



When Surrender Fails: Divine Absence, Human Resistance, and the Limits of Religious Acceptance: A Comparative Clinical Theology of Faithful Non-surrender

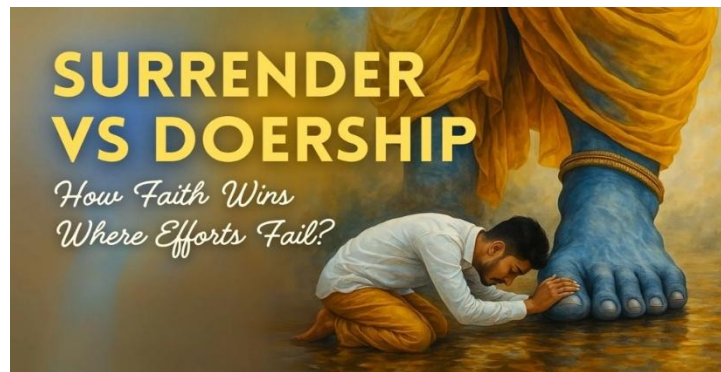
Julian Ungar-Sargon

Former Clinical Director, PA Program, Borra College of Health Sciences, Dominican University, River Forest, Illinois

Abstract: Surrender holds a privileged place in recovery, in palliative care, and in religious counsel. I have defended it in earlier work as the relinquishment of omnipotence that restores responsible agency. This article asks the question those papers left open: what is owed to the person in whom surrender does not happen? Four such persons organize the argument: the dying patient who understands her prognosis and will not consent to it, the man in recovery who cannot believe, the survivor who cannot forgive, and the believer who keeps praying and withholds one blessing. The first claim is that surrender is not performable on demand. That finding is not a critic's imposition. It was reached independently by Harry Tiebout within the psychiatry of Alcoholics Anonymous, by the Śrī Vaiṣṇava schools in their dispute over prapatti, by Shinran in his analysis of self-power and Other Power, by the early Daoist "paradox of wu wei," and by the Talmud's "a prisoner cannot free himself from prison." The second claim follows: what cannot be performed cannot be prescribed. A prescribed surrender yields compliance, shame, or exit. The third claim is that Jewish covenantal protest supplies what the traditions of surrender mostly lack, a standing place for the one who does not surrender. Berakhot 5b gives that place a formula, "neither they nor their reward," and a clinical gesture, "give me your hand." From these I define faithful nonsurrender: omnipotence is relinquished, assent is withheld, and the address is kept. I distinguish it from surrender, compliance, omnipotent refusal, and exit. I test it against the empirical literature on religious struggle, protest toward God, and end-of-life care, and I derive rules for the bedside, the recovery room, and the survivor's therapy. Surrender can be conjugated in the first person. It has no legitimate imperative.

Keywords: surrender, acceptance, religious struggle, Twelve Steps, palliative care, Shinran, Other Power, prapatti, wu wei, Job, Berakhot 5b, anti-theodicy, hermeneutic medicine





INTRODUCTION: THE SECOND FAILURE

There is a moment at which the language of surrender becomes unbearable to the person it is meant to help. It comes in the clinic after the last disease-modifying option has failed. It comes in a meeting room when a man is told, for the fourth month, that he has not yet “turned it over.” The sufferer is no longer asked only to endure. He is asked to hold the correct attitude toward what he endures, and his failure to hold it becomes a second failure laid on top of the first.

Surrender is not a marginal idea. It is the hinge of the Twelve Steps, whose third step asks for a decision to turn one's will and life over to the care of God as one understands God [1,2]. It is the last of Kübler-Ross's stages and, in the palliative care literature since, a goal that organizes how the dying is described and managed [3,4]. The consensus framework for spiritual care in serious illness lists anger at God and religious struggle among the spiritual concerns a clinician should identify and address [5]. And the psychology of religion has measured surrender as a coping style, found it associated with lower distress, and described it, accurately, as a paradoxical path to control [6,7].

I do not think these literatures are wrong. Human beings do suffer from the attempt to master what cannot be mastered, and much of my own writing argues that releasing that attempt is the beginning of truthful action. But the word carries an ambiguity the literatures rarely mark. To surrender may mean giving up the fantasy that one controls the outcome. It may also mean abandoning a legitimate struggle, suppressing a justified anger, or consenting to someone else's account of what one's suffering means. These are different acts, and they do not have the same moral standing.

The ambiguity matters most when surrender fails. The usual response is to recommend more of it: deeper willingness, more honest prayer, further letting go. That response makes the doctrine unfalsifiable. If every failure of surrender is charged to the one who failed to surrender, the doctrine can never be wrong about anyone. A teaching that began by asking the sufferer to give up omnipotence has acquired an omnipotence of its own.

This article takes the other possibility seriously: surrender sometimes fails because it has been asked to do something it cannot do. The argument has three steps. First, surrender is not performable on demand, and the traditions that prize it most discovered this for themselves. Second, what cannot be performed cannot be prescribed; a prescribed surrender yields something else. Third, Jewish covenantal protest supplies what those traditions mostly lack: a standing place for the person in whom surrender does not occur.

A word on method. I read Hindu, Buddhist, and Daoist sources as a neurologist and a student of rabbinic and Hasidic texts, not as a specialist in those traditions. I follow the practice of comparative theology, in which one reads another tradition closely to see one's own differently [8]. I hold myself to Sandmel's warning against parallels that prove more than they can [9]. The convergence I describe is structural. I claim no genealogy and no common essence.



WHAT I HAVE ALREADY ARGUED, AND WHAT IT LEAVES OPEN

I have written on surrender from several directions, and a reader is entitled to know what this article adds.

In the clinical register I argued that the vulnerability shared by physician and patient is not an obstacle to healing but a resource for it [10]. In the recovery register I read Rami Shapiro's theology of the surrendered life against the Hasidic dialectic of being and non-being [11,12]. In an unpublished study I traced the movement from Step Two to Step Eleven through the Hasidic pair *sovev kol almin* and *memale kol almin*, the divine that surrounds all worlds and the divine that fills them. Its thesis was that surrender releases control, strengthens responsibility, and cultivates receptivity [13].

Around these stand papers on the difficulty of belief itself: on coming to believe when belief is no longer culturally available [14], on the tension between a transcendent Higher Power and an intimate one [15], and on the *yehidah*, the innermost point of the soul, as a Higher Power that requires no doctrine [16]. Two further papers hold that the personal God who is addressed and the impersonal ground that cannot be addressed form an antinomy that a theology of recovery should not resolve [17,18]. A clinical paper brought the serenity of the Steps to patients facing catastrophic illness [19].

A second line of work refuses explanation. I have read Job as a clinical text [20], proposed an anti-theodicy of the Shoah [21], and set out rules of bedside speech under which the divine name is never predicated of the event that harms the patient [22]. I have argued that we must not surrender to explanations that relieve us of responsibility [23], and I have written on the refusal of consolation [24].

A third line concerns the clinician. Contraction, self-emptying, and the making of room belong to the one who holds power in the encounter [25,26], a model I have recently

revised [27]. I have also written on Eastern religious symbols in therapeutic practice [28]. I first asked whether hospice care conflicts with Jewish values in 1987 [29] and returned to the coercive potential of comfort care nearly four decades later [30].

What do these leave open? Each assumes that surrender, rightly understood, occurs. They ask what it is, to whom it is made, and what it must not be confused with. None asks what is owed to the person in whom it does not occur at all, and none asks whether the fault might lie in the prescription. A second unpublished manuscript came nearest, asking whether surrender and *devekut* are the same spiritual act [31]. The present article begins where that question stops.

It also corrects my earlier work in one respect. I wrote of surrender as something a person does. The sources examined below say that it is something that happens to a person, and that the difference is clinically decisive.

