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# The Last Council of Myth: Sussex, 1993, and the Long Formation of a Hermeneutic Medicine

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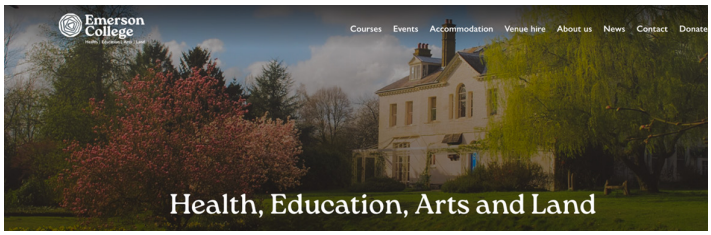
## ABSTRACT

*In the winter of 1993–94 a small circle of men gathered in an English field around a fire, a drum, and a body of stories. The teachers who moved through those years — Robert Bly, James Hillman, Martín Prechtel, Michael Meade, Richard Olivier — represented four incompatible epistemologies: poetry, image, ritual, and dramatic action. This essay argues that the mythopoetic gatherings of the early 1990s constituted the last sustained Western attempt to reunite poetry, depth psychology, ritual, and communal grief into a public mode of knowing, and that their dispersal was not a failure of ideas but a consequence of professional and technological reorganization. It further argues — against the movement's own self-understanding — that its central weakness was theological rather than political: it possessed a rich doctrine of the archetype and no doctrine of the broken vessel. The Lurianic categories of tzimtzum, shevirat ha-kelim, and tikkun supply what the archetypal imagination could not, and the substitution of the fracture for the archetype is what converts a mythopoetic sensibility into a clinical method. The essay closes with the personal image with which the Sussex week ended for this author, and with an account of the five transpositions by which a men's retreat in Sussex became, over thirty years, a hermeneutic medicine.*

**Keywords**
Mythopoetic movement, James Hillman, Robert Bly, Martín Prechtel, Archetypal psychology, Lurianic Kabbalah, tzimtzum, Hermeneutic medicine, Grief, Clinical epistemology.




## The Field

History rarely announces its turning points. They occur in monasteries and cafés, in salons and remote villages, and occasionally in an English field where a few dozen men gather around a fire believing themselves to be attending another workshop. Only decades later does one recognize that something larger had briefly come into existence and then, without anyone deciding it, ceased.

I attended such a gathering in Sussex in the winter of 1993–94. I went as a neurologist in mid-career, twenty years into practice, competent in neuro-diagnostics and increasingly uncertain what competence was for. I came home with a guided image on the floor of a pond that has organized the remaining thirty years of my intellectual life.

This essay is not a memoir, though it contains one. It is an attempt at intellectual history in the service of a clinical argument. The claim is double. First: the mythopoetic gatherings of the early 1990s were the final flowering of a lineage — Jung's lineage — that had held poetry, psychology, ritual, and community in a single conversation, and their dissolution marks a real discontinuity in Western intellectual culture rather than the exhaustion of a fad. Second: that lineage could not survive contact with the clinic on its own terms, because it lacked a theology adequate to catastrophe. What it lacked, Lurianic Kabbalah supplies. The passage from Sussex to the bedside runs through the doctrine of the shattered vessels, and it is that passage, not the men's movement as such, that produced whatever is original in my subsequent work.

A note on evidence. The precise composition of the Sussex platform in those years — which teachers taught on which weekend, under whose sponsorship, in which venue — is not something I can establish from memory alone, and I decline to manufacture a roster. The organizational history of the British men's work of that period is thinly documented and deserves proper archival treatment: attendance rosters, event flyers, the recollections of surviving participants and organizers. What is certain and publicly documented is the shape of the intellectual field: that Bly, Hillman, and Meade were by then long-standing collaborators; that they had jointly edited a poetry anthology explicitly designed for use in such gatherings [1]; that Prechtel had entered that circle after his flight from the Guatemalan highlands; and that Richard Olivier was at that time a working theatre director engaged in British men's work, a decade before the leadership consultancy for which he is now known. Where I reconstruct, I say so.

## A Civilization Rich in Information, Poor in Initiation

The early 1990s were a period of extraordinary confidence and quiet impoverishment.

The Cold War had ended. Liberal democracy was widely declared to have won. Universities multiplied knowledge at an unprecedented rate. Psychology grew more empirical each year. Religion continued to fragment into denominational subcultures. Communication accelerated; the World Wide Web became publicly usable in 1993, though almost no one at the fire that winter had heard of it.

Beneath the triumph lay a deficit difficult to quantify and impossible to ignore. People knew more than ever and possessed fewer stories by which to live. Initiation had substantially disappeared from Western life. Communities retained education, therapy, and entertainment; almost nowhere remained an institution whose function was to accompany an adult through suffering, vocation, grief, fatherhood, aging, and mortality — not to explain these, not to treat them, but to accompany them.

