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Time, Rupture, and Presence: Reconstructing Temporality in the Therapeutic Relationship

Julian Ungar-Sargon, MD, PhD

Former Clinical Director, Borra College of Health Sciences, Dominican University IL, River Forest IL USA.

***Corresponding Author**
Julian Ungar-Sargon, MD, PhD
Former Clinical Director, Borra College of Health Sciences, Dominican University IL, River Forest IL USA.

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Abstract

Time is not a neutral container within which clinical experience unfolds. It is itself constitutive of suffering, identity, and healing. This essay argues that the therapeutic relationship is, at its deepest level, a temporal intervention — a site in which fractured, collapsed, or petrified time is reconstructed into something livable. I have proposed elsewhere that the clinical encounter functions as a form of sacred space in which the patient is received as a sacred messenger rather than a diagnostic object, and that the physician's vocation requires what I have called therapeutic tzimtzum: a disciplined self-withdrawal that creates room for the other (Ungar-Sargon, 2025; Ungar-Sargon, 2025). The present essay extends that argument into the dimension of time specifically, drawing on four traditions that have grappled most seriously with temporal experience: Western biblical linearity and sacred interruption, Eastern cyclicality and transcendence, the existential pragmatism of the Twelve-Step movement, and the Kabbalistic theology of rupture and repair as elaborated by Elliot R. Wolfson. The synthesis offered here proposes a theory of therapeutic temporality in which the clinician functions as a temporal witness — one who holds time open for the patient long enough for healing to become possible. Drawing on my sustained engagement with these themes across more than a decade of clinical practice and medical humanities scholarship, I argue that healing, understood at its deepest level, is not primarily a biological event but a temporal one.

Keywords: Therapeutic relationship; temporality; Kabbalah; Twelve-Step recovery; hermeneutic medicine; sacred time; Wolfson; tzimtzum; medical humanities; sacred brokenness.

Introduction : The Poverty of Clock-Time in Clinical Medicine

Modern medicine's relationship with time is impoverished. The electronic health record timestamps encounters to the minute; evidence-based protocols are built from survival curves and hazard ratios; prognosis is rendered in median survivals and five-year projections. Time, in this biomedical framework, is what a clock measures — a homogeneous, quantitative medium through which disease advances and through which the clinician tracks it. I have argued at length that this reductionism constitutes a fundamental distortion of the clinical vocation — that the physician who attends only to the biological substrate of suffering abandons the patient at precisely the level at which healing most needs to occur (Ungar-Sargon, 2025; Ungar-Sargon, 2025). But the distortion is not only ontological; it is temporal. Patients do not suffer in clock-time alone. They suffer in what phenomenologists since Husserl have called lived time: the texture of duration as it is experienced from the inside.

Traumatic time circles back on itself. Depressive time flattens. Anxious time accelerates toward imagined catastrophe. Chronic

illness — which constitutes the majority of a neurologist's and pain specialist's clinical world — collapses the future into a permanent, unrelieved present. I have written of the experience of chronic pain as a spirituality in its own right, a mode of existence that transforms the patient's entire temporal horizon and demands a correspondingly transformed clinical response (Ungar-Sargon, 2025; Ungar-Sargon, 2025). These are not merely psychological phenomena requiring adjustment to illness; they are the illness as the patient experiences it, and no clinical intervention that ignores them can claim to be fully therapeutic.

This essay proposes that a richer understanding of time — drawn from four great traditions that have grappled most seriously with its nature — can transform how clinicians understand and enact the therapeutic relationship. The four traditions are: the Western biblical tradition with its linear, covenantal, and morally weighted time; Eastern religious philosophies (principally Buddhism and Hinduism) with their cyclical, impermanent, and ultimately transcendable time; the Twelve-Step movement with its radically present-centered, narratively reconstructive temporality; and the Kabbalistic mystical tradition, above all as elaborated by the philosopher Elliot R. Wolfson, with its conception of time as emerging from divine rupture and requiring ritual repair. The methodological framework for this cross-traditional comparison is provided by Michael Stausberg, whose survey of approaches to the study of time in the history of religions remains indispensable (Stausberg, 2003-2004).

The thesis that emerges is that healing, understood at its deepest level, is not primarily a biological event but a temporal one. To heal is to reconstitute one's relationship with past, present, and future — to transform a fragmented or foreclosed temporality into one that is narratable, livable, and open. In my work on hermeneutic medicine, I have proposed that the patient functions as a sacred text to be read with patience, attention, and reverence — and that the clinical encounter is itself a hermeneutic event in which meaning is co-created between clinician and patient (Ungar-Sargon, 2025; Ungar-Sargon, 2025). The temporal dimension of this hermeneutic encounter is what the present essay seeks to articulate. The clinician who enters this sacred space is not merely a technician of pathophysiology but a temporal witness: one who participates, through attentive presence, in the patient's reconstitution of time.