FOUR PATIENTS

The following are illustrative composites. No individual patient is described, and the identifying details are invented.

The patient who understands and does not consent. A retired schoolteacher of sixty-one has multiple system atrophy. She has had three opinions and asks me for a fourth. She can state her prognosis more accurately than her family can. The palliative care note reads: “patient remains in denial; goals-of-care discussion deferred.” When I ask her about the note she says, “I am not in denial. I know exactly what I have. I just don’t agree to it.” She has completed an advance directive. She declines the chaplain, who has twice spoken to her about peace.

The man who cannot believe. An electrician of fifty-four became dependent on opioids after two lumbar fusions. He has been abstinent for five months on buprenorphine and attends meetings four times a week. He has stalled at the Third Step. His sponsor tells him he is unwilling. He tells me, “I’ve been on my knees every morning since June. I say the words. Nobody is there. So now I’m an addict and a liar.”

The survivor who cannot forgive. A woman of forty was assaulted years ago by a relative who has never acknowledged it. She has migraine and a pain syndrome without a lesion. Her counselor has told her that her body will not let go until she does. Her pastor has told her that unforgiveness is a poison she is drinking. She says, “Everyone wants me to finish this for them.”

The believer who withholds one blessing. An observant man of seventy has a painful small-fiber neuropathy that no treatment has touched. He prays three times a day, as he has since childhood. For two years he has omitted a single blessing from the weekday *Amidah*: the eighth, which praises God as healer of the sick of Israel. “I say the other eighteen,” he tells me. “I am not leaving. I am not saying that one.”

None of the four is in denial in any useful sense. Weisman distinguished denial of the facts from denial of their implications and from denial of extinction itself, and he observed that the word describes a relation between a patient and a listener as much as a state of mind [32]. Each of the four has been pressed toward a story that resolves whether restitution or the quest that finds meaning, by listeners who cannot bear the story that does not

resolve. Frank called that story chaos and noted how quickly clinicians move to repair it [33].

What the four share is a prescription that cannot be filled. They also share something the prescribers have not noticed. The schoolteacher has signed her directive. The electrician has given up the drug and his mornings. The survivor has given up revenge. The old man has given up the expectation of cure. None of them claims control of the outcome. What each withholds is assent.



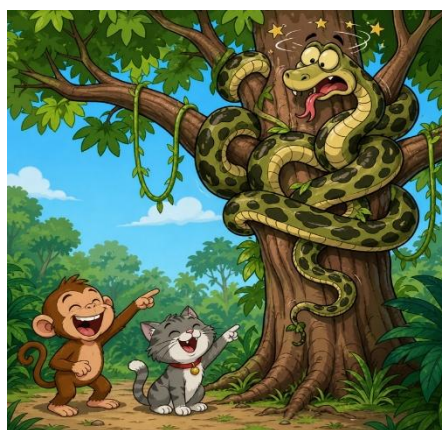
SURRENDER CANNOT BE PERFORMED ON DEMAND: THE RECOVERY LITERATURE'S OWN FINDING

The strongest evidence that surrender cannot be prescribed comes from the man who introduced the concept to psychiatry. Harry Tiebout observed Alcoholics Anonymous from 1939 and treated several of its early members. In 1949 he described “the act of surrender” as the turning point of recovery, and he was careful about its nature: it is an unconscious event. The patient does not decide to surrender. He finds that he has [34]. Four years later Tiebout drew the consequence. There is a state that looks like surrender and is not. He called it compliance: a conscious yes resting on an unconscious no. The compliant patient agrees, attends, and says the words, and means them as far as consciousness goes. Underneath, nothing has moved. Tiebout regarded compliance as an obstacle, because it satisfies everyone, the patient included and so blocks the real event [35].

William James had seen the same structure half a century earlier. He distinguished a volitional type of conversion from a type by self-surrender and then observed that even in the volitional type of the last step is not willed. The will carries a person to the edge and must then be let go, and the letting go is not one more act of the will [36]. The founders of AA read James closely. The Big Book cites him in the appendix that reassures members whose awakening is gradual, of the “educational variety,” rather than sudden [1]. Kurtz's history of the fellowship names its central recognition in two words: not-God. The alcoholic recovers by accepting that he is limited [37]. That acceptance is first-personal. It cannot be supplied from outside.

Set this against the Third Step. Its verb is “made a decision” [2]. Read with Tiebout, the step asks the conscious will to decide what only an unconscious event can accomplish. For many members this causes no trouble; the decision is a posture of willingness within which the event later occurs. For the electrician of Section 3 it is a trap. The harder he tries, the more his trying is the very self-management the step was meant to end. When his sponsor reads the failure as unwillingness, the only move left to him is compliance. He can say that he has turned it over. Tiebout tells us what follows.

None of this is an argument against Twelve-Step programs. Manualized Twelve-Step facilitation performs as well as other established treatments for alcohol use disorder on most outcomes, and better for continuous abstinence [38]. But the studies of mechanism matter here. The best-supported pathways are social and behavioral: a changed network, greater self-efficacy, better coping. Spiritual change contributes for some members, more clearly among the more severely affected [39,40]. In Project MATCH, atheists and agnostics attended AA less often, but those who attended benefited as much as believers did. The group that fared worst was the one unsure what it believed [41].



That last finding deserves attention. It suggests that the person at risk is not the one who disbelieves but the one held in suspense: the one told that recovery waits on a faith he is trying and failing to produce. I have argued elsewhere that the Twelve-Step and medical models should be integrated, not ranked [42,43]. The present point is narrower. A fellowship can require attendance, honesty, and service. It cannot require an unconscious event, and when it tries, it manufactures compliance.

Two clinical literatures reach adjacent conclusions. Motivational interviewing treats resistance as a product of the interaction, provoked by the helper’s “righting reflex,” the urge to set the patient straight [44]. Welwood’s term *spiritual bypassing* names the use of spiritual ideas to step around unfinished psychological work [45]. Prescribed surrender is a bypass administered by a third party.

FOUR TRADITIONS, ONE PARADOX

The same discovery was made, in other vocabularies, wherever surrender was prized. I take four cases. I have written before on Eastern symbols in clinical work [28]. Here the interest is narrower: what each tradition found when it asked whether surrender can be *done*.

Arjuna, the Monkey, and the Cat

The Bhagavad Gītā begins with a refusal. Arjuna, set between two armies that contain his teachers and kin, puts down his bow. Krishna's long answer does not counsel acceptance. It separates action from ownership of its results: one has a claim on the act and none on its fruit (2.47). It ends with a call to refuge: let go of all other duties and come to me alone; I will free you; do not grieve (18.66) [46]. The teaching exists because a man refused, and without his refusal there is no teaching. I leave aside the grave question of what that refuge licenses on the battlefield. It parallels the Akedah and needs its own treatment.

The verse at 18.66 became the foundation of the Śrī Vaiṣṇava doctrine of *prapatti*, taking refuge. Rāmānuja reads it without cancelling moral obligation: what is abandoned is the sense of oneself as the agent who secures liberation, not the acts themselves [47]. His heirs then divided over precisely the question this article asks. Is taking refuge something, the devotee does? The northern school, following Vedānta Deśika, held that it is: a real if minimal act, a means. The southern school, following Pīlḷai Lokācārya and Maṇavālamūnī, held that it is not. Grace is uncaused. Refuge is only the end of resistance, and to treat it as a means is to bring self-effort back in at the last moment [48]. Later tradition summarized the dispute in two images. The infant monkey clings to its mother. The kitten is carried by the scruff.

For the clinic the dispute is more useful open than closed. The monkey theology tells the electrician to hold on harder. The cat theology tells him that holding on was never the mechanism. Six centuries before Tiebout, a tradition of surrender had already split over whether surrender is an act.