The mythopoetic movement arose in that vacuum. It is now routinely caricatured as nostalgic masculinity, and the caricature mistakes a symptom for a cause. Its deeper concern was never masculinity. It was the disappearance of a public grammar for meaning. Men happened to be the population in which the deficit was most visible and least articulate, and so they became the presenting complaint. The diagnosis lay elsewhere.

Two developments of exactly those years frame everything that follows, and they were invisible to us in the field.

In November 1992, the Evidence-Based Medicine Working Group published its manifesto in *JAMA*, naming and codifying a new paradigm for clinical practice — one that explicitly demoted clinical intuition, unsystematic experience, and pathophysiologic rationale in favor of formally appraised evidence [2]. Whatever its immense and real benefits, and they are immense and real, the manifesto also constituted a claim about what a physician *is*: a rigorous appraiser of aggregate data. Nothing in that description makes room for the physician as witness, interpreter, or fellow sufferer.

In January 1993, the *New England Journal of Medicine* published Eisenberg's survey documenting that a third of American adults used unconventional therapies, most without telling their doctors, and that visits to unconventional providers exceeded visits to all U.S. primary care physicians [3]. The medical establishment read this as a market problem or a public-health hazard. It was neither. It was a report of exile. Patients were seeking, outside the clinic, the accompaniment the clinic had ceased to offer.

The men in the Sussex field and the authors in those journals were addressing the same fracture from opposite sides and in mutually unintelligible languages. That is the historical situation this essay is about.

## Four Epistemologies

What made those gatherings intellectually unusual — genuinely unusual, not merely unconventional — is that they placed in one room four incompatible theories of knowledge and refused to adjudicate between them.

## Robert Bly: Poetry as Initiation

For Bly, myth was never literature. Iron John had appeared in 1990 and spent more than a year on the bestseller list, and its readers, hostile and admiring alike, largely missed what it was doing [4]. It was not an argument about men. It was an argument about symbolic perception: that a fairy tale is a compressed map of psychic transformation, and that reading it correctly requires the same discipline as reading a poem. Bly's earlier essay on the shadow had already made the method explicit — the long bag we drag behind us, into which everything unacceptable is placed in childhood and from which, in middle age, it must be retrieved [5].

His pedagogy was accordingly strange. He would recite a Rilke poem three times, refuse to explain it, and let the silence do the work. The poet was neither entertainer nor scholar but guide — a figure with no place at all in the modern division of intellectual labor.

## James Hillman: Soul Against Reductionism

Hillman had spent two decades arguing that the psyche speaks in images and that both the medical and the humanistic responses to those images are forms of violence [6]. To interpret an image literally is to misunderstand it; to explain it away as a symptom of something more basic — neurochemistry, childhood, social structure — is to destroy it. The alternative he proposed was to stay with the image until it discloses itself: to "stick to the image", to resist the reflex of translation.

In 1992 he had published, with Michael Ventura, a book-length polemic arguing that a century of psychotherapy had left the world worse [7]. That is the Hillman who was in circulation in Britain in 1993 — not the sage of *The Soul's Code*, which came later and made him famous in a way he found unhelpful, but the furious critic who had concluded that the interior turn had been a catastrophe of misdirected attention.

For a physician, Hillman is the most immediately dangerous and most immediately useful of the four. Dangerous, because his hostility to biological explanation, taken literally, would abolish my specialty. Useful, because he identifies with total precision the characteristic error of my specialty: the reflex substitution of mechanism for meaning, so complete that we no longer experience it as a substitution [8,9].

## Martín Prechtel: Ritual as Ecology, Grief as Praise

Prechtel introduced into that circle something almost entirely absents from modern intellectual culture: grief treated as a competence rather than a pathology.

His position — later given full literary form, though in 1993 it reached us only orally, before any of his books existed [10-12] — was that grief and praise are a single act, that the intensity of mourning is the exact measure of what was loved, and that a community which cannot grieve loses its capacity to praise and therefore its capacity to see. Ritual, in this account, is not symbolic behavior. It is the maintenance of reciprocal obligation between the living, the dead, the land, and the unseen. Modernity had not merely forgotten ceremony. It had defaulted on a debt.

The clinical translation is immediate and, for a neurologist, unavoidable. My entire specialty is a study in irreversible loss: the stroke that does not recover, the degeneration that does not arrest, the memory that does not return. We have built an elaborate technical apparatus for the management of these losses and no ritual whatever for their mourning — not for the patient, not for the family, and least of all for the physician [13,14].

## Richard Olivier: Dramatic Action and the Inherited Father

Olivier's contribution in that period has been retrospectively misdescribed, including in my own earlier drafts, and the correction is instructive.

