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Review Article

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Fracture Within Mercy: A Revision of Therapeutic Contraction

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Abstract

Clinical teaching holds that limits express care — that declining the late call or ending the visit is a mature form of the disposition that makes a good physician. This paper argues that the claim is structurally false, that its falsity is costly, and that a body of eighteenth-century kabbalistic reasoning states the correct account more precisely than anything in the clinical literature. In Jonathan Eibeschütz's Wa-Avo ha-Yom el ha-Ayin, analysed by Elliot Wolfson, judgment cannot be derived from unbounded lovingkindness by ordinary causation, since an effect resembles its cause and one may not posit opposites in a simple subject; it must therefore be spoken of as yesh me-ayin, something from nothing. The same source holds that the catastrophic breaking of the vessels occurs within Attiqa, a configuration characterised as entirely merciful, precisely because no judgment was present to impose restraint — unbounded efflux with no vessel being, in his phrase, seed spilled in vain. This yields a structural account of physician burnout that inverts the depletion model

and is consistent with evidence that organisation-directed interventions outperform individual resilience training and that sustainable clinical closeness is differentiated rather than boundless. I set out the kabbalistic argument at length, including its transmission through the Chabad reading on which therapeutic applications have rested, and then state in detail where the position departs from my own previous publications on therapeutic ṣimṣum, self-kenosis, and sacred listening — including one direct reversal, since that earlier work prescribed further self-emptying as the remedy for burnout. Three theses result: limit is created rather than derived and must be taught as a distinct competence; the vessel that renders giving receivable is largely institutional; and the boundary is not the price of therapeutic space but its constitution.

Keywords: Zelem, Divine Body, Anthropomorphism, Eyn-Sof, Tzimtzum, Atzmus, Dirah Be-Tachtonim, Apophasis, Theosophical Kabbalah, Habad, Va-Avo Ha-Yom El Ha-Ayin, Elliot R. Wolfson

1. The Physician Who Cannot Stop

Every department has one, and in some seasons it is each of us. She answers messages at eleven at night and does not experience this as a problem. Her clinic runs ninety minutes over because she will not cut a patient short. She takes the transfer nobody else will take. Colleagues describe her admiringly and slightly warily. When she is eventually spoken to about hours, or documentation lag, or the effect on the people covering for her, the conversation goes badly — not because she is defensive, but because the request appears to her as a request to care less, and she is not willing to care less.

She is not wrong to refuse that. The request, as she hears it, is one no serious clinician should accept.

The trouble is that she has heard it correctly. Our standard account of clinical limits makes them a form of caring, which means any request to set one arrives as a question about how much she cares. Wellness curricula make the same move from the other direction, telling her that setting limits is itself an act of self-compassion and therefore continuous with her vocation. Neither framing helps, and both rest on a common error about where limits come from.

This paper argues that the error has been diagnosed with unusual precision in a body of material clinicians have no reason to know, and that correcting it changes what we teach, what institutions owe, and how we understand the therapeutic space itself. It also requires me to revise several positions I have published, and section 11 sets out that revision in detail.

2. What the Burnout Literature Has Not Established

The dominant folk model treats burnout as depletion. A finite reserve of empathy is drawn down until exhausted; the remedy is replenishment — rest, mindfulness, resilience training, self-care. Maslach and Leiter's foundational work never made the claim in that form. Their model set emotional exhaustion alongside depersonalisation and reduced personal accomplishment, and located all three in the fit between the person and the domains of the work environment [1]. But the depletion picture is what filtered into institutional practice, and it is what most physicians have absorbed.

The evidence has not been kind to it. Panagioti and colleagues' meta-analysis of controlled interventions found that organisation-directed interventions produced significantly larger reductions in burnout than those directed at individual physicians [2]. West, Dyrbye, and Shanafelt locate the principal drivers in workload and job demands, efficiency and resources, control and flexibility, work–life integration, social support, and the culture and values of the practice environment — not in individual fragility [3]. Epstein and Krasner, defending resilience as a legitimate construct, were explicit that promoting it cannot substitute for addressing the conditions of work others have argued directly that resilience training addresses only part of the problem and risks locating the fault in the sufferer [4,5].

Most instructive here is Kearney and colleagues' study of clinicians who sustain end-of-life work across decades. What protects them is not distance from patients. It is a particular structured closeness the authors call exquisite empathy: highly present, intimate, warm, and simultaneously well-differentiated [6]. The protective factor is not less engagement but bounded engagement.

So, the literature has established that the problem is not a shortage of compassion, and that the effective remedies are structural. What it has not supplied is an account of why boundedness should be constitutive of sustainable caring rather than a subtraction from it. Without such an account, "well-differentiated" reads as a trait some clinicians happen to possess, and boundary-setting continues to be taught as a species of self-care — that is, as compassion redirected inward.

I want to propose that boundedness is not a variety of caring at all, and that this is precisely why it is so hard to acquire.