The Second Arrow, and its Misuse

The Buddha's discourse on the arrow distinguishes two injuries. The untaught person, struck by a painful feeling, grieves and resists, and is thereby struck by a second arrow. The taught disciple feels the first and not the second [49]. This is not a doctrine of acceptance. The first noble truth is a diagnosis, and the path that follows aims at the ending of suffering, not at consent to it.

Modern clinical borrowings are careful on the point when they are done well. In acceptance and commitment therapy, acceptance means willingness to have an experience while acting on one's values. It is defined against resignation and against mere tolerance [50]. In chronic pain it means giving up the struggle to control pain, not the struggle to live [51]. The misuse is equally modern. The second arrow becomes an accusation: you are suffering because you are resisting. Pain becomes an error of attitude, and the structural causes of distress become private failures of mindfulness [52]. The discourse gives no licence for this. It describes what a trained disciple no longer does. It does not say that an untrained person can stop on instruction, and it does not say that the first arrow should be left in.

Shinran: Surrender for those Who Cannot Surrender

The Japanese Pure Land teacher Shinran (1173-1263) pushed the problem to its limit. He begins from a suspicion of religious effort as such. All practice undertaken to secure one's own liberation is *jiriki*, self-power, and it is shot through with calculation (*hakarai*). This

includes the effort to trust. A person who tries to produce faith is relying on himself. Liberation comes by *tariki*, Other Power, the working of Amida's vow, and the entrusting heart (*shinjin*) is not something the person generates. It is given [53].

The *Tannishō*, the record kept by his disciple Yuien, draws two conclusions that bear directly on the four patients. The first is the well-known inversion: if even a good person attains birth in the Pure Land, how much more so an evil one. The person who knows he cannot manage it himself is the one for whom the vow was made [54]. The second is in the ninth section. Yuien confesses that when he says the *nembutsu* he feels little joy and no eagerness for the Pure Land. Shinran does not correct him. He answers that he has had the same question, and that the absence of joy is the mark of the blind passions for whose sake the vow exists. The failure to feel what one is supposed to feel is not a disqualification. It is the description of the one addressed [54,55]. I know of no text in the literature of surrender that does this so plainly. The teacher places himself beside the disciple who cannot produce the required state and declines to treat the incapacity as a fault.

Two cautions. Amida's vow belongs to a specific Mahāyāna cosmology and cannot be translated into the God of Israel or the Higher Power of the rooms. And Other Power can itself become a consolation imposed from outside: "grace is already working in you, though you cannot feel it." Said to the schoolteacher of Section 3, that sentence is Job's friends in another dialect. What I take from Shinran is only the structural point. Spiritual incapacity is not moral failure, and no one is obliged to feel what he cannot feel.

***Wu wei*: Trying not to Try**

Early Daoist texts prize *wu wei*, action that is unforced and without contrivance. Water yields and wears down stone [56]. Cook Ding's blade finds the spaces in the ox and never dulls [57]. The ideal is not passivity. It is responsiveness without strain.

Slingerland has shown that these ideal carries a paradox the early Chinese thinkers recognized and never dissolved. *Wu wei* cannot be achieved by trying, because trying is the condition it is defined against. Yet no one arrives at it without effort. Every school that taught it had to say how one strives to stop striving, and each solution reopened the problem [58]. The clinical use of *wu wei* is as a question put to the helper, not as counsel for the patient. Is my next intervention a response to this person's situation, or to my own need to have acted? One more test, one more drug, one more urging toward peace: the same act can come from either source.

What the Convergence Shows

A psychiatrist in Connecticut, Tamil and Sanskrit theologians, a Japanese teacher who called himself neither monk nor layman, and the authors of the *Zhuangzi* reached the same structural finding. The state they valued cannot be produced by the will that wants it, and the attempt to produce it yields a counterfeit. Tiebout called the counterfeit compliance [35]. The southern Śrī Vaiṣṇavas called it self-effort disguised as refuge. Shinran called it calculation. I do not conclude that these traditions teach the same thing. Their accounts of the self, of the ultimate, and of liberation differ too deeply, and the parallel proves no more than it shows [9]. I conclude something smaller and more useful. If independent

traditions of surrender agree that surrender cannot be commanded, then a clinician, chaplain, or sponsor who commands it is not transmitting those traditions. He is contradicting them. What none of the four provides, with the partial exception of Shinran, is an account of the person in whom the event does not occur that is anything other than an account of someone who has not arrived yet. For that I turn to my own tradition.



A STANDING PLACE: THE COVENANT OF PROTEST

“Neither they nor their Reward”

At the opening of tractate Berakhot the Babylonian Talmud develops a doctrine of *yissurin shel ahavah*, sufferings of love: afflictions sent not as punishment but as a mark of favor, to be received with love. Then, on the same page, it tells three stories that take the doctrine apart [59].

R. Hiyya bar Abba falls ill. R. Yoḥanan visits him and asks: are your sufferings dear to you? He answers neither they nor their reward (*lo hen ve-lo sekharan*, לא הן ולא שכרן). R. Yoḥanan says: give me your hand (*hav li yadakh*, הב לי ידך). He gives him his hand, and R. Yoḥanan raises him.

Then R. Yoḥanan falls ill. R. Ḥanina visits, asks the same question, receives the same answer, says the same words, and raises him. The Talmud asks why R. Yoḥanan, the healer of the first story, could not raise himself. It answers: a prisoner cannot free himself from prison (*ein havush mattir atzmo mi-beit ha-asurim*, אין חבוש מתיר עצמו מבית האסורים).

In the third story R. Yoḥanan visits R. Elazar, who lives in a dark room. R. Yoḥanan bares his arm, light fills the house, and he sees that R. Elazar is weeping. He offers the usual consolations: is it Torah you did not learn enough of, or livelihood, or children? R. Elazar says: I weep for this beauty that will rot in the earth. R. Yoḥanan says: for that you are right to weep. And the two of them weep together. Only then does he ask: are your sufferings dear to you? Neither they nor their reward. Give me your hand.

Four things in this passage bear on the argument.

1. **The sufferers are the masters of the doctrine.** R. Yoḥanan debates its scope on the same page, and he buried ten sons. When the theology of meaningful suffering is offered to the men who teach it, they decline it, and they decline the reward along with the pain. This is not a patient who has yet to see the good in his illness. It is a patient who has seen the offer and turned it down.

2. **The visitor does not argue.** He asks, accepts the answer, and extends his hand. No explanation of the suffering is given before or after. What is spoken amounts to an invitation. In terms I have used elsewhere, the gesture is deictic: it points to the place where one person stands beside another and predicates nothing of the event [22].
3. **The healer cannot heal himself.** Ein havush is the Talmud's statement of the finding in Sections 4 and 5. The will cannot free the will. The consequence the Talmud draws is not that the prisoner should try harder. It is that someone must come.
4. **Some grief is ratified.** In the third story the consolations fail, and the visitor recognizes a loss that deserves to be wept. He does not say it should be accepted. He says: for that, weep. Then he weeps too.

This page gives the person who does not surrender something the traditions of Section 5 do not: a formula with canonical standing. *Lo hen ve-lo sekharan* is not a stage on the way to acceptance. The men who say it are raised from their beds without retracting it.

Job, Abraham, Moses, Hezekiah

The Book of Job is the long form of the same refusal. Job's friends are not cruel. They defend a world in which suffering is intelligible, and they are more loyal to the intelligibility than to the man [20]. Job will not buy consolation with a false confession, but he does not leave. His protest is addressed. At 13:15 the written text (*ktiv*) reads "I have no hope" and the read text (*qere*) reads "I hope in Him." On either reading the verse continues: yet I will argue my ways to His face [60]. Hope is uncertain. The address is not.

The ending is commonly read as capitulation. It need not be. Newsom reads the book as a contest of moral imaginations that the ending does not close [61], and Greenstein argues on philological grounds that at 42:6 Job is not repenting at all [62]. Whatever one decides, God's verdict at 42:7 is that the friends did not speak rightly and Job did.