The Shakespeare-as-civic-mythology work — Mythodrama, the Globe residency, Henry V as a leadership curriculum — belongs to 1997 and after [15]. It is not what he brought to a Sussex field in 1993. What he brought then was something rawer and more pertinent: the problem of the inherited father. To be the son of Laurence Olivier is to have been handed an archetype in place of a parent, and Olivier's men's work of that era circled the question of how a son extracts a life from beneath a monument [16].

That the same man later industrialized the material into an executive training product is not a betrayal to be sneered at. It is the single most economical illustration of this essay's central historical claim. The mythopoetic insight did not die. It was absorbed, priced, and made deliverable. The council became a consultancy.

## The Structure of the Disagreement

Set the four side by side and the incompatibility is stark. Bly trusted the poem; Hillman trusted the image and distrusted any use to which it might be put; Prechtel trusted the ritual act performed in an actual community with actual obligations; Olivier trusted embodied dramatic action.

Each held that modernity had confused explanation with wisdom. None proposed a return to medieval religion. None proposed abandoning reason. What they sought was a third position: the rehabilitation of imagination without the surrender of intelligence.

That third position has never been institutionalized in the West. That is the historical fact worth dwelling on. We have institutions to produce explanation, and institutions for the consumption of entertainment, and nothing whatever for the disciplined public use of image.

## The Jungian Genealogy and Its Dispersal

Here I want to advance a thesis I have not found stated in the scholarship, and then, as intellectual honesty requires, test it against what would falsify it.

## The Thesis

The gatherings of the early 1990s were the last moment at which the principal heirs of Jung's symbolic imagination stood inside a shared conversation. Jung died in 1961. His conviction that myth, dream, image, and ritual are indispensable to psychic life passed to Hillman, who radicalized it by stripping away its therapeutic and developmental apparatus. Bly transposed it into poetry and public performance. Prechtel embodied it in ritual practice grounded in an actual surviving cosmology rather than a reconstructed one. Olivier carried it into embodied dramatic action, and later into organizational life. By the late 1990s the cultural center of gravity had moved decisively toward evidence-based practice, cognitive-behavioral protocol, neuroscience, executive coaching, and the internet. The heirs dispersed into separate and mutually unreadable disciplines. They have not reconvened.

## What supports it

The dispersal is documentable and fast. Within a decade, Hillman was a trade-press author, Bly was primarily a poet and translator again, Prechtel was running his own school in New Mexico with its own idiom, Olivier was billing Fortune 500 companies, and Meade had founded a separate institute with a separate mission. The shared platform did not fragment gradually. It stopped.

## What complicates it

Three things, and they are serious. First, the Eranos precedent. The Jungian-symbolic conversation had a prior and more distinguished institutional form — the Eranos conferences at Ascona, which from 1933 assembled Jung, Scholem, Corbin, Eliade, and others in precisely the kind of cross-disciplinary symbolic inquiry I am claiming ended in the 1990s. If Eranos is the benchmark, Sussex is a late and thinner echo, not a culmination. And Scholem's own trajectory is a warning: he participated in that circle for decades while growing steadily more distrustful of the psychologization of Kabbalah, and Idel has since made the philological case against archetypal readings of Jewish mystical material with considerable force [17,18].

Second, the movement's own intellectual thinness. Very little of what happened at those gatherings was written down at the level of argument. That is partly a feature — the whole point was that the knowledge was not propositional — but it means the "conversation" I am claiming was interrupted may never have been rigorous enough to sustain the weight of the claim.

Third, continuity. The Minnesota Men's Conference still convenes. Prechtel's school operated for decades. The lineage did not vanish; it decentralized and lost its capacity to command general attention, which is a different thing from ending.

## Where I come out

The strong form of the thesis — that Sussex was the last flowering — overstates. The defensible form is this: the early 1990s were the last period in which the symbolic-imaginal tradition had *public standing* in the West, in which a book of that lineage could sit on the bestseller list for a year and a general reader could be expected to have an opinion about it. What ended was not the lineage. What ended was its claim on the general culture. After 1995, symbolic knowing survives as a specialty product for self-selected audiences, priced accordingly. That is the discontinuity, and it is quite bad enough.

There is a further point, which belongs in Drob's territory rather than mine. [19,20] Jung's own most powerful visionary experience — the 1944 hallucinations during his cardiac illness, in which he witnessed what he understood as a kabbalistic wedding of *Tiferet* and *Malkhut* — was Lurianic in content. Jung recorded it as the most overwhelming experience of his life. The tradition that ran from Jung to Sussex thus began, at its most intense moment, in exactly the symbolic material to which I would myself be sent on the last morning in that field. Whether that is genealogy or coincidence I leave open. It is at minimum a strange rhyme.