3. The Doctrine and Its Standard Transmission

The material I am drawing on concerns ṣimṣum, the divine self-contraction by which, in the kabbalah of Isaac Luria as transmitted chiefly through Ḥayyim Viṭal, an infinite God makes room for a world. The bare account runs as follows. Prior to creation the light of Ein Sof filled all. In order that finite worlds might exist, the infinite withdrew itself from a central point, leaving a vacated space, ḥalal panuy, into which a line of light, the qaw, was then drawn, and within which the worlds were constituted [7,8].

The question that occupied the tradition for the next three centuries is what kind of event this was. Was the withdrawal real — a genuine

absence of divinity from the vacated space — or figurative, a concealment of a presence that never in fact departed?

The dispute is not a scholastic curiosity. It determines whether the vacated space is empty or full, and therefore whether the world stands in the absence of God or in his hiddenness. And it determines what a therapeutic appropriation of the doctrine is entitled to claim.

The Lubavitcher Rebbe set out the alternatives with unusual clarity in a letter of 1939. He identifies four positions: that the contraction is to be read literally and affects God's essence, a view he attributes to the misnagdim of the Alter Rebbe's day and glosses sympathetically as resting on the impossibility of the King being found in a place of filth; that it is literal but affects only His light; that it is non-literal but affects the Source of light as well, a position he assigns to R. Ḥayyim of Volozhin in Nefesh ha-Ḥayyim, noting that in this he departs from his master the Vilna Gaon; and that it is non-literal and affects only the light, not its Source. Chabad, he states, follows the fourth alone [9,10]. In a later responsum he adds the decisive procedural point: the whole dispute turns on what Oṣerot Ḥayyim and Mavo She'arim say about the first contraction, as R. Immanuel Ḥai Ricchi made explicit in Yosher Levav [11,12].

The fourth position is the one that reached the therapeutic literature, and it reached it through a specific development. In Sha'ar ha-Yiḥud ve-ha-Emunah and throughout the Maggid's circle the contraction is glossed pedagogically: the light is not diminished but veiled, as a teacher condenses what he knows into a form a student can receive, or a parent addresses a child in the child's own idiom [13]. This is the reading on which every therapeutic application of ṣimṣum rests, including Mordechai Rotenberg's account of contraction as the social act by which one party makes space for another's becoming and including my own [14-16].

Note what the pedagogical reading assumes. It assumes an antecedent plenitude. The teacher possesses the knowledge and then accommodates. The parent has the full range of speech and then condenses. Nothing in the model asks where the capacity to condense comes from, because the model treats it as obvious: a good teacher accommodates because he wants the student to learn. Limitation is an expression of the desire to give.

That assumption is what the following sections dismantle.

4. Where Contraction Can Occur

Jonathan Eibeschütz, [following Nathan of Gaza] the eighteenth-century Talmudist and Prague-Altona rabbi whose kabbalistic writings were long suppressed and have been reconstructed and analysed by Elliot Wolfson, asks a question the pedagogical reading never puts [17]. Not how literally the contraction is meant, but where it can occur at all.

His treatment of the First Cause is as radical an apophaticism as the tradition contains. No name applies to it, only to its will. He declines to predicate divinity — elohut — of it, reserving that term for Elohei Yisra'el, and states that it is neither mentioned in the Torah nor the address of prayer. Wolfson observes that this borders on a mystical atheism, an atheological surpassing of the theological, and connects it to his broader argument that apophasis characteristically fails to overcome what it negates [17-18].

The structural consequence is what matters here. Were the contraction located in the First Cause, Eibeschütz argues, boundary and middle would not be possible — for of that which admits no image, no aspect, and no name, one cannot say that there is a midpoint from which to withdraw. Contraction is possible within the image of the ten sefirot. It is not possible in what has no image at all [17,20].

He presses the point as a question: if the contraction were in the First Cause, what would the Shekhinah be for? Israel Sarug's formulation — that he contracted his Shekhinah so there would be a place for worlds — answers it. Viṭal's ṣimṣem aṣmo be-emṣa is accordingly relocated: the constriction occurs in the point of Zion, the secret of the womb, be-malkhut be-aṣmuto, and when Viṭal writes of Ein Sof throughout Eṣ Ḥayyim he means, on this reading, Elohei Yisra'el rather than the ultimate ground [17].

Whether that is a fair reading of Viṭal is a separate question, and Wolfson is careful to say there is no evidence that it is a proper interpretation. The structural claim survives the exegetical doubt: withdrawal requires a locus that has already been named.

The locus is the point engraved within the thought of the infinite — called maqom, the place that contains the supernal aspects; the even shetiyyah, the foundation stone; the point of Zion, whence all worlds emerge and whither they return. It is not neutral. It is already gendered, and against the philosophical grain: potentiality masculine and actuality feminine, an inversion of the hylomorphism assigning form to the male and matter to the female, with precedent in Azriel of Gerona's reading of ḥokhmah as koaḥ mah against binah as bo hu. Because the point is the more actualised in relation to the emanation, it is nuqba. Wolfson's gloss is worth having exactly: the indeterminacy of the actuality of the potential exceeds the determinacy of the potentiality of the actual.