Job is not an anomaly. Abraham interrogates the Judge of all the earth over Sodom (Gen 18:25). Moses, told to stand aside so that Israel may be destroyed, refuses, and offers his own name in exchange (Exod 32:32). The Talmud says he seized the Holy One as a man seizes his fellow by the garment [59]. Hezekiah, told by Isaiah that he will die, tells the prophet to finish his prophecy and go. He has a tradition from his grandfather's house: even with a sharp sword at his neck, a person should not stop asking for mercy [59]. A patient dismisses the prognosticator and keeps praying, and the Talmud approves. A line of scholarship has gathered this material as a tradition of arguing with God and has shown that the rabbis treat such confrontation as piety, not as its lapse [63,64]. Blumenthal built a theology of protest on it [65]. I have read Moses' last bargaining in Deuteronomy Rabbah the same way. His pleas are overruled by *rav lakh* (רב לך), "enough," and never withdrawn [66].

The Countertradition, Stated Fairly

It would falsify the sources to stop here. The same tractate rules that a person must bless God for the bad as for the good. It tells of R. Akiva, who taught that all the Merciful One

does is for good, and who died under torture with the *Shema* on his lips. Naḥum of Gamzu met every disaster with “this too is for good” [59]. *Tzidduk ha-din*, the justification of the judgment, is recited at Jewish burials.

Rabbinic Judaism does not replace acceptance with protest. It canonizes both and does not rank them. The same R. Yoḥanan debates sufferings of love and refuses them. What the tradition will not do is make acceptance the test of fidelity. Psalm 88 ends on the word “darkness,” without a turn, and it was kept in the Psalter [60].

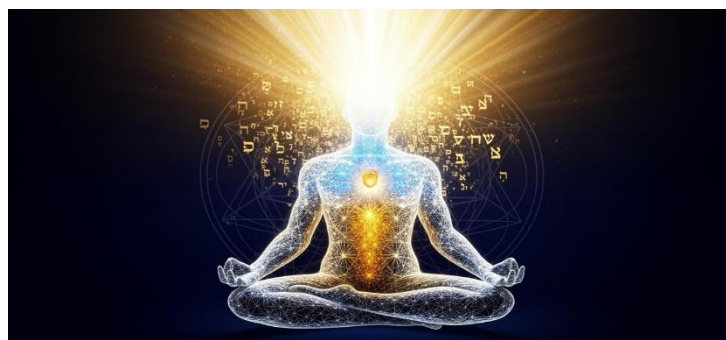
After 1942

The modern test of this tradition is the Shoah. R. Kalonymus Kalman Shapira, the Rebbe of Piaseczno, preached in the Warsaw Ghetto from 1939 to 1942, and his sermons record a theology changing under pressure [67]. The early sermons teach the acceptance of suffering with love. The later ones turn to the talmudic image of God weeping in the inner chambers, a divine grief too great for the world to hold. Late in 1942 he added a note to an earlier sermon, withdrawing its claim that such sufferings had precedent [68]. A Hasidic master, inside the catastrophe, took back a consolation he had himself offered.

Rubenstein, Fackenheim, Greenberg, and Jonas differ deeply among themselves [69-72]. What they share Braiterman named antitheodicy: the refusal to justify, explain, or accept the relation between God and catastrophic suffering as it stands [73]. Levinas gave the refusal its ethical form. The suffering of the other is useless, and to justify my neighbor's pain is where immorality begins [74]. I have worked through these positions elsewhere [21,75].

Kabbalistic symbolism adds that the divine presence is itself in exile. The unreconciled person is therefore not out of step with a harmonious order, because there is no such order to be in step with. I have traced that motif at length [76] and repeat only the warning that belongs with it. The exile of the Shekhinah licenses protest. It does not explain anyone's illness.

The Jewish contribution, then, is not a preference for rebellion over acceptance. It is a place to stand. The person who says “neither they nor their reward” is inside the tradition, addressed by it, and visited.



THE DIRECTION OF THE DEMAND: *BITTUL* REVERSED

Jewish mysticism seems at first to stand against the previous section. Hasidic thought prizes *bittul*, the nullification of the self before the divine reality that alone truly is. In the Habad

formulation, creation stands to its source as the sun's ray stands within the sun, with no existence of its own [77]. The tradition distinguishes a nullification of the self's claim to sovereignty (*bittul ha-yesh*) from a deeper nullification of existence as such (*bittul bi-metzi'ut*), and neither means psychological extinction [78]. The most searching account of how Habad holds nullification and embodied life together is Wolfson's [79].

The Izbica school presses furthest. R. Mordechai Yosef Leiner inverts the talmudic rule that everything is in the hands of Heaven except the fear of Heaven: at the root, the fear of Heaven is in Heaven's hands too [80,81]. I have explored what that teaching offers the theory of addiction, where it bears on the question of illness versus moral failure [82], and I have written on the dissolving of the self as a clinical event [83].

Two observations turn this material in an unexpected direction.

The first is a matter of logic. To say that the self has no independent ground is an ontological claim. It does not follow that the self's judgments, griefs, and protests are worthless, or that the self owes obedience to whoever speaks for God. That step needs an argument the language of nullification does not supply. And the more seriously one takes divine transcendence, the less available the step becomes. Maimonides holds that nothing positive can be predicated of God's essence [84]. If so, no counselor can know that a particular patient's illness is God's will for her, and no sponsor can know what God asks of the man on his knees. Apophasis is a restraint on those who would speak in God's name before it is anything else [85].

The second is a matter of direction. In the sources I know, *bittul* is something a person does to himself, before God or before his teacher. It is not something done to him. I have argued that in the clinic the corresponding act belongs to the clinician: the contraction that makes room, the emptying of the need to explain [25,26]. The present argument adds the converse. When the person with power in the room asks the person without it to nullify herself, the act changes its nature. It is no longer *bittul*. It is submission to a human being, dressed in sacred words, and people who have been harmed by religious authority recognize it at once [86]. So, the reversal is this. The one who must surrender at the bedside is the clinician, and what he surrenders is his desire to see the patient at peace. That desire is honorable. It is also his, not hers. The schoolteacher's chaplain wants her reconciled, and part of what he wants is relief from watching someone die unreconciled. Levinas would say that he has made her suffering useful to himself [74].

A grammatical rule follows from the two observations. Surrender can be conjugated in the first person: I let go; I find that I have let go. It has a third person, as description: she came to accept. It has no legitimate second-person imperative. "You must surrender" is ill-formed in the way that "be spontaneous" is ill-formed, and for the reason Tiebout gave. The event it commands is not under the command of the one addressed [35].

The rule extends one I proposed for theological speech at the bedside: the divine name may be used to point and never to predicate [22]. It also rests on a test I have called detachability. May a practice be offered without the doctrine that makes the patient's suffering necessary [87]? Prayer, silence, the Steps, breath, and presence all pass that test. The instruction to accept does not, because it is not a practice. It is a verdict on the patient's inner state.

WHAT THE EVIDENCE SAYS, AND DOES NOT SAY

An argument of this kind should be tested against data that could embarrass it. Some do.

Surrender, when it occurs, is associated with benefit: Pargament's early work distinguished self-directing, deferring, and collaborative styles of religious coping [88]. Later work isolated surrender as a further style, an active giving-over distinct from passive deferral, and found it associated with religious well-being and lower distress [6,7]. I have no quarrel with these findings. They describe people in whom the event has occurred. They are observational, and they do not show that the event can be induced.

Religious struggle carries risk: In a two-year study of nearly six hundred medically ill older inpatients, those who felt abandoned or punished by God, or who questioned God's love, had a modestly but significantly higher risk of death [89]. Anger toward God is common in bereavement and in cancer, and when it is intense or prolonged it tracks with poorer adjustment [90]. This is the strongest evidence against any romance of protest. The four patients of Section 3 are not in a safe place, and a clinician who merely applauds their refusal has not helped them.