Toward a Pluralist Study of Religious Temporality

Stausberg's 2003–2004 essay, 'Approaches to the Study of Time in the History of Religions,' offers the most rigorous methodological survey available of how the academic discipline of religious studies has understood time (Stausberg, 2003-2004). Its importance lies not only in its erudition but in its critical edge: Stausberg systematically dismantles the assumption, dominant from Henri Hubert and Marcel Mauss through Mircea Eliade, that religious time constitutes a unified, qualitatively distinct phenomenon opposed to secular or profane time (Stausberg, 2003-2004). Hubert's foundational 1905 essay established the key opposition between quantitative ordinary time and qualitative religious or magical time. This distinction was built into the architecture of twentieth-century phenomenology of religion. In Eliade, it became a governing thesis: homo religiosus desires above all to escape profane, historical time into the eternal, reversible, regenerative time of origins.

Stausberg's critique is incisive. He argues that the Eliadean construction of 'sacred time' is a cultural critique masquerading as descriptive analysis — a romantic protest against industrial, clock-dominated modernity — rather than a faithful representation of the diverse ways in which religious traditions actually construct temporal experience (Stausberg, 2003-2004). More fundamentally, he insists that there is no single 'religious experience of time' to be extracted from the traditions; there are only historically situated, socially embedded, ritually enacted temporalities in the plural. This methodological pluralism prohibits dissolving the four traditions examined here into a common essence. Biblical time, Buddhist time, Twelve-Step time, and Kabbalistic time are genuinely different; their differences matter and should not be collapsed.

Stausberg also directs attention toward practice rather than doctrine. Time in religion is most fundamentally constructed through ritual — through daily demarcation, weekly Sabbath observance, annual festival cycles, and rites of passage (Stausberg, 2003-2004). Time is not merely thought; it is done. This has direct implications for the therapeutic encounter, which I understand as itself a form of ritual time-making. As I have argued in my work on sacred listening and primordial silence, the structure of the clinical encounter — the greeting, the open-ended question, the attentive silence, the shared reflection — constitutes a ritual that creates the conditions for trust and temporal repair (Ungar-Sargon, 2025; Ungar-Sargon, 2025). The clinician who allows the appointment to be rushed, who interrupts the patient's narrative, who reduces the encounter to a checklist of symptoms, is not merely being inefficient; she is desecrating a sacred temporal space.

Stausberg's discussion of the Egyptian distinction between neheh (virtual or potentialized time) and djet (actualized or completed time) is particularly evocative for clinical purposes (Stausberg, 2003-2004). In Egyptian cosmological thought, the continuity of these two temporal registers cannot be taken for granted but must be ritually maintained: if the necessary rituals are not performed, time risks standing still. This is precisely the situation of the patient in the grip of trauma or severe depression: her neheh — the virtual potentiality of becoming, of possible futures — has ceased to flow into djet. The therapeutic encounter, on this reading, is the ritual performance that gets the patient's time moving again.

Western Biblical Time: Creation, Linearity, Covenant, and Sacred Interruption

The Western biblical tradition inaugurates a distinctive model of time with what is arguably the most consequential sentence in human intellectual history: 'In the beginning, God created the heavens and the earth' (Genesis 1:1). The force of this sentence is not merely cosmological but ontological: time itself is created. Before the beginning, there was not simply emptiness but the pre-temporal reality of the divine. With creation, time enters the world — and with time, irreversibility.

This is the first great feature of biblical time: its linearity. Unlike the cyclical cosmologies dominant in the ancient Near Eastern world, biblical time moves forward. The covenant between God and Israel is made in history, fulfilled or broken in history, and awaits its eschatological completion in history. As Steensgaard has observed, Jewish time is fundamentally historical — not in the modern secular sense of mere chronological sequence, but in the sense of a narrative with direction, agency, and moral weight (Steensgaard, 1993). God acts in time; human beings respond in time; the consequences unfold in time. The past is not dissolved in cyclical recurrence but preserved as memory, as foundational event, as the basis for ongoing obligation.

This historical linearity produces a distinctive psychological structure that maps directly onto clinical experience. The past is the domain of memory — and, for patients, often of trauma. The future is the domain of promise — and, for patients, often of anxiety. The present is the domain of obligation — and, for patients suffering from depression or chronic illness, often of paralysis. I have written extensively of the phenomenon of patient guilt — the crushing, immovable past that forecloses any future — and of the physician's responsibility to receive this guilt without judgment (Ungar-Sargon, 2025). The biblical tradition offers two responses to this experience: the prophetic tradition of teshuvah, in which the past is acknowledged but not permitted to determine the future absolutely; and the covenantal insistence on the openness of the future, its resistance to closure by the past. Both responses are operative in the clinical setting whenever a physician holds a patient's shame without recoiling from it.