Wolfson coins a formulation for this gradation that I take as the paper's hinge. Working through the passage in which the point unifying the place is said to possess greater actuality than what is other to it, he poses the objection: what could be other to that of which it is said there is nothing outside, and therefore nothing other? His answer is that the other to the not-other alludes to malkhut de-ein sof — the capacity that receives, the quality of judgment imposing measure on immeasurable light, and the matrixial space from which the worlds are made [17].

Two consequences follow, and both bear on clinical practice.

First, there is no undifferentiated fullness that subsequently contracts. Differentiation is the site, not the result. Applied to the clinician: he never withdraws from bare presence, but always

within a position already named by role, coat, room, schedule, and institution.

Second — and this is the sense in which the vacated-space picture misleads — the place in question is not merely emptied. An emptied space is defined by what has been removed from it. A matrixial space is defined by what becomes possible within it. I return to this in section 10.

5. Judgment as Yesh Me-Ayin

Now the argument on which everything clinical in this paper depends.

Withdrawal requires din, judgment: the principle of limit, boundary, measure. Eibeschütz's problem is that judgment cannot be got from where it would have to come from.

The reasoning, as he sets it out in Shem Olam and returns to it in Wa-Avo ha-Yom, runs as follows. Everything that possesses boundary and measure is nothing but the aspect of judgment, for the nature of benevolent lovingkindness is to bestow good and to emanate without constraint. Measure and boundary — even where they are spiritual and not physical — nonetheless indicate constriction and contraction, qemiṭu we-ṣimṣum, which is judgment. But the ground is characterised as pure ḥesed, the source of lovingkindnesses, and it is incomposite in the extreme. And an effect resembles its cause. Judgment therefore cannot be derived from it in the ordinary manner of effect following cause, since to hold that it could would be to posit two opposites in a single simple subject. His conclusion is that din must be spoken of as yesh me-ayin, something from nothing, precisely because it does not stand in the relation of effect to cause [17,21].

He adds a further specification. The force of these judgments is called boṣina de-qardinuta, the hardened spark; and because the root of this light made measure and boundary at the beginning of emanation, when it descends into the worlds it is called qaw ha-middah, the line of measure, for it gives measure, border, and boundary to all the sefirot. Limit is not a subtraction performed upon what is given. It is a distinct principle with its own root and its own name.

Strip the theology and the claim is this. A principle of limitation cannot be generated by a principle of unlimited giving. However much you have of the second, you will never arrive at the first by having more of it. They are not points on a continuum, and the one is not the mature form of the other. Limit has to be introduced, and its introduction is a creation rather than a derivation.

That is precisely the claim I want to make about clinical boundaries, and precisely what our teaching denies.

6. Fracture Within Mercy

The same source supplies the consequence, and it inverts the picture most clinicians carry.

Eibeschütz holds that although Attiqa — the highest configuration — is entirely merciful, kullo raḥamim, its condition characterised as complete dissemination, ha-kol hitpashsheṭut, the catastrophic fracture nonetheless occurs within it. Not despite its mercy but because of it: there was no judgment present to serve as an impediment, no restraint or boundary to enact what the creative process requires, on the principle of balance between the masculine right and the feminine left. Expressed in the gendered idiom of the source, the efflux of Attiqa is without a female and is therefore only in the secret of zera le-vaṭalah, seed spilled in vain — and it caused the fracture; the broken vessels, on the Ari's teaching, are themselves in the secret of that wasted seed [17]. Wolfson notes the associated wordplay: the imbalance in Attiqa is offered as the explanation for its being called Edom, connected to dumiyyah, silence [17].

I want to sit with the structure of this claim before translating it, because it is unusual within its own tradition. The standard Lurianic account has breakage follow from the withdrawal — the vessels of the world of points cannot contain the light that enters after the contraction, and they shatter. Here breakage precedes and does not depend on withdrawal, and its cause is the absence of the limiting principle rather than the severity of its application. Fracture is what unbounded mercy does when there is nothing to hold it.

Note also what is not claimed. Nothing has been depleted. The mercy is entire, the dissemination complete, the outflow undiminished. Eibeschütz is not describing exhaustion. He is describing a structural failure in something operating at full capacity.

7. The Vessel and the One Who Says Dai

The counterpart to the fracture is the figure of the vessel, and without it the argument of section 5 is merely restrictive.

Reading em kol ḥai, mother of all living, Eibeschütz calls Eve the keli ha-ma'aseh, the instrument of action, for the secret of contraction: without her the aspects would have expanded impenetrably, and through her they were given a boundary. Hence, on the traditional wordplay, the Shekhinah is in the secret of Shaddai — she-amar dai, the one who said to the world enough [17].

Elsewhere he presses further. Without the feminine there would have been the secret of seed spilled in vain, because she is what forms everything into complete form, prescribed amount, and limit; she is qaw ha-middah and demiurge. As line of measure she guards against the powers of grace being absorbed and annulled in the masculine configuration; in this capacity she is matter, gathering, seal, and garment [17].