The kind of struggle matters: Exline and colleagues distinguish assertive protest, in which a person questions and complains to God within the relationship, from exit, in which the person holds the anger and leaves. In their samples, closeness to God went with seeing assertive protest, but not exit, as acceptable [91]. That is Job's distinction, found by survey. The old man who omits one blessing and says "I am not leaving" is on the assertive side of it. Read with the mortality data, the clinical task is not to end the protest. It is to keep protest from hardening into isolation. I suspect that nothing isolates a protester so reliably as being told that the protest is the problem.

Religious patients do not, as a group, surrender at the end: Among patients with advanced cancer, those who relied most on religious coping were about three times as likely to receive intensive life-prolonging care in their last week [92]. Whatever is preached about acceptance, Hezekiah's rule is the one practiced.

Patients want peace, which is different from owing it: In a large survey, being at peace with God ranked among the things dying patients considered most important, close to freedom from pain [93]. This must be heard. Most people hope to die reconciled, and nothing in this article opposes helping them. The difficulty lies with the patient who wants peace and cannot find it, or who does not want it on the terms offered.

Neither fighting nor accepting changes the disease: In a population cohort of women with early breast cancer, fighting spirit conferred no survival advantage, while helplessness and hopelessness were associated with worse outcome [94]. The inner attitude is not a treatment in either direction. No one can be told to accept, or to fight, on the ground that it will help the illness.

"Acceptance" functions as a norm in palliative care: Zimmermann's two discourse analyses show that the literature treats acceptance as a goal and denial as an obstacle, that accepting patients are described as easier to care for, and that the vocabulary both invites patients to plan their deaths and labels those who decline [4,95]. A sociological critique of the "good death" had made the point earlier [96]. More recent palliative practice speaks of prognostic awareness, which fluctuates and can be cultivated gently [97]. As I read it, that

leaves room for a patient who understands and does not accept. The schoolteacher has full prognostic awareness. Her chart records denial because she lacks the second thing.

Spiritual care helps, overall: The most comprehensive recent review finds that attention to spirituality in serious illness is associated with better quality of life, and that patients want it [98]. The argument here is not against spiritual care. It is against one move within it.

Taken together: surrender helps those in whom it happens. Struggle harms when it is chronic and isolated. Protest inside a relationship is distinguishable from exit. The pressure to accept belongs to our institutions as much as to our patients, and atheists who stay in the rooms do as well as believers [41]. Nothing in the data shows that surrender can be produced by recommending it.



FAITHFUL NON-SURRENDER DEFINED

I can now say what the four patients are doing. *Faithful non-surrender* is the stance of a person who has relinquished the claim to control the outcome, who withholds assent to the outcome, and who keeps the address open. There are three clauses, and each is necessary.

Omnipotence is relinquished. The person does not believe that enough effort, prayer, or will can abolish the disease, reverse the past, or compel God. This separates faithful nonsurrender from the refusal my earlier work rightly criticized: the demand that reality yield [13].

Assent is withheld. The person does not say that what has happened is good, deserved, meant, or acceptable. Cassell defined suffering as the distress brought on by a threat to the intactness of the person [99]. Assent extracted under that threat adds to it. To withhold assent is to keep hold of one's own judgment when little else is left.

The address is kept. The person goes on speaking: to God, to the physician, to the fellowship, to the one who did the harm or to those who stand in for him. This is what makes the nonsurrender faithful. It distinguishes protest from exit [91], Job from the counsel of Job's wife, and the man who omits one blessing from the man who has stopped praying. Table 1 sets the stance beside its neighbors.

Table 1: Five responses to what cannot be changed

Response	Claim to control the outcome	Assent to the outcome	Address (to God, clinician, community)	How it arises
Surrender	Released	Given	Kept	Occurs; cannot be willed or prescribed
Compliance	Released in words	Spoken, not held	Formal	Produced by pressure to surrender
Faithful nonsurrender	Released	Withheld	Kept, as protest	Held knowingly; can be sustained
Omnipotent refusal	Held	Withheld	Kept, as demand	Arises from terror of limits
Exit	No longer at issue	Withheld	Broken	May follow the shaming of protest

Three points about the table.

Surrender and faithful non-surrender differ in one cell only. Both have given up omnipotence, and both keep the relationship. That is why the faithful protester is so often mistaken for someone who is almost there and needs a last push. The push produces the second row.

Faithful non-surrender and omnipotent refusal also differ in one cell, and this is the differential diagnosis that matters at the bedside. The patient who seeks a fourth opinion because she will not consent to her death is not the patient who seeks it because she believes the fourth physician will cure her. The first needs company. The second needs the truth told more plainly and usually needs help with terror. The way to tell them apart is to ask what the person expects, not what she wants.

The stance is not a stage. Nothing in its definition points it toward eventual surrender. A person may move from it to surrender; R. Akiva and R. Yoḥanan share a tractate [59]. A person may also die in it, as the Moses of the midrash does, with his plea overruled and unretracted [66].

Finally, faithful nonsurrender is not a refusal of responsibility. I have argued that we must not surrender to explanations that relieve us of responsibility [23]. The same holds here in mirror image. One may refuse the explanation and keep every obligation: to take the medication, to make the amends, to attend the meeting, to say the other eighteen blessings.

CLINICAL RULES: THE FOUR PATIENTS AGAIN

Five rules follow from the argument. They are meant for physicians, chaplains, counselors, and sponsors alike.

1. **Never prescribe an inner state.** Offer practices, truth, presence, and treatment. Do not instruct a patient to accept, trust, forgive, or let go. These are outcomes, and they are not hers to produce.
2. **Separate three things the chart runs together.** Understanding of prognosis is cognitive. Decisions about treatment are matters of capacity and consent. Emotional reconciliation is neither, nor its absence is not a finding.

3. **Diagnose the row.** Before responding to a refusal, determine whether it is omnipotent refusal or faithful nonsurrender, by asking what the person expects (Table 1).
4. **Put the wu wei question to yourself.** Whose distress will this recommendation relieve?
5. **Stay.** When explanation, cure, and consolation have all failed, the remaining act is R. Yohanan's: ask, accept the answer, and offer a hand [59].

The schoolteacher: The word “denial” should come out of her chart. She has prognostic awareness, a completed directive, and decision-making capacity [97]. What she lacks is assent, which no one is entitled to require. The fourth opinion is discussed on its merits: what it might add, and what it will cost her in strength. If it will change nothing, I tell her so, and I arrange it or decline it for that reason and not as a lesson. The chaplain is asked to visit without an agenda, or not to visit. I have written on what presence to the dying asks of the clinician [100], and on how readily comfort becomes control [30]. Her sentence, “I know what I have; I don't agree to it,” is not a symptom. It is the most accurate statement in her record.

The electrician: His sponsor has read a failed surrender as unwillingness and has thereby closed every door but compliance [35]. I tell him three things, each of them true. The man who described surrender for AA said it cannot be decided [34]. People who do not believe and stay in the rooms do as well as those who believe [41]. And a teacher of the thirteenth century, when his student confessed that prayer brought him no joy, answered that he had the same question [54]. Then the practical counsel. Keep the meetings, the medication, the inventory, and the amends, all of which are his to do. Put down the project of producing faith, which is not. If trust comes, it will come as it came to most members, slowly and through other people. If it does not come, he is still sober.