Yet biblical time is not simply linear. It is punctuated by sacred interruptions — Sabbath, festivals, revelation — moments where eternity enters history. The Sabbath is not merely a day of rest; it is a temporal practice that reconstitutes the human being's relationship with time itself. By interrupting the week's forward momentum, it creates space for presence, gratitude, and the experience of time as gift rather than burden. I have elsewhere proposed that the clinical encounter itself functions as a form of Sabbath interruption: a moment set apart from the relentless forward pressure of the productive week, in which the patient is invited to stop moving and simply be (Ungar-Sargon, 2025). The sacred temporal container of the physician's office — properly maintained — is an analogue of the sacred temporal container of the seventh day.

The biblical God reveals himself to Moses as 'I am who I am' (Ehyeh asher Ehyeh, Exodus 3:14) — a formulation that resists temporal fixity and suggests a divine being perpetually in the process of self-disclosure. Time, on this reading, is the medium of ongoing revelation. The clinician who remains genuinely open to the patient's ongoing self-disclosure — who does not foreclose the encounter with a premature diagnostic formulation — is enacting something analogous to this covenantal attentiveness. My concept of the patient as sacred text, developed across several essays on hermeneutic medicine, draws on precisely this biblical intuition: the patient, like the divine text, is always saying more than has yet been heard, and the physician's task is to remain in a posture of receptive interpretation (Ungar-Sargon, 2025; Ungar-Sargon, 2025).

Eastern Conceptions of Time: Cyclicality, Impermanence, and Transcendence of Temporal Bondage

Eastern religious traditions offer a fundamentally different relationship with time. Where biblical religion is linear and covenantal, Eastern traditions are (with important qualifications) cyclical and soteriological: they conceive of liberation primarily as liberation from time rather than fulfillment within it. I have engaged with these traditions in my clinical work and have found in them resources that complement and challenge the Western framework in productive ways (Ungar-Sargon, 2025).

Buddhist Temporality: Dependent Origination, Impermanence, and the Clinical Limits of Detachment

Buddhist philosophy begins its analysis of time with the doctrine of dependent origination (pratītyasamutpāda): all phenomena arise in dependence on conditions, persist through the continued presence of those conditions, and cease when the conditions are withdrawn. The fundamental characteristic of this unfolding is impermanence (anicca):

all conditioned phenomena are transient. Suffering (dukkha) arises, in the Buddhist diagnosis, precisely from the failure to accept impermanence — from the human tendency to cling to pleasant experiences and to resist painful ones. As Pande summarizes, Buddhism regards time as an aspect of causality that is the deepest feature of conditioned reality while looking beyond it to the attainment of the timeless, unconditioned reality (Stausberg, 2003-2004).

Buddhist-inflected therapeutic approaches, including mindfulness-based stress reduction (MBSR) and mindfulness-based cognitive therapy (MBCT), work precisely at the level of temporal experience — not by resolving the patient's narrative but by loosening the patient's identification with it, creating what has been called a witnessing awareness that can observe thoughts and sensations without being consumed by them (Kabat-Zinn, 1990). I have found this framework clinically valuable in chronic pain treatment, where the patient's suffering is intensified by the secondary layer of resistance to the pain — the refusal to accept the reality of what is being experienced in the present moment (Ungar-Sargon, 2025; Ungar-Sargon, 2025). The Buddhist invitation to meet impermanence without clinging can transform the pain patient's temporal experience by releasing her from the exhausting project of willing the past to have been different or the future to be already here.

The clinical application of Buddhist temporality, however, requires what I would call hermeneutic discernment. For patients whose suffering arises from the opposite direction — not from excessive attachment to continuity but from the traumatic disruption of continuity — the Buddhist invitation to loosen identification with the temporal self may constitute a second wounding. The patient who has already been robbed of her narrative does not need to be told that narratives are illusions; she needs help in reconstructing one. The skilled clinician must therefore know which temporality the patient needs: more presence and less narrative, or more narrative and more continuity. As I have argued in my work on tragic consciousness and therapeutic presence, the physician's central hermeneutic task is to read the patient's temporal situation accurately enough to offer the response the situation actually requires, rather than the response the physician's own framework most readily supplies (Ungar-Sargon, 2025).

Hindu Temporality: Cosmic Cycles, the Eternal Brahman, and the Qualitative Experience of Sacred Time

Hinduism, as Stausberg emphasizes following Balslev's analysis, is not a unified tradition but an extraordinarily diverse cluster of traditions, and any attempt to extract a single Hindu conception of time distorts its irreducible plurality (Stausberg, 2003-2004). The dominant cosmological framework involves vast cycles of time — the four yugas constituting a mahayuga of approximately 4.32 million years — within which human history occupies only a vanishingly small portion. At the metaphysical level, many Hindu philosophical traditions posit an ultimate reality (Brahman) entirely beyond time — eternal, unchanging, self-luminous. The soteriological goal, in most of these traditions, is some form of realization of one's identity with or relation to the eternal.