The claim embedded there is not that limit restrains a gift that would otherwise be greater. It is that without limit there is no gift, only discharge. Grace with no vessel is absorbed and annulled — which is to say it does not arrive anywhere.

There is a further passage worth having, from Naftali Bachrach's Emeq ha-Melekh, because it addresses an objection that arises immediately. If the vessel is required, and if at the moment of contraction there is as yet no vessel, how does anything begin? Bachrach's answer is that when the light was raised to make an empty place there were as yet no female waters, because there were as yet no righteous men — and that it sufficed for the divine thought to think about the righteous, from which act the joy arose. Wolfson draws out the implication: in the absence of a real receiver, the infinite invokes an imagined one and derives joy from the confabulation. Eibeschütz says it outright — the vessel of the feminine, even if merely imagined and not ontically real, is what saves the outflow from being spilled in vain [17,22].

The vessel may be imagined before it exists. It may not be dispensed with.

8. Burnout as Shevirah

Now the translation.

The depletion model says: a reserve is drawn down; replenish it. Eibeschütz's structure says something the depletion model cannot say. Nothing has run out. The outflow is complete, the mercy entire and genuine — and it breaks, because there is no boundary constituting it as a gift to someone rather than a discharge into nothing.

This is a structural account of burnout, and it differs from the depletion account in three respects that can be checked.

First, it predicts that burnout should be worst not in those with least compassion but in those whose giving is least bounded. This is consistent with the documented vulnerability of idealistic and highly engaged trainees, and with Kearney's finding that what protects veteran clinicians is differentiation rather than distance [6]. It also predicts that a measure of unbounded giving should outperform a measure of empathy in predicting burnout, which to my knowledge has not been tested directly.

Second, it predicts that interventions supplying boundary should outperform interventions supplying replenishment. Boundary in this sense means schedule control, staffing, scope limits, protected time, and explicit institutional permission to stop — not personal recovery time. This is what the meta-analytic evidence shows [2,3].

Third, it predicts that resilience framing should not merely fail but wound. A physician fracturing because his giving is unbounded is told that he needs greater capacity to give. The insult is not incidental to the intervention; it is entailed by it. This is the strongest reason to think the structural account is doing real work, because the depletion model has no explanation for why a well-intentioned offer of support is so often experienced as an accusation.

A theological argument cannot establish an empirical claim, and I do not offer it as evidence. What it supplies is the mechanism that renders an established pattern intelligible — the reason boundedness turns out to be constitutive rather than subtractive — together with a prediction the existing model does not generate.

And it supplies the second half, which the burnout literature almost entirely omits**: unbounded availability degrades what the patient receives.** The literature is framed around harm to clinicians. But grace without a vessel does not arrive. A relationship with no shape leaves the patient unable to calibrate what is owed, unable to predict access, and unable to distinguish being cared for from being absorbed into someone else's need to give. Patients of the physician in section 1 often report feeling grateful and, simultaneously, obscurely burdened. They are not confused. They are registering the absence of a vessel.

9. Why "Limits are an Expression of Compassion" Fails

We teach the opposite of what the argument implies, and we teach it constantly. Limits express care. Declining the midnight call is a form of love. The frame protects the work. Saying no to this patient is saying yes to the next.

Pragmatically these are often true. Structurally they are false, and the falsity has a specific cost.

If limit is a form of care, then the clinician who cares enough will find the boundary obvious. The corollary follows immediately and inescapably: difficulty in setting a boundary is evidence of insufficient care. No curriculum says this. Every trainee infers it, because it is what the premise entails.

And so the physician in section 1 waits. She waits for a boundary to arrive as the refinement of a feeling, and it does not arrive, because feelings of that kind do not produce boundaries — they produce more of themselves. Her failure to find the limit obvious confirms, to her, that she has not yet cared correctly. The remedy she reaches for is more of what is breaking her.

The alternative is blunter and, I think, kinder. The capacity to say enough is discontinuous with benevolence. It cannot be deduced from it, is not its mature form, and does not grow as compassion deepens. It has to be made, each time, out of nothing.

I would put it to residents in three sentences. Your boundary will never follow from your caring. You will have to make it, separately, as its own act. And making it will always feel like a failure of caring — that feeling is the normal phenomenology of the act, not evidence about your character.

10. The Boundary Is the Room

This reframes the therapeutic space itself.

The model I have worked with describes the clinician's self-limitation as an emptying: he restrains his knowledge, speech, and diagnostic authority, and the patient occupies what has been evacuated. The picture is defective in a way I could not see from inside it. An emptied space is defined negatively, by what has been taken out. It makes the patient's emergence a function of the

clinician's abstention. And it quietly flatters the clinician, whose contribution consists in his absence.

The matrixial formulation says something different. Such a space is defined not by what has been removed but by what can occur within it, and by the restraint holding it open. The restraint is generative rather than merely permissive.