The survivor: Jewish law is exact here, and the exactness protects her. Forgiveness for a wrong between persons begins with the wrongdoer: acknowledgment, restitution, and a request, repeated if need be. Only then does the law turn to the injured party and ask her not to be hard [101]. Her relative has done none of this. No one else can ask in his place, and no one else can grant in hers. Wiesenthal, asked by a dying SS man to forgive what had been done to others, answered with silence [102]. Améry defended resentment as the moral refusal to let time do the work that only acknowledgment can do [103,104]. I have written on reconciliation between perpetrator and victim [105]. Clinically, her pain is treated as pain. The claim that her body will not heal until she forgives is withdrawn, because no evidence supports so strong a claim and because it makes her responsible for her assailant's unfinished business. She has already given up revenge. That was the surrender that was hers to make.

The old man: He is the clearest case of assertive protest without exit [91]. He prays, he keeps the commandments, and he withholds one sentence because he will not say what he does not find to be true. The risk in his position is isolation, not impiety [89]. The useful intervention is therefore not to restore the blessing. It is to see that he is not alone with its omission. I tell him about R. Hiyya bar Abba. I ask whether his rabbi knows, and whether he would like him to. The neuropathy is treated as far as it can be. I do not tell him that God

is healing him in ways he cannot see. I do not know that, and the rule of bedside speech forbids me to predicate what I can only point toward [22].

The clinician: Each of these encounters leaves something with the physician, and the pressure to see patients reconciled is partly a way of discharging it. I have written about physician grief after a patient's death [106]. There is also a grief before the death, for the patient who will not die well by our lights, and it is ours to carry. The clinician's surrender is to let the patient remain unresolved.

OBJECTIONS

“These licenses futile treatment.” It does not. The physician's obligation to tell the truth about what medicine can do, and to decline interventions that offer only harm, is untouched. Hezekiah's rule protects prayer and hope from being closed off by a prognosis. It does not require the surgeon to operate. What the argument removes is one bad reason for limiting treatment, namely that the patient ought to be accepting by now, and one bad use of the limitation, as an instrument for bringing acceptance about. Rule 2 keeps the questions apart.

“Religious struggle harms patients, and you are encouraging it.” The data on struggle are real, and I have cited them against myself [89,90]. But they describe struggle that is chronic, intense, and solitary. The same literature distinguishes protest within a relationship from exit [91], and nothing in it shows that struggle is shortened by an instruction to stop. If the hazard is isolation, the remedy is company. The clinician who says “many faithful people have said exactly that” is, on the evidence available, the safer companion.

“Surrender works. Why tamper with it?” Twelve-Step programs work [38], and for many people surrender is the name of what happened to them there. The argument does not touch them. It concerns the minority in whom the event does not occur. The studies of mechanism suggest that these members can recover by the same social and behavioral routes as everyone else, provided they are not driven out or driven into pretense [39-41].

“You have dressed a Jewish preference as a universal ethic.” There is something to this, and I would sooner concede it than disguise it. The standing I claim for the unreconciled person comes from Berakhot and Job. But the central premise, that surrender cannot be commanded, is drawn from Tiebout, from the Śrī Vaiṣṇava debate, from Shinran, and from the Daoist texts. It would stand if the Talmud had never said *ein havush*. Nor is Judaism of one mind: R. Akiva and Naḥum of Gamzu are in the same tractate [59]. I do not claim that protest is the truer religion. I claim that it is a legitimate one, and that no clinician can rule otherwise for a patient. The comparison is offered under Sandmel's limit [9].

“Shinran's grace and your ‘standing place’ are theodicies by another door.” They would be, if they were said to the patient as explanations. “You cannot surrender because the vow is for such as you” is a consolation and offered uninvited it repeats the error it means to correct. That is why I took from Shinran only the structural point and the gesture: the teacher who says he has the same question [54]. The same discipline applies to Berakhot

5b. R. Yoḥanan does not tell R. Ḥiyya that his refusal is holy. He asks for his hand. A standing place is something one makes room for. It is not something one explains [22].

“Some patients are stuck, and a little pressure helps.” Some patients are stuck, and the differential in Table 1 exists for that reason. Omnipotent refusal is a clinical problem. It responds to plain truth and to help with fear, which is what the cultivation of prognostic awareness consists of [97]. It does not respond to the demand for an attitude. Pressure toward acceptance makes patients easier to care for [4]. That is a benefit to us.

CONCLUSION

I began from a doctrine I have defended and still hold: the release of omnipotence is where truthful action starts. I have tried to show its limit. The release cannot be ordered. Every tradition that has cared about it most has said so in its own words, and the psychiatrist who gave the concept to medicine said it first in ours. A surrender that is demanded yields compliance in the docile, shame in the conscientious, and exit in the proud. In none of them does it yield surrender.

The person in whom surrender does not happen is therefore not a failed case of anything. She may have given up every claim to control and kept only her refusal to call the thing good. The Talmud has words for her, spoken by its own sages from their sickbeds: neither they nor their reward. It also has an instruction for the one who visits, and it is not an argument. Give me your hand. To treat the patient as a text is to accept that some passages do not resolve, and that the reader's task there is to stay with the difficulty and not to emend it [107].

Three limits should be stated. The four patients are composites, built to carry an argument and not to prove it. My readings of the Hindu, Buddhist, and Daoist sources rest on translations and on the scholarship cited, and specialists will find them thin. And the five rules are derived, not tested. Whether they reduce the isolation that makes religious struggle dangerous is an empirical question, and I hope someone will ask it.

Surrender remains what it was: a gift, when it comes. This article adds the other half. We may give up the fantasy of control without giving up the demand for justice, the love of a threatened life, or the truth of an injury. We may confess that we cannot explain and still refuse to leave. Where surrender does not come, fidelity can remain. R. Ḥiyya bar Abba was raised from his bed on the strength of it.

REFERENCES

1. Alcoholics Anonymous World Services. Alcoholics Anonymous: the story of how many thousands of men and women have recovered from alcoholism. 4th ed. New York: Alcoholics Anonymous World Services; 2001.
2. Alcoholics Anonymous World Services. Twelve steps and twelve traditions. New York: Alcoholics Anonymous World Services; 1953.
3. Kübler-Ross E. On death and dying. New York: Macmillan; 1969.
4. Zimmermann C. Acceptance of dying: a discourse analysis of palliative care literature. Soc Sci Med. 2012;75(1):217-24.