The auspiciousness-inauspiciousness oscillation that Stausberg, following Fuller, identifies as characteristic of popular Hinduism represents a third level of temporal experience — neither the philosophical transcendence of the Upanishads nor the cosmic cycles of the Puranas, but the lived, embodied experience of time as marked by moments of varying sacred quality (Stausberg, 2003-2004). This qualitative temporality resonates with the patient's experience of illness as transforming the quality of time, making some moments unbearable and others, unexpectedly, charged with presence and meaning. In my work on embodied theology for end-of-life care, I have observed that patients approaching death often develop a heightened sensitivity to the qualitative texture of temporal moments — an intensified awareness of the sacred within the ordinary that resembles what Hindu traditions identify as the experience of the auspicious (Ungar-Sargon, 2025). The physician who attends to this qualitative dimension participates in the patient's temporal experience at a depth that purely quantitative medicine cannot reach.

Time in the Twelve-Step Movement: Existential Pragmatism and the Reconstruction of Temporal Experience

The Twelve-Step movement represents a fundamentally different kind of wisdom about time — not philosophical or theological in the formal sense, but deeply practical, embodied, and born from the lived experience of those for whom ordinary temporal experience had catastrophically broken down. Addiction is, among other things, a disorder of time: a condition in which the drive for immediate relief overwhelms the capacity for temporal self-regulation, in which the future is sacrificed to the present, and in which the past accumulates as a weight of shame and regret that further fuels the drive toward intoxicating relief. I have written at length on the theology of addiction and sacred brokenness, arguing that the recovering person's experience of powerlessness constitutes an ontological revelation — a disclosure of the human condition that religious traditions have addressed across millennia (Ungar-Sargon, 2025; Ungar-Sargon, 2025).

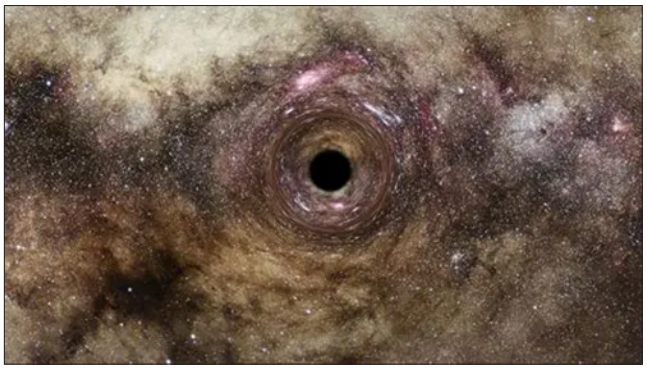
The Twelve-Step framework addresses temporal disorder at multiple levels simultaneously. Its most immediate temporal intervention is the principle of radical presentism, crystallized in the slogan 'one day at a time.' This deceptively simple prescription represents a sophisticated temporal reframing. The question 'Can you stay sober for the rest of your life?' is

unanswerable and therefore paralyzing. The question 'Can you stay sober today?' is answerable and therefore empowering. By compressing the temporal horizon to the immediately manageable, the Twelve-Step tradition makes possible a form of agency that the overwhelming future had foreclosed. This radical presentism resonates with the biblical tradition's daily dependence ('Give us this day our daily bread'), with the Buddhist mindfulness tradition's cultivation of moment-to-moment awareness, and with what I have called the serenity of meeting calamity: the capacity to inhabit each moment of difficulty without being destroyed by it (Ungar-Sargon, 2025).

Steps Four through Nine address the relationship with the past through a sophisticated temporal operation: the past is not repressed, denied, or simply accepted as irreversible. It is brought into the present, witnessed by another person, integrated into a revised self-narrative, and where possible, its relational damage is repaired. This sequence — searching moral inventory, witnessed disclosure, amendment — is a form of what I have described as the sacred dialectic of powerlessness: the movement from the confession of inability to the discovery of a deeper capacity that operates precisely through acknowledged weakness (Ungar-Sargon, 2025). The psychoanalytic parallels are evident: the Twelve-Step tradition independently arrived at something like the therapeutic value of making the unconscious conscious, of speaking the unspeakable to a witnessing other. But the temporal logic is distinctive. The goal is not cathartic discharge but narrative integration — the transformation of the past from a source of shame-driven compulsion into a narrated story that can be held, owned, and eventually used in service of others.