## Why the Convergence Dissolved

Reconstructing the retreats matters less than answering this. I count five causes, in ascending order of importance.

## Professionalization

Every one of the four had, by 2000, a defined market. Markets require differentiation. A shared platform is commercially irrational once each participant has a distinct product.

## The evidence-based turn

The 1992 *JAMA* manifesto did not merely change how trials were appraised; it changed what counted as a reason. Within a decade, an intervention without a randomized trial behind it was not merely unproven but epistemically disreputable. Nothing in the mythopoetic repertoire — grief ritual, poetry, initiatory drama — is trial-shaped. The problem is structural, not evidentiary: these practices have no manualizable independent variable and no outcome measure that survives operationalization without becoming a different thing [21].

## The gender-political critique

Between 1995 and 1999 the movement was subjected to sustained scholarly attack — for essentialism about masculinity, for a mythic framing that occluded material power relations, and for the appropriation of Indigenous ritual by white men who bore no obligations to the communities from which it came [22-24]. Some of this criticism was unfair and some of it landed. The appropriation charge in particular deserves better than the defensive dismissal

it usually receives from participants: a drum circle in Sussex is not, and cannot be, the ritual it imitates, because ritual efficacy in Prechtel's own account depends on standing debt to a specific living community and a specific piece of ground. We had neither.

### The internet

The gatherings depended on an economy of scarcity: to hear these men you had to travel, sit, and stay. Once the material was available on demand, the container dissolved. What was lost was not information but *the constraint*, and the constraint was the pedagogy. Initiation cannot be streamed, because its operative element is that you cannot leave.

### The absence of a doctrine of catastrophe

This is the one that matters, and it is the pivot of the essay.

The mythopoetic movement possessed a rich account of the archetype and no account whatever of the *fracture*. It could describe the Wild Man, the King, the Lover, the Warrior. It could say that a man's suffering was the shadow-side of an image he had not integrated. What it could not say — what it had no vocabulary to say — was that some breaking is not a stage in a developmental sequence, not a shadow awaiting integration, not a summons to a fuller self, but simply damage.

Every clinician meets this weekly. The young man with a brainstem stroke. The mother with early-onset dementia. The child with a mitochondrial disease. There is no archetypal reading of these that is not obscene. The archetype always implies a *telos*: this breaking is for something. Told to a family in a neurology clinic, that is a cruelty.

The movement's great gift was permission to feel. Its great limitation was that it could not distinguish between suffering that transforms and suffering that only destroys — and it lacked the theological equipment even to pose the question. A framework that cannot say "this is simply broken" will eventually be recruited to justify the breaking. That is not a hypothetical risk. It is what happened to a good deal of the wellness industry that succeeded it.

### The Stone in the Pond

On the last morning, Bly led a guided imagery. I remember the fire had gone down, and the room was cold and someone had propped the door open onto the wet field.

I found myself in a walled garden, and the garden was heavily perfumed — that is the detail I have never been able to explain, because guided imagery is supposed to be visual and this was not, it was olfactory, and overwhelming. At the center was a pond of extraordinarily clear water. I dove. On the bottom, among ordinary stones, was a stone I turned over, and incised on its underside was a single word:

***זהר Zohar. Splendor. Radiance.***

Also, of course, the title of the sacred book.

I want to be careful here, because this is exactly the sort of anecdote that invites two equally lazy responses.

The first is credulity: a revelation, a sign, a calling. I do not think that. I had a yeshiva education and a doctorate in Ancient Near Eastern languages; the Hebrew alphabet is not an exotic import into my unconscious, and a man raised on Daniel 12:3 does not require supernatural intervention to produce the word *Zohar* under stress. Hillman would have said, correctly, that the demand to explain the image is already a refusal of it, and that the explanation and the credulity are the same evasion in opposite directions.

The second lazy response is dismissal: an artifact of suggestion in a susceptible state, of no evidential value. That is true and beside the point. The image was not evidence of anything. It was an *instruction*. I had, at that moment, no serious knowledge of the Zohar. I began to acquire it. That is the whole of the claim I want to make: an image can reorganize a life without being true.

What is worth noticing is *what the image contained that the field did not*. Not an archetype. A book. Not a figure to embody, but a text to read. The mythopoetic gathering, at its close, sent me out of the mythopoetic. It handed me back to hermeneutics — to a tradition in which the response to suffering is not embodiment but *interpretation*, and in which interpretation is understood as itself a form of repair.

That is the hinge of everything I have written since.

### What Kabbalah Supplied That the Archetype Could Not

The Lurianic myth, in its barest form, has three moments, and each performs work the archetypal framework cannot [25-28].

### Tzimtzum

The Infinite contracts, withdrawing from a point in order that something not-itself may exist. Creation begins in an act of self-limitation. Presence is made possible by voluntary absence.