5. Puchalski C, Ferrell B, Virani R, Otis-Green S, Baird P, Bull J, et al. Improving the quality of spiritual care as a dimension of palliative care: the report of the Consensus Conference. *J Palliat Med*. 2009;12(10):885-904.
6. Wong-McDonald A, Gorsuch RL. Surrender to God: an additional coping style? *J Psychol Theol*. 2000;28(2):149-61.
7. Cole BS, Pargament KI. Spiritual surrender: a paradoxical path to control. In: Miller WR, editor. *Integrating spirituality into treatment: resources for practitioners*. Washington (DC): American Psychological Association; 1999. p. 179-98.
8. Clooney FX. *Comparative theology: deep learning across religious borders*. Chichester: Wiley-Blackwell; 2010.
9. Sandmel S. Parallelomania. *J Biblic Lit*. 1962;81(1):1-13.
10. Ungar-Sargon J. The sacred space of surrender: transforming physician-patient vulnerability into healing power. *J Behav Health*. 2025;14(1):14-26.
11. Ungar-Sargon J. Surrender as ontological revelation: Rabbi Rami Shapiro's recovery theology in dialogue with the dialectic of being and non-being. *Am J Med Clin Res Rev*. 2026;5(1):1-13.
12. Shapiro R. *Recovery—the sacred art: the Twelve Steps as spiritual practice*. Woodstock (VT): SkyLight Paths; 2009.
13. Ungar-Sargon J. The theology of surrender: from Step Two to Step Eleven through sovev kol almin and memale kol almin. Unpublished manuscript; 2026.
14. Ungar-Sargon J. Coming to believe in a post-belief world: mysticism, recovery, and clinical applications of Step 2. *Addict Res*. 2025;9(1):1-6.
15. Ungar-Sargon J. The dialectical divine: navigating the tension between transcendence and immanence and relevance for 12 step recovery. *J Addict Addict Disord*. 2025;12(2):197.
16. Ungar-Sargon JY. The Yechida as Higher Power: a personal theology distinguished from academic discourse. *Clin Rev Cases*. 2026;8(1):1-8.
17. Ungar-Sargon J. Neither object nor abyss: relational theology from Hasidism to the Twelve Steps to the bedside. *Am J Med Clin Res Rev*. 2026;5(1):1-15.
18. Ungar-Sargon J. Neither answered nor absorbed: the irreducible antinomy of personal address and impersonal ground in the theology of recovery. *Am J Med Clin Res Rev*. 2026;5(7):1-17.
19. Ungar-Sargon J. Meeting calamity with serenity: integrating Twelve-Step spirituality and Chassidic theology as clinical frameworks for patients confronting catastrophic illness. *Addict Res*. 2026;10(1):1-11.
20. Ungar-Sargon J. Suffering in the therapeutic space: Job's dialogue with suffering in contemporary medical practice. *J Relig Theol*. 2025;7(3):49-74.
21. Ungar-Sargon J. The wound as altar: an anti-theodicy of the Shoah. *J Relig Theol*. 2026;8(2):6-28.
22. Ungar-Sargon J. The third grammar: an anti-theodicy for the clinical encounter. *Am J Med Clin Res Rev*. 2026;5(9):1-30.
23. Ungar-Sargon J. Illness as the demonic II: why we must not surrender to explanations that relieve us of responsibility. *J Relig Theol*. 2025;7(4):108-20.
24. Ungar-Sargon J. Blackstar symbol, withdrawal, and the refusal of consolation. *J Psychol Neurosci*. 2026;8(1):1-10.

25. Ungar-Sargon J. Self-kenosis and the hermeneutic clinician. *Am J Med Clin Res Rev*. 2026;5(7):1-19.
26. Ungar-Sargon J. Epistemology versus ontology in therapeutic practice: the tzimtzum model and doctor-patient relationships. *Adv Med Clin Res*. 2025;6(1):94-101.
27. Ungar-Sargon J. Fracture within mercy: a revision of therapeutic contraction. *Arch Cienc Investig*. 2026;2(2):1-9.
28. Ungar-Sargon J. Eastern religious symbols in therapeutic practice: transcending epistemological categories for ontological transformation. *J Pharmaqube*. 2025;1(1):1-20.
29. Ungar-Sargon JY. Is hospice care in conflict with Jewish values? finding a common ground for the Jewish community. *Am J Palliat Care*. 1987 May-Jun;4:43-54.
30. Ungar-Sargon J. Comfort or control? A critical examination of hospice care and coercion in the modern healthcare system. *Adv Med Clin Res*. 2025;6(2):131-7.
31. Ungar-Sargon J. Beyond surrender: dveykut, negative theology, and Leonard Cohen's "If It Be Your Will." Unpublished manuscript; 2026.
32. Weisman AD. On dying and denying: a psychiatric study of terminality. New York: Behavioral Publications; 1972.
33. Frank AW. The wounded storyteller: body, illness, and ethics. Chicago: University of Chicago Press; 1995.
34. Tiebout HM. The act of surrender in the therapeutic process, with special reference to alcoholism. *Q J Stud Alcohol*. 1949;10:48-58.
35. Tiebout HM. Surrender versus compliance in therapy, with special reference to alcoholism. *Q J Stud Alcohol*. 1953;14:58-68.
36. James W. The varieties of religious experience: a study in human nature. New York: Longmans, Green; 1902.
37. Kurtz E. Not-God: a history of Alcoholics Anonymous. Center City (MN): Hazelden; 1979.
38. Kelly JF, Humphreys K, Ferri M. Alcoholics Anonymous and other 12-step programs for alcohol use disorder. *Cochrane Database Syst Rev*. 2020;3(3):CD012880.
39. Kelly JF, Magill M, Stout RL. How do people recover from alcohol dependence? A systematic review of the research on mechanisms of behavior changes in Alcoholics Anonymous. *Addict Res Theory*. 2009;17(3):236-59.
40. Kelly JF, Stout RL, Magill M, Tonigan JS, Pagano ME. Spirituality in recovery: a lagged mediational analysis of Alcoholics Anonymous' principal theoretical mechanism of behavior change. *Alcohol Clin Exp Res*. 2011;35(3):454-63.
41. Tonigan JS, Miller WR, Schermer C. Atheists, agnostics and Alcoholics Anonymous. *J Stud Alcohol*. 2002;63(5):534-41.
42. Ungar-Sargon J. Comparing and integrating the 12-step recovery model and classical medical model: toward a holistic framework for addiction treatment. *Addict Res*. 2025;9(1):1-12.
43. Ungar-Sargon J. Evidence-based addiction treatment comparison: a comprehensive analysis of substance use and process addictions. *Addict Res*. 2025;9(3):1-13.
44. Miller WR, Rollnick S. Motivational interviewing: helping people change. 3rd ed. New York: Guilford Press; 2013.
45. Welwood J. Principles of inner work: psychological and spiritual. *J Transpers Psychol*. 1984;16(1):63-73.

46. Patton LL, translator. *The Bhagavad Gita*. London: Penguin Classics; 2008.
47. Carman JB. *The theology of Rāmānuja: an essay in interreligious understanding*. New Haven: Yale University Press; 1974.
48. Mumme PY. *The Śrīvaiṣṇava theological dispute: Maṇavāḷamāṇuni and Vedānta Deśika*. Madras: New Era Publications; 1988.
49. Bodhi B, translator. *The connected discourses of the Buddha: a translation of the Saṃyutta Nikāya*. Boston: Wisdom Publications; 2000. Saṃyutta Nikāya 36.6 (Sallatha Sutta).
50. Hayes SC, Strosahl KD, Wilson KG. *Acceptance and commitment therapy: the process and practice of mindful change*. 2nd ed. New York: Guilford Press; 2012.
51. McCracken LM, Vowles KE. Acceptance and commitment therapy and mindfulness for chronic pain: model, process, and progress. *Am Psychol*. 2014;69(2):178-87.
52. Purser RE. *McMindfulness: how mindfulness became the new capitalist spirituality*. London: Repeater Books; 2019.
53. Hirota D, Inagaki H, Tokunaga M, Uryuzu R, translators. *The collected works of Shinran*. 2 vols. Kyoto: Jōdo Shinshū Hongwanji-ha; 1997.
54. Unno T, translator. *Tannisho: a Shin Buddhist classic*. Honolulu: Buddhist Study Center Press; 1984.
55. Ueda Y, Hirota D. *Shinran: an introduction to his thought*. Kyoto: Hongwanji International Center; 1989.
56. Lau DC, translator. *Lao Tzu: Tao te ching*. Harmondsworth: Penguin Books; 1963.
57. Ziporyn B, translator. *Zhuangzi: the essential writings with selections from traditional commentaries*. Indianapolis: Hackett; 2009.
58. Slingerland E. *Effortless action: wu-wei as conceptual metaphor and spiritual ideal in early China*. New York: Oxford University Press; 2003.
59. Talmud Bavli. Vilna ed. Berakhot 5a-5b, 10a, 32a, 54a, 60b-61b; Ta'anit 21a; Ḥagigah 5b; Yoma 87a.
60. Tanakh: *The Holy Scriptures*. Philadelphia: Jewish Publication Society; 1985.
61. Newsom CA. *The Book of Job: a contest of moral imaginations*. New York: Oxford University Press; 2003.
62. Greenstein EL. *Job: a new translation*. New Haven: Yale University Press; 2019.
63. Laytner A. *Arguing with God: A Jewish tradition*. Northvale (NJ): Jason Aronson; 1990.
64. Weiss DH. *Pious irreverence: confronting God in rabbinic Judaism*. Philadelphia: University of Pennsylvania Press; 2017.
65. Blumenthal DR. *Facing the abusing God: a theology of protest*. Louisville (KY): Westminster/John Knox Press; 1993.
66. Ungar-Sargon J. *Rav lakh: the dying of Moses, the bargaining patient, and an apophatic clinical theology*. Unpublished manuscript; 2026.
67. Shapira KK. *Sacred fire: Torah from the years of fury 1939-1942*. Worch JH, translator; Miller DL, editor. Northvale (NJ): Jason Aronson; 2000.
68. Polen N. *The holy fire: the teachings of Rabbi Kalonymus Kalman Shapira, the Rebbe of the Warsaw Ghetto*. Northvale (NJ): Jason Aronson; 1994.