This is not foreign to clinical thought; it is clinical thought in another vocabulary. Winnicott's holding environment is not an absence but an active, effortful structure within which development occurs that could not occur unheld [23]. Bion's container is not a vacancy but a function performed at cost, by which experience that cannot be borne becomes bearable [24]. The boundary literature in psychiatry has argued for three decades that the frame is constitutive of treatment rather than incidental to it, and that boundary crossings matter because they alter what the treatment is, not merely how it looks [25,26].

So the corrected formulation: the clinician does not withdraw so that a vacancy appears. He constitutes a bounded space, at cost, within which the patient can be something other than an object of description. **The boundary is not the price of the room. The boundary is the room.**

11. Where This Departs from My Earlier Work

My earlier work applied șimșum to the clinical encounter, most recently in an essay on self-kenosis and the hermeneutic clinician [27]. Honesty requires that I state which of those positions the present argument corrects rather than extends. There are six, and the third is a direct contradiction.

One: The Premise of The Over-Full Physician. The kenosis essay opens by diagnosing a practitioner who is, in its own phrase, too full — saturated with protocol, differential, and the vocabulary of pathophysiology, entering the room with no space left for the patient to appear [27]. The whole argument follows from that premise: the remedy for fullness is emptying. Eibeschütz's locus argument makes the premise unavailable. Contraction cannot occur in what has no image, and the site of contraction is differentiated before anything withdraws from it. There is no bare fullness to empty. What the physician occupies is a position already constituted by role, coat, room, schedule, and institution, and honest practice begins by naming that position rather than evacuating it. I had argued something adjacent from the patient's side, in the work on the anonymous case and name-centred practice and failed to turn it on the clinician [28].

Two: Containment Invoked But Never Derived. The kenosis essay is not naive about risk. It names three — dissolution without containment, abdication of responsibility, and false humility — and insists throughout that the self-emptying be ethically contained, bounded, reversible, and held within a robust professional structure [27]. What it never asks is where the containing capacity comes from. Containment appears as a given, an external frame supplied by professional ethics, and the sources it reaches for supply responsibility rather than limit: Idel's theurgic agency and the recovery tradition's distinction between surrendering control and abdicating responsibility [29,30]. Section 5 above attempts to supply what was missing. If judgment is yesh me-ayin, containment is not a frame one stands inside but an act one performs, and a discipline that requires containment while treating its source as external has not finished its work.

Three: Burnout — A Direct Reversal. This is the substantive contradiction, and I state it plainly rather than soften it. The kenosis essay argues that burnout and moral injury afflict medicine because the standard remedies leave untouched the spiritual structure of the over-full physician; that the practitioner trained as a master of disease is set up for the suffering of an omnipotence that fails; and that the discipline of self-emptying is therefore a path to the survival and renewal of the healer [27]. The prescription for the burning-out physician is more emptying.

Sections 6 and 8 above say the reverse. Fracture occurs within a configuration that is entirely merciful and completely disseminating, precisely because nothing restrains it. On that reading the physician who is breaking is not suffering from a failed omnipotence but from an unbounded outflow, and prescribing further self-emptying prescribes the cause as the cure. I do not think the earlier account was wrong about the over-full diagnostician; the fantasy of mastery is real and worth dismantling. I think it misidentified the mechanism of burnout, and that two different conditions have been run together. Emptying the diagnostic ego and bounding the giving self are distinct operations, and only the second addresses the fracture.

Four: Sacred Listening As Reception. The kenosis essay defines sacred listening as attention in Weil's sense — thought suspended, left detached and empty, ready to be penetrated by its object; the suspension of the clinician's interpretive grasp so the patient may be heard before being categorised [27,31,32]. That is a maximally receptive description, and section 7 above replaces it. Bachrach's passage on the imagined righteous describes something active and exposed: the receiver must be conjured before there is a receiver, and the clinician sitting with a patient not yet able to speak is not suspending his categories but performing an act of imagination whose object does not yet exist. The passive account was not merely incomplete. It left the first minutes of an encounter unaccounted for.

Five: The Space As Concealment Rather Than As Structure. Here I must be more careful than in earlier drafts, because the kenosis essay does not commit the crude version of the error. It explicitly declines to describe the clinical makom as a true void: drawing on the non-literal reading of contraction and on Wolfson's dialectic of concealment and disclosure, it characterises the space as a concealment-that-reveals, a silence saturated with presence, an apparent emptiness within which a deeper presence persists [27,33].

That is a real advance on a naive account of the emptied room, and I do not withdraw it. But it remains a withdrawal account. The space is still defined by what the clinician has taken out of it, with the theological work done by the claim that what was taken out is secretly still there. The matrixial formulation differs in kind: the space is defined by what can occur within it and by the boundary that holds it open. On the concealment account the clinician's contribution is a hidden presence behind his absence; on the present account it is a structure actively maintained at cost. The difference shows up in the failure mode. A concealment can be too thin, and the patient feels abandoned. A structure can fracture, and the clinician breaks. The second failure is what this paper is about, and the concealment model cannot describe it.