The future is addressed through the Twelve-Step tradition's radical theology of surrender. Steps One through Three involve the acknowledgment of powerlessness over addiction, the recognition that a power greater than us can restore sanity, and the decision to turn one's will and life over to that power's care. Whatever the theological content attributed to this Higher Power — and the tradition is deliberately non-dogmatic — its temporal function is clear: it represents the relinquishment of the fantasy of total control over the future. The recovering person does not resolve to master the future through willpower; she surrenders the future to a care that exceeds her own. The serenity prayer encodes this temporal wisdom with remarkable precision: 'God, grant me the serenity to accept the things I cannot change, the courage to change the things I can, and the wisdom to know the difference.' This is a complete philosophy of time in compressed form — the past and the structural given (cannot change), the present and the actionable (can change), and the wisdom to distinguish between them.

For the clinician, the Twelve-Step model offers several transferable insights that I have applied across my decades of clinical practice in neurology and pain management. The technique of radical temporal compression — attending only to today — is applicable far beyond addiction. The patient overwhelmed by a devastating diagnosis, the caregiver exhausted by the demands of a loved one's illness, the chronic pain sufferer who cannot imagine a future without pain: all can benefit from the invitation to compress the temporal horizon to the immediately manageable. Similarly, the Twelve-Step emphasis on narrative — on telling one's story to a witnessing community — points to the therapeutic importance of the clinical encounter as a space in which the patient's temporal narrative can be reconstructed in the presence of an attentive other. As I have proposed in my work on presence, witness, and meaning, the physician who truly listens is not merely gathering information; she is creating the conditions within which the patient's story can be told, and in being told, transformed (Ungar-Sargon, 2025).



Kabbalistic Time: The Theology of Temporal Fracture

The Kabbalistic tradition, and in particular the Lurianic Kabbalah elaborated in sixteenth-century Safed, offers perhaps the most radical rethinking of time available in any religious tradition — and, for the purposes of this essay, the most directly illuminating for the clinical encounter. Its central concepts — tzimtzum (divine contraction), shevirat ha-kelim (the breaking of the vessels), and tikkun (repair or restoration) — provide a metaphysical framework in which rupture, fragmentation, and suffering are not anomalies to be explained away but constitutive features of reality requiring active repair. I have been working within this framework across my published essays for more than a decade and find in it inexhaustible clinical and theological resources (Ungar-Sargon, 2025; Ungar-Sargon, 2025; Ungar-Sargon, 2025).

The scholarly resource that most fully articulates the relevance of these concepts for a philosophy of time is the work of Elliot R. Wolfson, one of the preeminent scholars of Jewish mysticism writing today. In Suffering Time: Philosophical, Kabbalistic, and Ḥasidic Reflections on Temporality, Wolfson undertakes a sustained examination of how Kabbalistic and Hasidic traditions have conceptualized the relationship between time, eternity, suffering, and redemption (Ungar-Sargon, 2026). His earlier Alef, Mem, Tau: Kabbalistic Musings on Time, Truth, and Death provides an intricate hermeneutic of the Hebrew alphabet as a symbolic encoding of temporal structure — beginning, unfolding, and completion — that itself folds back upon itself in recursive temporal paradox (Ungar-Sargon, 2025). Together, these works constitute an indispensable resource for any serious engagement with the Kabbalistic theology of time.

Time as the Residue of Divine Withdrawal

The Lurianic doctrine of tzimtzum begins with a cosmological problem: if God is infinite (Ein Sof — literally, 'without end'), how can anything other than God exist? The Lurianic answer is radical: God creates space for the world by withdrawing, contracting, making room. The universe comes into being not in a space outside God but in a space within God — the chalal, the void left by the divine contraction. The implications for temporality are profound. Time, in Lurianic cosmology, is not the eternal medium of God's self-expression but the finite residue of God's self-concealment. Wolfson emphasizes that this makes temporality inseparable from hiddenness, from absence, from what he calls the trace of a presence that has withdrawn (Ungar-Sargon, 2026).

I have applied the concept of tzimtzum extensively in my clinical writing. The physician who enters the encounter with a full agenda, a predetermined diagnostic hypothesis, and a treatment plan already formed leaves no room for the patient. Clinical tzimtzum is the practice of deliberate self-withdrawal in order to create space for the patient — the setting aside of one's preconceptions so that the patient's own story can emerge in its own terms and its own time (Ungar-Sargon, 2025; Ungar-Sargon, 2025). This is not clinical passivity but a disciplined presence-in-absence: the clinician is fully there, fully attentive, but her presence is organized around making room rather than filling space with her own authority. In my essay on the sacred epistemology of not-knowing, I argued that the physician's willingness to dwell in the space of genuine unknowing — to resist the premature closure of diagnostic certainty — is itself a form of therapeutic tzimtzum, a contraction of medical authority that creates room for the patient's truth to emerge (Ungar-Sargon, 2025).

This concept maps directly onto what the psychoanalytic tradition calls negative capability — Keats's famous phrase, adopted by Wilfred Bion to describe the analyst's capacity to tolerate not-knowing without irritably reaching after fact and reason. The clinician who can hold the patient's story without immediately resolving it into a diagnosis, who can sit with the patient's suffering without immediately moving to remediate it, who can allow the therapeutic encounter to take the time it needs rather than forcing it into the allotted appointment slot — this clinician is practicing a form of clinical tzimtzum that the Kabbalistic tradition illuminates with unusual precision.