69. Rubenstein RL. *After Auschwitz: radical theology and contemporary Judaism*. Indianapolis: Bobbs-Merrill; 1966.
70. Fackenheim EL. *God's presence in history: Jewish affirmations and philosophical reflections*. New York: New York University Press; 1970.
71. Greenberg I. Cloud of smoke, pillar of fire: Judaism, Christianity, and modernity after the Holocaust. In: Fleischner E, editor. *Auschwitz: beginning of a new era?* New York: KTAV; 1977. p. 7-55.
72. Jonas H. The concept of God after Auschwitz: A Jewish voice. *J Relig*. 1987;67(1):1-13.
73. Braiterman Z. (God) after Auschwitz: tradition and change in post-Holocaust Jewish thought. Princeton: Princeton University Press; 1998.
74. Levinas E. Useless suffering. In: Bernasconi R, Wood D, editors. *The provocation of Levinas: rethinking the Other*. London: Routledge; 1988. p. 156-67.
75. Ungar-Sargon J. Between divine judgment and divine absence: post-Holocaust theology in the dialectic of Midas HaDin and Midas HaRachamim. *J Relig Theol*. 2025;7(1):40-9.
76. Ungar-Sargon J. The pain of the Shekhinah: from midrashic exile through to embodied theology. *J Relig Theol*. 2026;8(1):58-77.
77. Shneur Zalman of Liadi. *Likutei Amarim—Tanya*. Bilingual ed. Brooklyn (NY): Kehot Publication Society; 1984.
78. Elier R. *The paradoxical ascent to God: the kabbalistic theosophy of Habad Hasidism*. Green JM, translator. Albany: State University of New York Press; 1993.
79. Wolfson ER. *Open secret: postmessianic messianism and the mystical revision of Menahem Mendel Schneerson*. New York: Columbia University Press; 2009.
80. Leiner MY. *Living waters: the Mei HaShiloach*. Edwards BP, translator. Northvale (NJ): Jason Aronson; 2001.
81. Magid S. *Hasidism on the margin: reconciliation, antinomianism, and messianism in Izbica/Radzin Hasidism*. Madison: University of Wisconsin Press; 2003.
82. Ungar-Sargon J. Divine predestination and human culpability: the Tree of Knowledge, theological determinism, and the question of illness versus moral failure in addiction theory. *Adv Educ Res Rev*. 2025;2(2):87-100.
83. Ungar-Sargon JY. The dissolving self in the therapeutic encounter: mysticism, ego dissolution, and clinical transformation. *Adv Med Clin Res*. 2025;6(2):229-37.
84. Maimonides M. *The guide of the perplexed*. Pines S, translator. Chicago: University of Chicago Press; 1963.
85. Ungar-Sargon JY. The sacred epistemology of not-knowing: uncertainty and doubt as foundations for humility in medicine and religion. *Clin Rev Cases*. 2026;8(1):1-8.
86. Ungar-Sargon J. Religious trauma and the hermeneutic clinical encounter: from modern scholarship to an integrated recovery-informed framework. *Biomed J Sci Tech Res*. 2026;65(4):57897-909.
87. Ungar-Sargon J. A remedy travels alone: Greek medicine, rabbinic law, and the limits of influence. *Am J Neurol Res*. 2026;5(3):1-24.
88. Pargament KI, Kennell J, Hathaway W, Grevengood N, Newman J, Jones W. Religion and the problem-solving process: three styles of coping. *J Sci Study Relig*. 1988;27(1):90-104.

89. Pargament KI, Koenig HG, Tarakeshwar N, Hahn J. Religious struggle as a predictor of mortality among medically ill elderly patients: a 2-year longitudinal study. *Arch Intern Med*. 2001;161(15):1881-5.
90. Exline JJ, Park CL, Smyth JM, Carey MP. Anger toward God: social-cognitive predictors, prevalence, and links with adjustment to bereavement and cancer. *J Pers Soc Psychol*. 2011;100(1):129-48.
91. Exline JJ, Kaplan KJ, Grubbs JB. Anger, exit, and assertion: do people see protest toward God as morally acceptable? *Psychol Relig Spiritual*. 2012;4(4):264-77.
92. Phelps AC, Maciejewski PK, Nilsson M, Balboni TA, Wright AA, Paulk ME, et al. Religious coping and use of intensive life-prolonging care near death in patients with advanced cancer. *JAMA*. 2009;301(11):1140-7.
93. Steinhauser KE, Christakis NA, Clipp EC, McNeilly M, McIntyre L, Tulsky JA. Factors considered important at the end of life by patients, family, physicians, and other care providers. *JAMA*. 2000;284(19):2476-82.
94. Watson M, Haviland JS, Greer S, Davidson J, Bliss JM. Influence of psychological response on survival in breast cancer: a population-based cohort study. *Lancet*. 1999;354(9187):1331-6.
95. Zimmermann C. Denial of impending death: a discourse analysis of the palliative care literature. *Soc Sci Med*. 2004;59(8):1769-80.
96. Hart B, Sainsbury P, Short S. Whose dying? A sociological critique of the 'good death'. *Mortality*. 1998;3(1):65-77.
97. Jackson VA, Jacobsen J, Greer JA, Pirl WF, Temel JS, Back AL. The cultivation of prognostic awareness through the provision of early palliative care in the ambulatory setting: a communication guide. *J Palliat Med*. 2013;16(8):894-900.
98. Balboni TA, VanderWeele TJ, Doan-Soares SD, Long KNG, Ferrell BR, Fitchett G, et al. Spirituality in serious illness and health. *JAMA*. 2022;328(2):184-97.
99. Cassell EJ. The nature of suffering and the goals of medicine. *N Engl J Med*. 1982;306(11):639-45.
100. Ungar-Sargon J. Embodied theology for end-of-life care: a being-with-nonbeing approach to dying patients. *KOS J Public Health Integr Med*. 2025;1(2):1-23.
101. Maimonides M. *Mishneh Torah, Hilkhoh Teshuvah 2:9-11*. Standard printed editions.
102. Wiesel S. *The sunflower: on the possibilities and limits of forgiveness*. Rev ed. New York: Schocken Books; 1997.
103. Améry J. *At the mind's limits: contemplations by a survivor on Auschwitz and its realities*. Rosenfeld S, Rosenfeld SP, translators. Bloomington: Indiana University Press; 1980.
104. Brudholm T. *Resentment's virtue: Jean Améry and the refusal to forgive*. Philadelphia: Temple University Press; 2008.
105. Ungar-Sargon J. The shared abyss: trauma, responsibility, and the space between mutual wounding and the ethics of reconciliation between perpetrator and victim. *Adv Med Clin Res*. 2025;6(2):194-205.
106. Ungar-Sargon J. When the healer mourns: physician grief after a patient's death. *Trends Gen Med*. 2025;3(4):1-10.
107. Ungar-Sargon J. Hermeneutic approaches to medicine: from objective evidence to patient as sacred text. *Adv Educ Res Rev*. 2025;2(1):40-5.