Six: The Direction of Fracture. The kenosis essay gives the standard Lurianic sequence, in which the vessels are unable to contain an overwhelming influx and shatter, and reads the three-beat rhythm of contraction, shattering, and repair onto the clinical situation [27]. Elsewhere I have treated breakage as following from contraction and concealment [34-36]. The Attiqa passage reverses this: fracture occurs within complete and undiminished mercy because nothing restrains it. That is not a variation on the earlier claim but its inverse, and it is why this paper concerns the physician's limits rather than theodicy.

What survives from the earlier work is the central commitment, sustained across the papers on hermeneutic medicine and carried into the monograph: that the clinical encounter has the structure of self-limitation, and that a theology of contraction illuminates it [37,38]. What does not survive is its innocence — the picture of a whole physician graciously diminishing, whose limits express his goodness, whose room is made by his absence, and whose exhaustion is to be treated with more of the emptying that produced it.

12. What This Changes

Teach Limit As a Separate Competence. Not as a module inside empathy training, not as self-care, not as professionalism. Separately taught, separately assessed, and explicitly decoupled from the moral quality of the trainee. The single most useful thing a supervisor can say to a resident who cannot stop is that the difficulty is not diagnostic of a deficiency in them.

Name the Phenomenology in Advance. Setting a limit feels like a failure of caring. Trainees told this beforehand can act despite the feeling. Trainees not told treat the feeling as information and defer.

Locate The Vessel Institutionally. If limit cannot be derived from the individual's disposition, it cannot be supplied by exhorting the individual. Panel size, schedule control, coverage, scope, and protected time are not amenities that support caring; they are the vessel without which caring produces fracture [2,3].

Stop Prescribing Resilience to The Unbounded. The physician breaking because he cannot stop giving does not need enlarged capacity. Offering it is not neutral; it identifies the fracture as a deficiency in him and prescribes its cause as its cure.

Watch For Demand Without Vessel In The Reform Literature Itself. The paradigms proposed to humanise medicine are vulnerable to the structure they are meant to correct. Del Giglio's suffering-based medicine is a serious and humane example: the physician elicits a suffering construct through comprehensive listening, interprets it hermeneutically using the humanistic disciplines, and offers adjunct measures — counselling, bibliotherapy, philosophic therapy — with the explicit acknowledgement that this requires longer encounters, additional training, and an expanded curriculum [39]. Nothing in it is wrong, and I have argued for much of it myself. But it is an unbounded enlargement of the physician's role, addressed to clinicians already fracturing, and it proposes no vessel. The additional work is presented as running parallel to existing practice and not interfering with it, which is exactly the assumption that fails when the binding constraint is the clinician rather than the paradigm. A humanistic reform that specifies what more the physician should attend to, without specifying what he may therefore stop attending to, is ḥesed without din. By the argument above it will not merely fail to be adopted. It will contribute to the fracture it hopes to relieve.

Attend to what the patient receives. Boundlessness is not experienced by patients as generosity. Ask whether the relationship has a shape they can locate themselves within.

13. Objections

That the argument proves too much. If limit cannot be derived from care, does anything constrain where a clinician sets it? No — and this is a genuine cost of the position. Because limit is created rather than deduced, it can be created badly, self-servingly, or cruelly. Nothing in the structure distinguishes a good boundary from a defensive one. That distinction must come from elsewhere: from the purpose the boundary serves, from supervision, and from whether the bounded space is one in which the patient can actually appear. The argument establishes that limit must be made, not that any made limit is legitimate. It is worth adding that the source itself insists on balance between right and left rather than the supremacy of either, and that a configuration of unmixed judgment fares no better in that literature than one of unmixed mercy.

That this is merely metaphor. It is not offered as evidence. The empirical claims in section 8 stand or fall on the clinical literature cited, and I have marked which are established and which conjectural. What the theological material supplies is a structure that makes an established pattern intelligible, together with predictions the depletion model does not generate. Metaphors decorate; structures predict.

That the sources will not bear the use. Solomon Elyashiv held that translating kabbalistic terminology into matters of worldly comportment — psychology, sociology, nationalism — is a category error, since this literature speaks upward and not

downward [40]. The objection is serious. Two things weigh against it here. The Hasidic tradition had already converted the cosmogony into a pedagogy of accommodation, so the downward translation is internal to the tradition rather than imposed on it. And Wolfson himself performs a psychological translation of adjacent material in the same essay, glossing the light that has no thought as the consciousness that is unconscious [17,41]. Neither point licenses every appropriation. But the argument does not finally depend on the sources being correctly interpreted: it depends on the structural claim in section 5, which can be examined on its own terms.

That the gendered idiom is unusable. The material figures limit as feminine and unbounded efflux as masculine throughout, and I have retained the idiom because removing it would obscure the argument's structure. The clinical claim does not depend on it, and section 14 states what the idiom carries with it.

14. On the Use of These Sources

Three qualifications belong on the record rather than in a footnote.