### Shevirat ha-kelim

The vessels prepared to receive the divine light prove unable to hold it and shatter. This is not sin, not punishment, not a stage. The catastrophe is structural — built into the design, occurring before any human act. Sparks of light fall and lodge in the fragments.

### Tikkun

Repair proceeds by attention to particulars — the raising of individual sparks from specific shells — and is never complete.

Set this against the archetypal framework and the differences are not stylistic. They are the difference between two theories of suffering.

### First: The fracture precedes us

In Jungian and mythopoetic thought, the wound is generally *mine* — my unintegrated shadow, my failed initiation, my father's absence. In Luria, the breaking happened before anyone was there to cause it. Clinically, this is the single most useful theological proposition I know. It permits me to tell a patient the truth: that

what has happened to you is not a lesson, not a consequence, and not about you. Some things are simply broken, and the brokenness is older than you are.

### Second: Withdrawal is a mode of presence

*Tzimtzum* names something no psychological vocabulary I know names as precisely: the act by which one contracts one's own presence to make room for another's. The physician who stops explaining, who withholds the reassurance, who declines to fill the silence, is not being passive or withholding. He is performing an act with a structure and a cost [29]. I have argued elsewhere that the whole architecture of the therapeutic encounter can be rebuilt on this: not the physician's expertise expanding into the patient's uncertainty, but the physician's expertise contracting so that the patient's account has somewhere to stand [30].

### Third: The light is in the fragments

Not in the recovered wholeness, not in the integrated archetype — in the shards. This is the point at which Lurianic theology becomes a clinical method rather than a consolation. It licenses attention to the discarded particular: the odd detail in the history, the thing said on the way out the door, the symptom that fits no syndrome. Mythopoetic practice sought the underlying pattern. Lurianic practice attends to what fell out of the pattern [31,32].

### Fourth: Repair is endless and that is not a failure

Neurology is a specialty of incurable disease. A framework in which completion is the criterion of success renders my working life a sustained defeat. A framework in which repair is constitutively unfinished renders its ordinary work.

### Situating the Claim

I should be exact about where this places me among scholars whose work I depend on.

Elliot Wolfson has made the case, more rigorously than anyone, that the kabbalistic tradition thinks in a structure of simultaneous disclosure and concealment — that the veil is not an obstacle to revelation but its condition, and that the tradition's own erotics of interpretation resist the domestication that sympathetic readers characteristically impose on it [33,34]. My debt is total and my use is different: Wolfson reads the tradition on its own terms and with a scrupulous refusal of edification. I am doing something he would likely regard with suspicion — extracting a usable clinical posture from a body of thought that did not intend to supply one.

Michael Fishbane has shown how exegesis functions in Jewish tradition as a mode of religious existence, and how myth persists in and is generated by rabbinic literature rather than being suppressed by it. [35-37] This is the closest structural analogue to my own project: if reading can be a form of religious life, then reading a patient can be too — which is the thesis of my forthcoming monograph [38-40].

Sanford Drob has done the essential work on the Jung–Kabbalah relation, including its evasions [19]. His account permits the genealogical claim of Section IV to be made without romance.

Biti Roi's work on the *Tikkunei Zohar* demonstrates how the mystical text constructs the Shekhinah through the labor of exegesis itself [41]. Melila Hellner-Eshed's reading of the Zohar's own narrative circles — the *hevraya* walking, arguing, weeping over a verse — describes, better than any account I know, what a company of interpreters actually looks like [42]. That is what the Sussex circle was reaching for and could not sustain, and that is why the Zohar was, in retrospect, the right instruction to have received.

And Moshe Idel's critique stands as a permanent check on all of this: the philological caution that archetypal and psychological readings of kabbalistic material systematically flatten it [18]. I accept the caution and proceed anyway, with the disclosure that what I am doing is *appropriation for a clinical purpose*, not exegesis. The distinction matters. I am not claiming Luria taught bedside manner. I am claiming that his account of catastrophe is better than the one my profession uses.

## The Practice: What Sussex Looks Like in a Neurology Clinic in 2026

Everything to this point is intellectual history and theology. This section is the answer to the only question that finally matters: what does any of it do on a Tuesday afternoon in Merrillville, Indiana, in a room with a stopwatch running?

I want to be concrete, and I want to begin by conceding how hostile the conditions are.

The clinical encounter available to me in 2026 bears almost no resemblance to the one for which any of this was designed. The slot is fifteen minutes and frequently less. The documentation burden has migrated from the chart to the ambient AI scribe, which is a genuine improvement in the mechanics of note-writing and a subtle disaster for something else I will come to. Prior authorization consumes hours of clinical staff time weekly and functions, whatever its stated purpose, as a system of deterrence. Coverage is being withdrawn from precisely the patients least able to withstand its withdrawal [43]. Reimbursement rewards procedures and RVUs and is structurally indifferent to whether anyone was heard.