The Shattering of the Vessels and the Fracture of Time

The second great act in the Lurianic drama is shevirat ha-kelim — the breaking of the vessels. As the divine light re-enters the chalal through a series of vessels designed to contain it, the lower vessels shatter under the force of the influx. The shards (nitzotzot, sparks) of the broken vessels fall, carrying with them exiled sparks of divine light. The world as we experience it is this broken world — a world of scattered sparks and shattered vessels in which the divine and the human are mixed together in ways that conceal the sacred within the profane. In my essay 'Shattered Vessels in the House of Healing,' I have applied this doctrine directly to the medical setting, arguing that the hospital is itself a house of broken vessels — a space where the divine sparks of human dignity persist within conditions of maximal vulnerability and institutional fragmentation (Ungar-Sargon, 2025).

Wolfson's analysis of shevirah and its temporal implications is particularly illuminating (Ungar-Sargon, 2025). The breaking of the vessels is not merely a cosmological event located in mythic prehistory; it is a structure that is repeated in different registers throughout the history of creation. Every instance of suffering, rupture, and loss recapitulates the primordial shattering. Temporality itself, Wolfson argues, is characterized by this discontinuity — time is not a smooth, homogenous flow but a series of ruptures, interruptions, and repairs. The experience that patients most commonly describe in the aftermath of serious illness, trauma, or loss is precisely a temporal rupture — a sense that time has been split into 'before' and 'after,' that the person who existed before the traumatic event and the person who exists after it are not quite the same. I have described this experience in my clinical essays as the shared abyss: the zone of rupture that the patient inhabits and that the physician must be willing to enter alongside her, without flinching and without premature attempts at resolution (Wolfson, 2021).

The Recursive Structure of Sacred Time

In Alef, Mem, Tau, Wolfson undertakes a sustained hermeneutic of the three Hebrew letters that spell emet (truth) — alef, mem, and tav — as encoding a philosophy of time that is simultaneously linear and recursive, temporal and eternal (Ungar-Sargon, 2025). Alef, the first letter, represents the moment of beginning — the primordial incipit, the opening of time. Mem, the middle letter, represents the unfolding process — the medial movement of temporal becoming, neither origin nor completion but the perpetual middle in which all actual life is lived. Tav, the last letter, represents completion — the seal of time, the moment toward which all temporal unfolding moves. But Wolfson's analysis does not stop at this linear sequence. He argues that this structure folds back: the tav, the last letter, contains within it the beginning; the end harbors the origin; the completion opens back onto the inaugural moment. Time is not only linear but recursive, not only historical but eschatological, not only moving forward but circling back.

The clinical implications of this recursive temporality are significant and connect directly to my work on hermeneutic medicine. The patient's story is not simply a chronological sequence of events but a temporal loop in which the end — the patient's present condition, her current suffering and her current self-understanding — interprets and transforms the beginning. The meaning of early events in a patient's narrative is not fixed at the time of their occurrence but remains open to revision in light of subsequent events and, crucially, in light of the therapeutic encounter in which the narrative is retold. The telling of the story is itself a temporal event that transforms the time it recounts. As I have proposed in my work on the patient history as sacred text, the clinical history is not a

neutral recording of chronological data but an interpretive act that participates in the constitution of the patient's temporal identity (Wolfson, 2006).

Repair as the Vocation of Clinical Time

The third element of the Lurianic triad is tikkun — repair, restoration, rectification. Tikkun is the human vocation in a broken world: the gathering of the scattered sparks, the repair of the broken vessels, the restoration of the divine image that was shattered in the primordial event. Wolfson emphasizes that tikkun is an irreducibly temporal practice (Ungar-Sargon, 2026). It happens in time — one act of repair at a time, one moment of intentional presence at a time. It is never complete in any given moment; the Lurianic tradition is realistic about the depth of the world's brokenness and the length of the repair process. But each genuine act of tikkun — each moment in which a human being acts with justice, compassion, or intentional presence — participates in the process of cosmic restoration. Time is not merely the medium in which repair happens; it is itself being repaired.

I have proposed that the clinical encounter, at its best, constitutes a moment of tikkun (Ungar-Sargon, 2025; Ungar-Sargon, 2025). Each moment of genuine attentiveness between clinician and patient — each moment in which the patient's suffering is witnessed without being minimized, in which the patient's narrative is held without being redirected, in which the patient's personhood is honored in its full complexity — is a moment of repair. It repairs not only the therapeutic relationship but, in some small measure, the broken temporality that illness has introduced into the patient's life. This is what I mean when I speak of hermeneutic medicine as a sacred practice: not that it invokes religious authority, but that it participates in the ongoing work of repair that constitutes the deepest meaning of human vocation in a broken world.