On the tradition. The therapeutic reading of contraction descends through the fourth of the Rebbe's four positions — contraction as concealment rather than absence, the light undiminished behind the veil — and I have previously argued for the clinical fertility of that non-literal reading [27,33]. Eibeschütz's question runs across that axis rather than along it. I take his account of locus while continuing to rely, as any clinical use of this material must, on the accommodation model the fourth position supports, and I note the borrowing rather than let it pass.

On priority. I have written as though the differentiation of the site were not preceded by an undifferentiated state. That is a construal. The sources narrate sequentially, and Wolfson's exposition follows them: a severance, a longing to return, a disentanglement still incomplete. What supports the non-sequential reading is his own methodological commitment, developed against Scholem's distinction between contraction into a point and *withdrawal* from one, that concealment causes disclosure and disclosure concealment, so that every expansion is a contraction and every contraction an expansion [17,19,42]. If that holds, the sequence cannot be temporal. The tension is inside the scholarship and I have not resolved it.

On gender. Wolfson's essay is not a celebration of the feminine principle whose mechanism I have borrowed. It is an argument against one — against Moshe Idel's case for a privileged divine feminine — and its thesis is the ontological containment of the feminine within the masculine: the demiurgic capacity conferred is real but derivative, and the apparent inversion of potentiality and actuality sustains the hierarchy it seems to overturn [17,43]. He notes, decisively, that while the sources may forbid predicating the feminine of the highest configuration, no parallel injunction forbids predicating the masculine. I cite him for the mechanism, which he establishes, and not for a valuation he explicitly rejects. Anyone wanting the valuation must argue against him, and should begin with his reply to Idel [44].

15. Coda

The physician in section 1 is not failing to care. She is caring in a form that has no vessel, and the fracture that follows is not a measure of her limits but of their absence.

What we have been telling her is that a boundary is what caring looks like when it matures. It is not. A boundary is a separate thing she will have to make, repeatedly, out of nothing, against the feeling that making it is a betrayal — and the institution she works in either supplies the conditions for that making or does not.

I have spent a decade writing that the physician must empty himself. I would now put it differently. He must bound himself, which is a harder discipline and a less flattering one, and it is not accomplished by wanting more strongly to give.

The tradition has a name for the one who says enough, and it is not the name of an adversary. Without her, nothing is given at all.

References

1. Maslach, C., & Leiter, M. P. (2016). Understanding the burnout experience: recent research and its implications for psychiatry. *World psychiatry, 15*(2), 103-111.
2. Panagioti, M., Panagopoulou, E., Bower, P., Lewith, G., Kontopantelis, E., Chew-Graham, C., . & Esmail, A. (2017). Controlled interventions to reduce burnout in physicians: a systematic review and meta-analysis. *JAMA internal medicine, 177*(2), 195-205.
3. West, C. P., Dyrbye, L. N., & Shanafelt, T. D. (2018). Physician burnout: contributors, consequences and solutions. *Journal of internal medicine, 283*(6), 516-529.
4. Epstein, R. M., & Krasner, M. S. (2013). Physician resilience: what it means, why it matters, and how to promote it. *Academic Medicine, 88*(3), 301-303.
5. Card, A. J. (2018). Physician burnout: resilience training is only part of the solution. *The Annals of Family Medicine, 16*(3), 267-270.
6. Kearney, M. K., Weininger, R. B., Vachon, M. L., Harrison, R. L., & Mount, B. M. (2009). Self-care of physicians caring for patients at the end of life:"Being connected... a key to my survival". *Jama, 301*(11), 1155-1164.
7. Vital, Ḥ. E. (2013). Eṣ Ḥayyim. Jerusalem.
8. Scholem, G. (1995). Major trends in Jewish mysticism. Schocken.
9. Schneerson, M. M. (1939, February 8). Letter of 19 Shevat 5699 (Letter No. 11). In E. Touger (Trans.), Letters from the Rebbe. Sichos in English.
10. Lamm, N. (1989). Torah Lishmah: Torah for Torah's Sake in the Works of Rabbi Hayyim of Volozhin and His Contemporaries (Vol. 1). KTAV Publishing House, Inc.
11. Schneerson, M. M. (n.d.). Various kabbalistic and prayer-related questions (Letter No. 503). In E. Touger (Trans.), Letters from the Rebbe. Sichos in English.
12. Ricchi, I. Ḥ. (1737). Yosher Levav. Amsterdam. (Beit 1, Ḥeder 1, Chapter 14).
13. ZALMAN, S. (1993). Likkutei Amarim—Tanya by Rabbi