Nothing in the Sussex inheritance addresses any of this, and I want to say plainly that the encounter I am about to describe is not available at will. It is achieved against the architecture of the system, not within it, and the achievement is intermittent. Any account of hermeneutic practice that does not begin from the political economy of care is decoration [44-46]. I have argued elsewhere that the physician-retention crisis is not primarily a wellness problem but an epistemological one: physicians leave when the work no longer resembles the work they trained for, and no quantity of resilience modules addresses that [47,48].

So, the honest form of the claim is not "here is how to practice". It is here is what survives compression, and why some things survive it better than others.

The good news, such as it is, is that the practices Sussex left me are cheap in time and expensive in attention. The ninety seconds of named loss costs ninety seconds. The three minutes of unrecorded listening costs three minutes. What they cost is a kind of exposure the fifteen-minute slot is designed to prevent, and that cost is borne by me rather than by the schedule.

## Ten Practices

### The first minutes belong to the patient

Bly's discipline — receive the poem before analyzing it — transposes exactly. The patient's account of illness is a composed narrative with a structure, a set of omissions, a governing image, and an implied audience. Extracting "the relevant history" from it is a legitimate operation that nonetheless destroys the object.

The operational form is small: I do not type or write for the first several minutes, and now, when I use ambient transcription, I do not look at the screen at all. The yield is consistent enough that I would defend it on efficiency grounds alone. What arrives in minute six is categorically different from what arrives in minute two, and it is almost never elicitable by direct question. Patients do not front-load what frightens them. They bury it, and they bury it in a predictable position — after the medical recitation is complete and before they stand up [49-52].

This is also where the AI scribe introduces its subtle problem. Ambient transcription rewards a certain kind of encounter: verbally explicit, structured, information dense. It cannot capture silence, and silence is where the clinically decisive material lives. I do not think this argues against the technology, which has given me back real hours. I think it argues for knowing exactly what the technology is optimizing and refusing to let the optimization become the standard [53-55].

### Names

I use the patient's name, and I insist that trainees do. I say the name of a deceased patient aloud to the family rather than referring to "your mother's passing." I resist the ward habit of the anonymous case — the aneurysm in bed four, the interesting MS in clinic.

This sounds like etiquette and is not. In the Jewish mystical tradition, the name is not a label attached to a person but the point at which that person is individuated out of the undifferentiated whole; to know the name is to have access to the. The clinical corollary is a discipline of specificity: a syndrome has no name, a person does, and the diagnostic reflex is precisely a movement from the named to the categorical. I have made the extended argument in two places, and its most practical form concerns medical education, where the anonymizing habit is installed early and deliberately [56,57].

### Naming the loss before offering the plan

Prechtel's inheritance, and the single highest yield change I have made in thirty years.

When a diagnosis forecloses a life, the patient expected to have — the MS that ends the surgical career, the Parkinson's that ends the driving, the dementia that ends everything by degrees — I name the loss as a loss, in plain words, before I say anything about management. Ninety seconds, sometimes less.

The reason it works is that the alternative does something specific and destructive. Moving directly from diagnosis to plan communicates, unmistakably, that the loss is not a legitimate object of attention in this room. Patients receive this instruction and comply with it. They then bring their grief somewhere else, or nowhere, and it returns as non-adherence, as depression coded as a separate problem, as the family conflict that surfaces at month eight [13,58,59].

There is no ritual container for this in modern medicine. We are the only culture I know of that manages irreversible loss at industrial scale with no ceremonial form whatever. Ninety seconds of accurate naming is a poor substitute for a rite. It is what I have.

### Degenerative disease and the refusal of the redemptive frame

This is where the Lurianic correction does its hardest work, and where I break most sharply from the mythopoetic material I inherited.

Neurology is a specialty of the incurable. ALS, Huntington's, progressive supranuclear palsy, the dementias. The archetypal reading of these — the illness as summons, as initiation, as the shadow demanding integration — is not merely inadequate. Said aloud to a forty-one-year-old woman with bulbar-onset ALS and two children, it is an atrocity.

The doctrine of the shattered vessels permits me to say something true instead: the fracture preceded you, it is not about you, it is not a lesson, and there is nothing you failed to do. This is not consolation. It is the removal of a burden that patients are routinely handed by well-meaning people — the burden of finding the meaning in it — and its removal is experienced as relief with a reliability I did not expect when I started saying it [60-63].

What remains after the redemptive frame is withdrawn is not nihilism. It is the sparks-in-the-fragments claim: that whatever is recoverable is recoverable in particulars, locally, incompletely, and without any promise that the particulars add up. Which is, as it happens, an accurate description of what palliative neurology consists of.

