemispheric perspectives—represented anatomically by the corpus callosum—serve as both metaphor and mechanism for the integration of different modes of knowing. By strengthening these connections in our own understanding, we as clinicians become better equipped to accompany patients through their suffering, recognizing both its measurable dimensions and its existential significance.

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