Schneur Zalman of Liadi. Bi-Lingual Edition. Translation and Introductions by Mindel, N. Mangel, N.-Posner, ZI-Schochet, JI New York: *Kehot Publication Society,* 21-26.
14. Rotenberg, M. (1983). Dialogue with deviance: The Hasidic ethic and the theory of social contraction. *University Press of America.*
15. Ungar-Sargon, J. (2025). Epistemology versus ontology in therapeutic practice: the tzimtzum model and doctor-patient relationships. *Adv Med Clin Res, 6(*1), 94-101.
16. Ungar-Sargon, J. (2025). Bridging neural circuits and sacred spaces: Integrating neurobiological mechanisms with intangible experience. *Med Clin Res Open Access, 6*(1), 1-11.
17. Wolfson, E. R. (2021). „Malkhut Ein Sof and Ṣimṣum: Gender Construction in the Kabbalistic Speculation of Jonathan Eibeschütz, with Special Reference to Wa-Avo ha-Yom el ha-Ayin ". Kabbalah. *Journal for the Study of Jewish Mystical Texts, 50*, 7-77.
18. Wolfson, E. R. (2020). Giving Beyond the Gift: Apophasis and Overcoming Theomania. *Fordham University Press.*
19. Wolfson, E. R. (2019). Heidegger and Kabbalah: Hidden gnosis and the path of poiesis. *Indiana University Press.*
20. Maciejko, P. (2016). Eibeschütz J. And I came this day unto the fountain., editor. 2nd rev ed. Los Angeles. Cherub Press.
21. Eibeschütz, J. (1891). Shem Olam: Iggerot u-Teshuvot be-Inyenei Qabbalah (A. S. Weissmann, Ed.). Vienna.
22. Bachrach N. (2003). Emeq ha-Melekh. Jerusalem.
23. Winnicott, D. W. (1965). The Maturational Processes and the Facilitating Environment. London (Hogarth) 1965.
24. Bion, W., & Hinshelwood, R. (2023). Learning from experience. *Routledge.*
25. Gutheil, T. G., & Gabbard, G. O. (1993). The concept of boundaries in clinical practice: theoretical and risk-management dimensions. *The American journal of psychiatry, 150*(2), 188-196.
26. Gabbard, G. O., & Nadelson, C. (1995). Professional boundaries in the physician-patient relationship. *Jama, 273*(18), 1445-1449.
27. Ungar-Sargon J. (2026). Self-kenosis and the hermeneutic clinician: decreation, therapeutic contraction, and the physician's self-emptying in the clinical encounter. *Essays on Healing.*
28. Ungar-Sargon, J. (2025). Beyond the anonymous case: integrating sacred epistemology and namecentered healing practice. *Academic Medicine and Clinical Religion, 30*(1), 45-62.
29. Idel, M. (1988). Kabbalah: new perspectives. *Yale University Press.*
30. AA, O. O. (2001). Alcoholics anonymous.
31. Times, C., Eliot, T. S., Gide, A., & Muggeridge, M. Gravity and Grace.
32. Ungar-Sargon, J. (2025). Applying hermeneutics to the therapeutic interaction: the act of interpreting the patient history as a sacred text–sacred listening as experiential encounter versus rational faith. *International Journal of Psychiatry Research, 8*(1), 1-6.
33. Ungar-Sargon, J. (2025). Divine presence and concealment in the therapeutic space. *EC Neurology, 17*(5), 01-13.
34. Ungar-Sargon, J. (2025). Divine error and human rectification: tzimtzum as theological rupture and therapeutic possibility. *Adv Educ Res Rev,* 2(1), 76-86.
35. Ungar-Sargon J. (2026). The wound that gives: the pain of self-contraction in creation, revelation, and the therapeutic encounter. *American Journal of Medical and Clinical Research & Reviews. 5*(6),1–15.
36. Ungar-Sargon, J. (2026). Makom, tzimtzum, and the collapse of the horse-and-rider parable/mashal. *Am J Med Clin Res Rev, 5*(6), 1-23.
37. Ungar-Sargon, J. (2025). Hermeneutic approaches to medicine: from objective evidence to patient as sacred text. *Adv Educ Res Rev, 2*(1), 40-45.
38. Ungar-Sargon J. (Forthcoming). Hermeneutic medicine: the patient as sacred text. Wilmington (DE): Vernon Press.
39. Del Giglio, A. (2020). Suffering-based medicine: practicing scientific medicine with a humanistic approach: A. Giglio. *Medicine, Health Care and Philosophy, 23*(2), 215-219.
40. Reiser, D. (2021). Reiser, Tsimtsum in Life of Pi, Journal for Cultural and Religious Theory 20, 1 (2021), pp. 107-143. *Journal for Cultural and Religious Theory.*
41. Boulouque, C. (2020). The Abyss, the Oversoul, and the Kabbalistic Overtones in Emerson's Work: Tracing the Pre-Freudian Unconscious in America. *In Kabbalah in America (pp. 51-71). Brill.*
42. Franks, P. (2020). The Midrashic Background of the Doctrine of Divine Contraction: Against Gershom Scholem on Tsimtsum.
43. Idel, M. (2018). The privileged divine feminine in Kabbalah (Vol. 10). Walter de Gruyter GmbH & Co KG.
44. Wolfson, E. R. (2021). Suffering Time: Philosophical, Kabbalistic, and Ḥasidic Reflections on Temporality (Vol. 30). Brill.