### Dementia, and forgetting as something other than deficit

My largest and most theologically interesting population. The standard framing is entirely subtractive: MMSE points lost, functions lost, the person "no longer there." Families arrive already fluent in this vocabulary and devastated by it.

I have spent several papers arguing that the subtractive frame is a choice rather than a finding, and that a phenomenology of forgetting is available which does not require pretending the disease is benign [64-66]. The person is differently constituted, not absent. Memory in the Jewish liturgical tradition is not a storage function but a relational act, performed communally — which

means that a person who cannot perform it individually can still be held inside a community that performs it on their behalf [67,68].

What this changes in the room: I ask families what the patient can still do rather than only cataloguing what is gone, I take seriously the affective and musical channels that persist long past the linguistic ones [69], and I decline to describe the person in the third person while they are present. That last one is a small discipline that costs nothing and that I have watched change a family's entire posture in a single visit.

## Chronic pain, addiction, and the free-will problem

The population where my profession is at its worst and where the theology earns its keep.

Adherence language assumes a free agent who chooses correctly or incorrectly. Addiction medicine's disease model assumes a compromised agent who cannot be blamed. Neither is adequate, and the incoherence is not academic — it determines whether the patient in front of me is treated as a defector or a case. I have argued that the bounded-choice question is genuinely unresolved and that clinical practice should be built to tolerate that irresolution rather than pretending to have settled it [70,71].

The practical consequence is a posture: I do not moralize non-adherence, and I do not relieve patients of agency either. The Hasidic material on the animal soul, and the twelve-step tradition's insistence that surrender and responsibility are compatible rather than opposed, both models exactly this doubled stance — which is why I have spent so much time on the twelve steps as a clinical framework rather than a program to which I refer people [72-75].

## Trauma, and holding the neuroscience and the theology at once

I have a substantial PTSD practice. The temptation runs in both directions: to reduce the presentation to a network dysregulation with a protocol attached, or to spiritualize it into a soul-wound requiring no biological attention.

The discipline is to hold both readings without collapsing — which is Hillman's method, stripped of Hillman's hostility to biology. The network-based accounts of trauma that have matured over the last few years are, in my reading, converging on something the ritual traditions knew: that trauma is stored somatically and released relationally, and that the therapeutic container matters as much as the technique [76,77]. The three-tier model I have proposed is an attempt to build a clinic in which the neurobiological, the therapeutic, and the spiritual are separately resourced and not required to justify themselves in each other's vocabulary [78,79].

Religious trauma deserves separate mention, because it walks into a neurology clinic constantly and is almost never named. Patients raised in high-control religious systems present with somatic and dissociative complaints and a well-founded distrust of any authority in a white coat. The hermeneutic posture is the only one I have found that does not immediately re-enact the injury [80].

## Not-knowing as a clinical stance

Perhaps a third of what walks into my clinic has no diagnosis and will not get one. Functional neurological disorder, medically unexplained symptoms, the long tail of post-viral syndromes.

The profession's habitual response to this is either premature closure or a referral, and both communicate the same thing: your presentation is a failure of my system and therefore a failure of yours. The alternative is a disciplined tolerance of not-knowing, which I take to be a religious competence before it is a clinical one, and which requires the physician to remain in the room without the protection of a category [81]. This is the oldest concern in my bibliography and long predates Sussex: my first paper on it, measuring stress levels in neurological patients given an ambiguous diagnosis, appeared in 1985 [82].

This is where *tzimtzum* becomes most concretely operational. My expertise expands by default and fills the encounter unless it is deliberately contracted. When I have nothing to offer diagnostically, the contraction is not a fallback — it is the intervention [30,83,84].

## The improvised encounter

Every consultation departs from the plan. The patient says something that reorganizes the visit at minute eleven; the family member who was not supposed to be there is there; the reason for the visit turns out not to be the reason.

Medicine trains for protocol and calls departure from protocol error. But the improvisational capacity — the willingness to work with what has shown up rather than what should have — is not a lapse in rigor. It is a distinct competence with its own theology, and the Hasidic notion of divine sufficiency in improvised circumstance names it better than anything in the medical literature [85-87]. The clinical form: when the visit goes sideways, follow it. The thing that derailed the visit is usually the visit.

## What the physician does with the accumulation

Thirty years of this accumulates in the physician, and the profession has no permitted form for it.

Physician grief after a patient's death is unritualized, undiscussed, and — this is the part that took me longest to see — cumulative [88,89]. The moral injury literature has given us a vocabulary for the institutional version, but not for the ordinary sediment of a career spent adjacent to catastrophe [90-92]. Burnout framings locate the problem in the individual's resilience. It is not there.