Time in the Therapeutic Relationship: Toward a Clinical Synthesis

Patients present to clinical encounters with temporally distorted modes of experience that can be mapped with precision onto the frameworks developed above. The most common temporal distortions include traumatic fixation, in which time is frozen at the moment of the traumatic event and the patient is unable to move forward; anticipatory dread, in which the future overwhelms the present and produces paralytic anxiety; depressive collapse, in which the future is foreclosed and all time flattens into an unbearable present; grief-induced rupture, in which the death of a significant other splits time into irreconcilable before and after; and the dissociation associated with chronic pain, in which the sufferer exists outside of ordinary temporal flow, suspended in a present of unrelieved sensation. I have encountered all of these patterns across five decades of clinical practice, and I find that the traditions examined in this essay illuminate each with a precision that the standard psychiatric and neurological frameworks cannot match (Ungar-Sargon, 2025; Ungar-Sargon, 2025; Ungar-Sargon, 2025).

Each distortion corresponds to a breakdown in one or more of the temporal dimensions elaborated above. Traumatic fixation is a failure of Kabbalistic tikkun — the scattered sparks cannot be gathered because the original rupture is too overwhelming to approach. Anticipatory dread is the biblical future (the domain of promise) become unmanageable anxiety — the covenantal openness of the future collapses into pure threat. Depressive collapse is the foreclosure of the Twelve-Step tradition's 'just for today' — even the minimal time-horizon of the present day cannot be inhabited. Grief-induced rupture corresponds most directly to shevirah — the breaking of the vessels in the patient's personal history. Chronic pain dissociation corresponds to what I have elsewhere called the dissolution of the self in the therapeutic encounter — the loss of the bounded, temporally integrated self that ongoing suffering produces (Ungar-Sargon, 2025).

The Clinician as Temporal Witness

What can a clinician offer to a patient whose temporality has broken down? The traditions examined here suggest a convergent answer: the clinician's primary temporal gift is presence — not the information, the diagnosis, or the treatment plan (though all of these matter), but the quality of attentive being that holds time open for the patient when the patient cannot hold it open for herself. This is what I mean by calling the clinician a temporal witness.

A witness is not a passive observer; she is one whose attentive presence makes it possible for something to be seen, acknowledged, and integrated. The temporal witness holds the past with the patient — not merely by recording it in the history but by receiving it, allowing it to matter, reflecting it back in a way that transforms it from raw suffering into narrated experience. The temporal witness holds the present with the patient — by being genuinely present in the encounter, resisting the pull toward the next appointment. And the temporal witness holds the future open for the patient — by maintaining hope when the patient cannot, by continuing to imagine possible futures when the patient's own imagination has been foreclosed. I have written of this dimension of clinical practice in my essay 'You're the Only Doctor Who Actually Listens to Me' — a phrase I have heard more than any other in fifty years of clinical practice, and which tells us everything about what patients most need and most rarely receive (Ungar-Sargon, 2026).

Studies of the therapeutic alliance consistently identify it as the most powerful predictor of positive outcomes across a range of therapeutic modalities, more powerful than the specific technique employed or the theoretical orientation of the clinician (Ungar-Sargon, 2025). The therapeutic alliance is, at its core, a relational achievement, and relation is irreducibly temporal: it unfolds in time, is sustained across time, and is the medium through which temporal repair becomes possible.

The Clinical Encounter as Sacred Time

The concept of sacred time, developed from Hubert and Mauss through Eliade and critiqued by Stausberg, has a legitimate

application — properly understood — to the clinical encounter (Stausberg, 2003-2004). The encounter is sacred not in the sense of belonging to a supernatural realm opposed to the profane world of clinical medicine, but in the sense that Stausberg identifies as most defensible: it is time set apart from ordinary time, structured by ritual, and oriented toward a transformation that exceeds mere information exchange. I have argued in 'Sacred Spaces, Clinical Encounters' that the physician's office and the hospital room function as sacred enclosures in which the patient is invited to be known in her vulnerability rather than in her social role — a genuine interruption of ordinary time that creates conditions unavailable anywhere else (Ungar-Sargon, 2025).

The ritual dimension of the clinical encounter is often underestimated. The handshake, the offer of a chair, the open-ended opening question — these are not mere social conventions but temporal rituals that create the conditions for trust. They signal that this time is different, that what happens here is not subject to the acceleration and superficiality of ordinary social exchange. The closing ritual — the summary of what was discussed, the plan, the next appointment — provides temporal closure and continuity, holding the encounter within a larger narrative of care. As Stausberg emphasizes following Rappaport, ritual is the basic means of constructing time by keeping it in motion (Stausberg, 2003-2004). The clinician who neglects the ritual structure of the encounter is not merely being informal; she is allowing the patient's time to stop.