What Prechtel understood, and what I have not found in any medical curriculum, is that grief unexpressed does not remain neutral. It converts into the specific deadness that patients accurately detect in their physicians and interpret as indifference. The technical term for this deadness in my profession is professionalism.

I do not have a solution to offer. I have a practice: I write. Nearly everything cited in these notes began as a way of metabolizing a specific clinical encounter I could not otherwise put down. Whether that constitutes a ritual or merely a coping mechanism

with an ISSN, I am genuinely unsure.

## Teaching It

The final and hardest question is whether any of this is transmissible, and here I am least confident.

I directed a PA program, and I have taught for decades, and my honest assessment is that the current apparatus of medical education selects against every capacity described above. Multiple-choice assessment rewards pattern-completion and penalizes the tolerance of ambiguity; the master-apprentice relation through which clinical judgment was formerly transmitted has been replaced by rotation blocks and standardized checklists [93-95]. Contextual errors — misjudgments arising from failure to attend to a patient's actual circumstances rather than from knowledge deficits — are a well-documented and substantial source of clinical harm, and they are precisely what the current curriculum is unequipped to reduce [96,97].

I have argued that the epistemology of clinical judgment is socially constructed and that the profession's confidence in its own objectivity is the main obstacle to improving it [98,99]. But I would not want to overstate what the alternative offers. The Sussex material was transmitted by immersion, over days, without assessment, to self-selected adults. Nothing in that transmission model is compatible with accrediting a cohort of two hundred. This is a real limitation, and I have not solved it.

What I can do, and do, is smaller: name the practices explicitly rather than modeling them silently, make the interpretive move visible when I make it, and tell students that the thing they are watching me do has a name and a literature [38,100,101]. Whether that is enough to survive them is not mine to know.

## Objections

Four, taken seriously.

### "This aestheticizes suffering"

The strongest objection, and the one I have felt most sharply at the bedside. There is a real and disgusting failure mode in which a physician finds a patient's catastrophe *interesting* — narratively rich, symbolically apt — and in which the interpretive posture becomes a form of connoisseurship at the expense of the person in the chair. The Lurianic frame is my defense against this precisely because it insists the fracture is not for anything. But the defense is theoretical, and the temptation is practical, and I do not claim immunity.

### "This is unfalsifiable and therefore not medicine"

Correct as to the first clause, and the second does not follow. None of what I have described competes with the evidence base or substitutes for it; every patient described above receives standard investigation and standard therapy. What is at issue is the conduct of the encounter within which evidence is deployed, and it is an error of category to demand that a stance toward another person be validated by randomization. That said, the boundary between this and outright pseudoscience is real, consequential, and requires policing rather than assertion — I have tried to specify where the line falls and why it must be defended [102].

### "The mythopoetic movement's critics were right"

Partly. On essentialism: the movement did trade in claims about masculine nature that will not survive scrutiny, and the version of this material I use has no gender content at all — a fracture is not a masculine fracture. On appropriation: the criticism lands, and Prechtel's own framework supplies the reason it lands, as noted above. On the occlusion of material power: this is the objection I take most seriously, and it is why a substantial share of my subsequent work has concerned the political economy of care rather than its phenomenology [43,44,103,104]. A theology of suffering that does not attend to who is made to suffer and by what arrangement is a sedative.

### "You have reconstructed Sussex to suit a conclusion you reached later"

Almost certainly, in part. Thirty years of subsequent reading sits between the field and this essay, and no act of recollection is innocent of what came after. I have tried to mark the boundary between what is documented, what is reconstructed, and what is remembered. The image of the stone is the one element I am confident has not been retrofitted, because I have told it, unchanged, for thirty years to people who had no idea what the word meant.

## The Council That Did Not Reconvene

Bly died in 2021, Hillman in 2011. The gatherings continue in decentralized form and no longer command the general attention they briefly held. The material has been variously absorbed into leadership consulting, into the wellness industry, into men's therapy groups, and into nothing at all.

What was lost was not a movement. It was a *format*: a room in which a poet, a psychologist, a ritualist, and a dramatist could disagree publicly about the nature of knowledge without any of them being required to produce a randomized trial or a market. We have no such room. Neither the university nor the clinic nor the internet has reproduced it, and the reasons are structural rather than accidental — each of those institutions requires precisely the differentiation the format forbade.

I do not think it will be reconvened. I think the correct response is not to mourn the council but to do what the last image of that week instructed: to go find the book, and read it, and read it against the patient in front of you and understand that the reading is itself the repair. The Zohar's own image of intellectual community is not a platform. It is a company of friends walking on a road, arguing about a verse, and weeping.

I dove into a clear pond in an imagined garden, and turned over a stone, and found on its underside a word I could read.
I have been reading it since.

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