Toward a Formal Theory of Therapeutic Temporality

From the four traditions examined and their clinical applications — developed across my own work and in dialogue with Stausberg, Wolfson, and the broader traditions they represent — I can now propose a formal theory of therapeutic temporality resting on six propositions.

First, time is constructed, not given. Temporal experience is not the passive reception of an objective clock-like flow but an active, socially and ritually embedded construction (Stausberg, 2003-2004). This means that temporal experience can be reconstructed — that the therapeutic encounter can, in principle, transform the patient's temporal world.

Second, suffering is characteristically a form of temporal disruption. The patient who presents with chronic pain, depression, anxiety, trauma, addiction, or grief is suffering from a distortion of temporal experience that has made the past unnarratable, the present unlivable, or the future unimaginable. Clinical assessment must attend to temporal phenomenology as a primary dimension of the patient's condition (Ungar-Sargon, 2025; Ungar-Sargon, 2025; Ungar-Sargon, 2025).

Third, healing involves the reconstruction of temporal experience. The goal of therapy, understood in its deepest sense, is not merely the elimination of symptoms but the transformation of the patient's relationship with past, present, and future. The past must become narratable — held with sorrow but not under its tyranny. The present must become livable — inhabited with something approaching equanimity. The future must become imaginable — open, however constrained by circumstance, to possibility.

Fourth, the clinical encounter is a temporal ritual. Like the Sabbath, the Twelve-Step meeting, the Kabbalistic tikkun, and the Buddhist meditation session, the therapeutic encounter creates a bounded, structured temporal space in which ordinary time is interrupted and transformation becomes possible. The clinician's role is not merely technical but ritualistic.

Fifth, the clinician's primary temporal gift is presence. Across all four traditions, the healing function is associated with a quality of attention that exceeds mere information processing. The temporal witness who holds the past, contains the present, and opens the future for the patient is offering something that no pharmacological or procedural intervention can provide. As I have argued in my work on sacred listening and the art of therapeutic presence, this witnessing function is not merely supportive of the technical clinical work; it is itself the deepest form that clinical work can take (Ungar-Sargon, 2025; Ungar-Sargon, 2025).

Sixth, the therapeutic relationship participates in tikkun. The encounter between clinician and patient, when conducted with genuine attentiveness and ethical seriousness, is a moment of repair in the Kabbalistic sense — a gathering of scattered sparks, a mending of broken vessels, a small but real contribution to the ongoing repair of a fractured world. This has been the animating conviction of my work in hermeneutic medicine from its beginning: that the clinical vocation is not merely technical expertise but a form of sacred responsibility, and that the physician who approaches her work in this spirit is practicing the deepest form of medicine available (Ungar-Sargon, 2025; Ungar-Sargon, 2025; Ungar-Sargon, 2024).

Conclusion

Modern medicine's poverty of time is not inevitable. It is a cultural and institutional choice — the result of a health system organized around productivity metrics, reimbursement rates, and evidence-based protocols that, while valuable in their proper sphere, have crowded out attention to the temporal dimensions of suffering and healing. I have written critically of this medicalization of time within healthcare systems and have advocated for temporal practices that restore the physician's capacity for moral presence (Ungar-Sargon, 2025; Ungar-Sargon, 2025). The traditions examined in this essay — biblical, Eastern, Twelve-Step, and Kabbalistic — do not offer a nostalgic retreat from evidence-based medicine; they offer a deepening of it, an extension of the clinical gaze to dimensions of human experience that the biological model alone cannot reach.

Time, in its deepest sense, is not the ticking of a clock but the unfolding of being. Religious traditions reveal that time can be created, transcended, ritualized, fractured, and repaired. The therapeutic relationship stands at the intersection of these possibilities. In the clinic, we encounter not diseases alone

but disrupted temporalities — human beings whose time has been shattered by illness, trauma, loss, or addiction, and who come to us not only for biological repair but for temporal reconstruction.

The work of healing is therefore, at its deepest level, the work of restoring time — not as it was before the rupture, which is impossible, but as it might yet become: a past that can be narrativized and owned, a present that can be inhabited with something approaching equanimity, a future that remains open to possibility however constrained by circumstance. The physician who approaches this work with the seriousness it deserves is not merely a technician of pathophysiology but a practitioner of hermeneutic medicine — medicine that attends to the patient as a text to be read, a narrative to be held, a temporality to be reconstructed.

In this sense, the therapeutic encounter is itself a sacred act: a moment in which eternity briefly touches the broken continuity of human life, in which the scattered sparks of a shattered temporal world are, however partially and provisionally, gathered. This is the deepest meaning of the physician's vocation — not to cure, which is not always possible, but to witness, to hold, and to help reconstruct the time within which a human life can once again become livable.

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